

# appendix

## RESEARCH DESIGN AND METHODOLOGY

This appendix describes the research design and methodology used in the study that formed the basis for this book. Beginning with a brief exploration of the nature of qualitative inquiry, a case is made for its use in nursing investigations that focus on human experience. The methodology used in the study, hermeneutic phenomenology, is discussed. Specifics about the study participants, collection, and methods of data analysis are described. Techniques used to maintain data trustworthiness, assumptions made, delimitations and limitations of the study, and ethical considerations are included.



### QUALITATIVE INQUIRY

This qualitative study was designed to explore aspects of exemplary nursing care. The goal of this type of study is the accurate portrayal and interpretation of what is being investigated from the participants' viewpoints.<sup>178</sup> Benner and Wrubel maintain that this approach is appropriate when studying human experience in complex, elusive, and still largely unexplored areas such as exemplary nursing care.<sup>179</sup>

The assumptions, premises, and expectations of qualitative research are most congruent with the traditional values of nursing as a personalized, intimate, and holistic human service. Qualitative research attempts to grasp the essential features of phenomena so the essence of the person, object, or experience is revealed.<sup>180</sup>

To accomplish this goal, qualitative researchers enter the participant's world to gather information first-hand through oral and written accounts, symbols, language, and observations. As Loiselle and Profetto-McGrath define this approach, it is characterized by a research design that is flexible and emergent; the researcher may reformulate and expand the study and approaches used as the study proceeds.<sup>181</sup> These design decisions reflect what the researcher has learned as the study takes place.

The goal of this study was an exploration of the nature of exemplary nursing. To succeed in such a quest, a method that encourages close contact with participants in their worlds is necessary in order to see the context in which they work and to view exemplary care in a holistic manner.

#### HERMENEUTIC PHENOMENOLOGY

The terms methodology and methods are often confused. Methodology refers to the philosophic framework, general orientation to life, the view of knowledge, and fundamental assumptions associated with a certain research approach. Method is the steps or procedures for gathering and analyzing research data.<sup>182</sup> In some ways, methodology is the theory behind the method. Van Manen adds that the methods that are used need to be developed in response to the research question and must be congruent with the methodology chosen.<sup>183</sup> The first step is the determination of the methodology. Once the methodology is clear, the research methods to be used become evident. The methodology for this study was hermeneutic phenomenology.

Hermeneutics is an approach to studying humans that is rooted in the philosophy, and based on the views, of phenomenologist Martin

Heidegger.<sup>184</sup> According to van Manen, hermeneutics is the interpretive study of the expressions of lived experiences in the attempt to determine the meaning embodied in them.<sup>185</sup>

Phenomenology is the study and description of human phenomena. As Lavery explains, the terms phenomenology and hermeneutics are often used interchangeably; however, phenomenology focuses on the “lived experience” whereas hermeneutics refers to the interpretation of the experience.<sup>186</sup> Gaut used the two words in combination, defining hermeneutic phenomenology as the interpretation of concealed meaning within a phenomenon.<sup>187</sup> It becomes difficult, and perhaps unnecessary, to differentiate between hermeneutic (the interpretation) and phenomenology (the description) since, at one level, a description is itself an interpretation.

A basic tenet of phenomenology is that each person is unique and possesses potential. Researchers who pursue phenomenological studies ask the question: “What is the essence of this phenomenon as experienced by these people?” Phenomenologists assume that this essence can be described and understood.

Merleau-Ponty explains that the word essence should not be mystified. He notes that essence may be understood as a description of a phenomenon. The essence is “a linguistic description that is holistic and analytical, evocative and precise, unique and universal, powerful and sensitive.”<sup>188</sup> According to van Manen, “The essence or nature of the experience has been adequately described in language if the description reawakens or shows us the lived quality and significance of the experience in a fuller or deeper manner.”<sup>189</sup>

Van Manen describes the characteristics of phenomenological research. It begins in the world of those being studied. Lived experience is the starting point and end point of phenomenological research. “The aim of phenomenology is to transform lived experience into a textual expression of its essence.”<sup>190</sup> In van Manen’s view, the phenomenological investigation does not result in a theory with which the world can be explained; rather, it offers plausible insights that

bring us all in more direct contact with the world.<sup>191</sup>

The focus of phenomenology is on meaning, and the goal is to explicate meanings as we experience them in our everyday existence. Hermeneutic phenomenology is a human science which studies persons. It is not interested in the generalizable; it is a philosophy of the unique, interested in what is essentially not replicable.<sup>192</sup>

Heidegger describes phenomenological research as a minding, a heading, a caring attunement.<sup>193</sup> To van Manen, it is “the attentive practice of thoughtfulness.”<sup>194</sup> The latter cautions, “To do hermeneutic phenomenology is to attempt to accomplish the impossible: to construct a full interpretive description of some aspect of the life world, and yet to remain aware that lived life is always more complex than an explication of meaning can reveal.”<sup>195</sup> Despite this cautionary note, an attempt at the impossible still has merit. Though a description can never be complete, it does bring us closer to an understanding of a phenomenon.

There is no step-by-step method for doing phenomenological research. Merleau-Ponty advises that the only way to learn it, and understand it, is to do it.<sup>196</sup> Gadamer, supporting this position, writes that the method of hermeneutic phenomenology is that there is no method.<sup>197</sup>

Although there is no specific method, there is a tradition, a set of guides and recommendations. Phenomenologists search for “the critical moments of inquiry.” As van Manen states, “such moments depend on the interpretive sensitivity, inventiveness, thoughtfulness, scholarly tact, and writing talent of the human science researcher.”<sup>198</sup> Benner and Wrubel maintain that the products of hermeneutic phenomenology inquiry may include thick description, paradigm cases, exemplars, and thematic analysis — all of which explicate meaning and ways of being.<sup>199</sup>

The hermeneutic phenomenology approach in this investigation contributes to our understanding of the experience and it can inform the way we think and feel about exemplary nursing care. In brief,

what this chosen methodology contributes is the rich contextualized detail of this human experience. Table 1 summarizes the elements of hermeneutic phenomenology.

**TABLE 1: ELEMENTS OF HERMENEUTIC PHENOMENOLOGY**

Derived from the philosophy of phenomenology
Behavior studied in context, direct contact with participants
Based on actual realities of people as they live through their experiences
Emphasizes meaning, lived experience, textual expression of the essence
Meaning guides behavior
Goal — discover meaning and further understanding of phenomena
Does not attempt to generalize
Analysis and data collection occur simultaneously
Interviews are main method of data collection
Interpretation of data aims to unveil hidden meaning
Analysis generates exemplars, cases, and themes
Data are left intact; researchers search for the essence
Literature review serves as background meaning for analysis
Validity is checked by participants responding to textual expression of the essence
Provides rich detail that can inform practice
Study dependent on creative insights of the researcher

## RESEARCH METHOD

This section describes the research project that informed this book: the participants, methods of data collection and analysis, trustworthiness, assumptions, delimitations and limitations, and ethical considerations.

### Participants

The general principles employed when selecting a group of participants in qualitative research are appropriateness and adequacy.<sup>200</sup> Appropriateness refers to the degree to which the choice of informants and method of selection fits the purpose of the study. Adequacy is related to sufficiency and quality of data. If the sample is “efficient,” (that is, the respondents freely provide insightful and numerous comments and examples, and there are many opportunities of meaningful observations), the size of the sample can be small and still be adequate.<sup>201</sup> It is desirable to have informants who are articulate, reflective, patient with the process, and willing to share their views with the researcher. To ensure appropriateness and adequacy, the researcher must have control over the sample.

My goal was to locate a group of nurses who were considered by their peers to be exceptionally competent practitioners. I had narrowed my clinical study area to oncology, so I attempted to find oncology nurses who met my criterion.

After gaining access to a nursing unit in a large, urban care facility where the majority of the patients had cancer, I distributed letters through the hospital mail system to all registered nurses (RNs) who worked on that unit. In the letter, I introduced myself and my research and asked them to independently construct a list of names of nurses who worked on their unit who they believed were exceptionally competent. This method of selecting exceptional practitioners had been used in studies of expert nurses,<sup>202</sup> and excellent physicians.<sup>203</sup> Benner and Wrubel report that expert nurses are easily identified by asking for nominations from their colleagues.<sup>204</sup>

To clarify for the nominating nurses what I meant by “exceptionally competent,” I asked them to consider those nurses who they would choose to have care for them or their family members if they had cancer. In my view, this was the essential criterion, the one that would encompass many of the important aspects of excellent nursing practice. As a side note, as I have explained my research method to groups of nurses across Canada in more recent years, this method of selecting exemplary nurses has received the approval of many audiences. When I say, “I am sure right now each of you could think of those nurses you work with that you would want to care for you” there is always a chorus of the affirmative responses from the audience. This gives me confidence in this participant selection process.

For the study, the nurses were free to nominate themselves and any other nurses from their unit that they believed met the criterion. To increase their level of comfort in participating in this exercise, the nurses were assured that no nurse would ever know for certain if he or she had been nominated, except for the nurses who were eventually invited to participate in the study. This was facilitated by choosing the actual study participants randomly from the list of nominated nurses.

The written, anonymous, nominations were placed by each nurse into a sealed envelope which was collected by the unit manager and delivered unopened to me. I did not know from whom each list of nominees had come. During the three-week period between the distribution of the letter requesting nominations and the submission of the nomination lists, I was available on the nursing unit at specified times to answer questions and concerns regarding the nomination process. There were very few questions, but this face time on the nursing unit did help the staff to get to know me and increased the comfort level between us which proved to be very helpful during the data collection phase.

After the nomination phase ended, I compiled the names. Of the 30 nurses who were asked for nominations, 25 responded with a list of nominees. There was remarkable consistency among the names of nominees. The same names appeared on most of the nomination forms to such an extent that I felt comfortable that I had a pool of exceptionally competent nurses from which to choose study participants. The eventual master list contained the names of nurses who were nominated at least 20 times. From this list, six nurses were randomly chosen to participate in the study.

The nurses who were selected as potential participants were sent letters formally inviting them to be part of the study. Those interested in becoming study participants signed an informed consent form and returned it to me. All the nurses who were approached agreed to be in the study. The names of other nurses who were nominated at least 20 times but who were not randomly selected from the master list were kept in reserve. By the end of the study, two more nurses were added to the sample for a total of eight participants.

Who were the exceptional nurses who were studied? A composite picture of the nurse participants emerges in the following description of the daily routine on the nursing unit where the study was based. The nurses featured in this scenario are the eight study participants. This illustration serves several purposes. First, it includes a depiction of the nurses studied, letting you see the pertinent demographics of the study participants. Though they were all unique, it is interesting that their demographics overlapped in many spheres. Second, this description provides an example of the routine followed by a clinical oncology nurse working on the study unit. This affords you an understanding of the context and setting in which oncology nurses work. While no two days, or two shifts, or two nurses were exactly the same, there were similarities that make it possible for this composite description of an average day to be constructed. To help the reader get to know the participants, their average day is described in the following section.

### An average day on the unit

It's 0700 hours and the eight RNs participating in the study (Jane, Maureen, Marie, Julie, Lana, Peter, Moria, and Cindy) were gathered around a table in the conference room to listen to a tape-recorded report on the condition of each patient staying on their unit. The report is provided by the nurses who are just finishing the night shift. As I look about the room, I am surprised at how alert the staff members look. I wonder how they can exude so much energy at this hour of the morning.

They have dressed thoughtfully. One is wearing a peach-colored uniform with a lacy collar that she crocheted herself. Another wears a bright smock over her scrubs. "We need a little color around here," she chirps when one of her colleagues comments on her uniform. As they wait for the nurse in charge to enter the conference room and begin report, the nurses enthusiastically exchange tales about their personal lives.

They are all women, except one, and the oldest of them has not quite reached her sixth decade — the youngest is 29. All but one are married. Most of the married nurses have children varying in age from toddler to young adult. Each nurse has worked on the study unit for a minimum of two years; the most senior has 11 years of oncology experience. For one woman, nursing is her third career. She had been a teacher and school principal before becoming an oncology nurse two years ago. One nurse had 20 years experience in the operating room before transferring to the cancer unit two years before. Stories of juggling the needs of their children, spouses, community, and other commitments permeate the pre-report conversations.

The charge nurse enters, and the air becomes quiet and professional. Outside the closed door of the conference room, the night-shift nurses hurry to finish their tasks — such as making notes on each patient's chart and answering call bells. Report begins. The day nurses and I listen to the jargon-laden details of each patient's condition.

“Mr. Jakes in room 10 slept well and needs to have a urine specimen collected this morning. Mrs. Kennedy in room 12 is due at the x-ray department today, and her intravenous bag only has 100 mL to be absorbed. Mr. Millright in room 14 experienced a lot of pain during the night and needed analgesic medication every three hours. He is due for a scan today. His daughter called and she was very tearful.”

The report goes on until details of each patient have been recounted. The nurses have carefully recorded the pertinent information regarding the patients assigned to them and, as the voice on the tape machine says, “Have a great day shift,” the nurses gather their notes, place them in uniform pockets, and set off to do morning rounds. As they leave the conference room, the nurse in charge calls out words of encouragement saying, “We are short one nurse today. Marg called in sick and they can’t replace her. It looks like we have a lot of heavy patients. Let’s work together!”

Each nurse is assigned to give care to a group of patients. The patients who are critically ill or close to death stay in private rooms; others may be in semi-private accommodations. The number of patients in a nurse’s assignment varies depending on the amount of care each patient requires. Jane has six patients today, while Maureen has only one very ill man to care for.

Morning rounds consist of a quick check on the patients to meet any immediate needs such as toileting assistance, replacement of intravenous bags that are low, or realignment of people who are uncomfortable. During rounds, priorities are set and plans are made by each nurse for the care to be given that day. The common morning rounds questions addressed to patients include, “What time would you like your bath? Are you expecting any visitors today? What is your pain level — should we try your pain pills every three hours? How is your breathing?”

The morning proceeds smoothly — a series of breakfast, baths, and personal hygiene interventions punctuated with administration

of medications and ongoing assessment of each patient's physical and emotional status. Interruptions by doctors seeking information, family members needing reassurance, and colleagues requiring assistance are all incorporated readily into the routine. "Routine," Peter explains, "is part of each day. You need it to make sure certain tasks get done.... It gives structure — backbone to the more creative parts of nursing."

I am fascinated by the perpetual motion. It seems the nurses never stop moving, talking, questioning, listening, lifting, and writing. Often they do two or more tasks simultaneously. Finally, they take a break. We gather at the elevator to go to the cafeteria for lunch. The nurses take their meal breaks in two shifts. Before leaving the unit, each nurse reports to another nurse who is staying behind, making certain all patients will be cared for in their absence.

At lunch, I find out more about these nurses. They have such busy lives outside their work. For example, one collects dolls, one sews, one golfs and swims, one paints, one enjoys the outdoors and nature, one plays four musical instruments, one teaches Sunday school and is president of her community league, and one has three preschoolers. Animated discussions tell me they are as passionate about their hobbies and interests as they are about nursing. In conversation, Lana says, "I believe that we can be better nurses if we have something else in our lives besides nursing." Everyone agrees with her.

We talk about their education. "Where did you study nursing?" I ask. They have all completed a registered nurse diploma program. Two have finished post-basic bachelor's degrees in nursing in addition to their diplomas. Lifelong learning is a value each nurse expresses, and they talk about the importance of "staying current" by attending conferences, reading professional journals, and asking questions.

Our break is short because there are medications that are due to be administered, Mrs. Jones needs to be repositioned, and the physiotherapist is coming to show them how to use a new patient-lifting device that will "save their backs." As we proceed toward the

elevator to return to the nursing unit, they make the transition in their speech and demeanor back to the world of work.

The afternoon goes by quickly. It seems most of the plans made this morning have been modified, and the nurses are now being driven primarily by the request of patients and physicians. There is a flurry of activity just before shift change at 1500 hours as the day nurses try to squeeze in time to complete the charted notes on each patient and to tape-record report for the nurses who will be working the afternoon shift. Simultaneously, they greet visitors, explain changes in each patient's status to doctors and family members, and answer patient call bells with grace and cheerfulness. I could best describe the afternoon as "endless interruptions," yet they all maintain their poise.

There is a detectable sense of relief in the air as the afternoon shift nurses begin to arrive. The day nurses are starting to look fatigued. Their once-fresh uniforms are wrinkled and stained, and their steps are a little slower. As they put on their coats to go home, they talk about how tired they are, but they still smile. There is a sense of achievement; the team has pulled together, and they collectively feel satisfied with the quality of care they were able to give. Getting on the elevator to leave, Julie turns back. She has forgotten to tell her replacement nurse that Mr. Yin asked for ice cream for supper, and she wants to make sure he gets it — she promised.

### Data collection

To be true to the tenets of hermeneutic phenomenology, I chose data-gathering approaches that ventured into the participants' worlds, thereby studying human experience in context. I sought to find ways of reaching into the realities of the exceptional nurses to try to capture how they were experiencing and functioning in their work worlds. By choosing to use a combination of field-based methods including observation, in-depth interviews (conversations), and narrative exchange, I endeavored to get a comprehensive view of exceptional nursing practice.

Each nurse was studied individually. Observations were conducted with each participant over a period of approximately 40 hours, covering a variety of shifts and days of the week. Following or during the observation period, I held an in-depth interview that was more like a conversation with each participant.

After a period of retreat from the study site and initial analysis of the data, further conversations were conducted with some of the participants. In addition, the process of narrative exchange was initiated with all participants. This resulted in several supplemental contacts with most participants.

### Observation

From the beginning of my field work, I recorded my observations, thoughts, and insights in a research journal. Throughout this discussion of data collection methods, I include excerpts from this log as I think they most clearly communicate the details of the process undertaken.

My field notes were not as precise in their execution as I first imagined they would be. I did make discoveries and change my data collection tactics as I proceeded. However, I always tried to remain very aware of what was happening, or where my research was leading me. I believe the result of my openness to letting go and learning from others is an accurate and intimate portrayal of exceptional nursing practice.

One example of a change in my approach was a move from a participant-observer role to that of an observer-participant. The following journal entry details this transition.

It's 0600 hours and I struggle out of bed and put on my uniform to start another day of observations on the unit. As I drive toward the hospital and think about my plans for the day, I am glad I made the decision to observe rather than participate.

When I started the study, I imagined being like a second set of hands to the nurse I was observing — a participant-as-observer in textbook terms. But it just wasn't working. Sure, I was a "big help" since I am an oncology nurse too, but I was missing the action as I ran here and there delivering cups of tea or answering call bells. The nurses were confused about what I could and couldn't do (as I wasn't an employee, I was limited to volunteer roles); in fact, even I got confused sometimes. It's hard to remember I'm a researcher and not a nurse right now.

Being an observer-participant is better for my purposes. Now I'm just like a shadow; I stay quiet and out of the way, and I am surprised that no one even seems to notice me anymore. I think what I am observing is more real somehow; the nurses aren't performing for me anymore. They seem to have forgotten that I am even there.

Pearsall was one of the first to describe the role continuum for participant-observers, a continuum ranging from complete observer to complete participant.<sup>205</sup> According to Pearsall, in the observer-as-participant role, the researcher remains "detached and objective" and observation takes precedence. Alternatively, in the participant-as-observer role, close interpersonal relationships may develop with informants as the observer enters the social and cultural milieu of the participants.<sup>206</sup> The observer-participant role was most appropriate during the observation phase of the study; however, during the interviews and narrative exchanges, I became more interactive and intimate with the participants.

My observations were primarily of nurse-patient encounters. However, as this entry from my research journal describes, I did expand the scope of my observations as the study progressed.

I find I am observing the nurses everywhere we go — not just with patient interactions, but also when they are on breaks, in conferences, or attending rounds. Perhaps because they know I'm a nurse, they seem really comfortable with me and invite me to follow them into the medication room and some of their other "insider" spaces.

When appropriate, brief notes regarding the observations were made during the shift. Notes were recorded away from the scene of the interactions. At the completion of every observation shift, I elaborated upon these comments in my research journal.

I originally planned to keep a separate diary to log research-related ideas, fears, mistakes, confusions, breakthroughs, and problems. However, it became difficult to separate feelings and observations, so both process items and the details of the research observations were documented in the same journal.

I believe that my experience as an oncology nurse prepared me to make meaningful observations and also to know how to observe without compromising patient care or making anyone uncomfortable. This journal entry summarizes that struggle.

I worried a lot at first about whether or not I would be sensitive enough to what was happening to know when it was in the patient's or nurse's best interest to step out and not observe a particular moment. I didn't want to prevent something important from being said, or make anyone feel uncomfortable. Today, I just stayed outside the room when Mr. Kim had his enema. Somehow I felt he would be uncomfortable with me there, too. Afterwards the nurse thanked me for being so tactful. When the mother of that girl with the brain tumour started to cry with the nurse I was observing, I just backed away to give them the private moment they needed.

The observation phase of the study provided very rich data. I wrote in my journal,

I am so glad that I decided to include observations in data collection. The nurses can't always put into words what they were doing and why. They couldn't tell me, but their actions showed me. The looks, tears, hugs, smiles, hesitations, or playful touches couldn't have been captured except by the camera of my mind. A lot of exceptional nursing care is in the non-verbal.

Levine advises that some things can only be learned by wading in slowly, from the direct experience of the ocean lapping against our bodies.<sup>207</sup> The observational phase of this study allowed me this opportunity to wade in and experience the oncology world the way the nurses were experiencing it.

#### Interviews

The interviews — or, more appropriately, the conversations — conducted as part of data collection were open dialogues about the meaning of exceptional practice and each nurse's experiences in oncology nursing. To encourage the informal nature of these encounters, they were held in places that the participants identified as most convenient and comfortable for them. Most of the conversations were taped with the permission of the nurses, and the tapes were transcribed. The conversations used an unstructured approach with open-ended questions. This seemed to unlock the idea gate and encouraged the participants to tell their stories in their own words. Polit and Hungler counsel that, "Imposing structure on the research situation by deciding in advance exactly what questions to ask restricts the portion of the subject's experience that will be revealed."<sup>208</sup>

I found the unstructured method resulted in long discussions filled with accounts of exceptional moments from the work lives of

the nurses. Through their stories, they freely shared their beliefs about oncology nursing, their feelings about what they do and why it is effective, and their attitudes about their work. Most conversations lasted between one and two hours.

### Narrative exchange

According to Benner, experienced nurses can readily bring to mind clinical situations that altered their approach to patient care. She called these paradigm cases.<sup>209</sup> A systematic study of these cases can reveal embedded knowledge. Following the observation and conversation phases, I turned to collecting the nurses' written stories of their most memorable practice moments — their paradigm cases.

During the data collection phase, I had written in my journal my own transformational patient-care experiences. As I asked study participants to record their stories for me, I became interested in the idea of narrative exchange, a written dialogue between the researcher and the participants. In my research journal, I wrote of this idea.

Today I had an interesting idea. What about talking to the nurses through my own stories? Sometimes hearing someone else's experience really triggers your own memory, and if someone is open with you, it encourages openness in return. Maybe if I share my stories with them, they will be willing to reciprocate. If we are really in this together like I have said we are, exposing part of me may liberate part of them. This is more like doing research with them instead of on them or to them. I think I will call this process narrative exchange.

The narrative exchange data-collection process involved me offering each participant a letter and several of my own narratives, suggesting that they too might have stories of exceptional practice moments they would be willing to share. In the letter, I asked, "Who are the

patients you still remember? Can you recall particular moments with them that were most important or perhaps changed you or your practice?"

The response was varied. One nurse wrote about a single critical moment, while others wrote many pages about detailed exchanges with their past patients. They all offered striking examples of exceptional nursing practice. The knowledge revealed through the stories was contextualized and personal. Each story was unique — rich with its own cadence, style, personality, and wisdom.

As Ellis and Flaherty believe, research methods need to “shrink the distance” between the research participants and their experience.<sup>210</sup> The writing of stories offers this opportunity. Ellis and Flaherty go on to say that, “writing stories is a conversation with self and through this conversation we come to know ourselves.”<sup>211</sup> Narrative exchange is a method that can make a lived experience understandable to self and others and a means by which this understanding can be communicated.

As the nurses wrote their stories, many stated in notes or conversations with me how meaningful the writing experience was for them. In a card, Marie wrote,

I would like to thank you for asking me to share some of my memories. After reading your memories, I wanted to begin to write immediately, but I couldn't. My special moments were hard to retrieve. Many of them were difficult, some were sad, but all left a deep imprint on my perception and on the way I do things today. This was indeed a valuable exercise for me; like you, I relived some successes and some fears too, all of which have produced the nurse I am now. I feel truly blessed by what I have taken from these experiences, for what I've become because of them, and for what I have been able to do for others.

Julie addressed these comments to me,

I just wanted to say thanks for helping me open up a part of me that I could have shared in no other way but by writing my stories. There was something so liberating about sitting down with a blank page. I just sat and talked to the paper, and to you. The memories just came flooding back. Perhaps I've guarded them, protected them like keepsakes stored away in a secret chest. Now I'm so happy to have the chance to share them. It has helped me see the whole picture of my practice.

The use of observations, conversation-like interviews, and narrative exchange as described was in keeping with the data-collection methods appropriate to hermeneutic phenomenology. These data-collection methods produced abundant data to be analyzed and understood.

### Data analysis

In qualitative research, most times data collection and analysis occur simultaneously in a spiral of increasing complexity rather than alone in a linear continuum. As the researcher ascends through the various levels in the spiral, new dimensions of understanding are uncovered and new questions emerge that expand and support the findings.

Polit and Hungler note that, "There is no systematic, universally accepted rules for analyzing and presenting qualitative data."<sup>212</sup> However, in approaching data analysis, there were certain principles that I sought to uphold. For example, I wanted to be true to the nurses who participated. To me, this meant including the context and, as much as possible, using the nurses' words — giving them a chance to express themselves in their own voices. Consequently, I used the nurses' stories and comments verbatim throughout the reporting of findings. Care was taken not to fragment the experiences because to do so would "distort that which they seek to describe."<sup>213</sup> The intact

stories facilitate knowledge being revealed to the reader without forcing interpretation.

There is no step-by-step method for analyzing phenomenological research data. As van Manen states, "The critical moments of inquiry are ultimately elusive to systematic explication. Identifying and communicating such moments may depend on the interpretive sensitivity, inventiveness, thoughtfulness, scholarly tact, and writing talent of the human-science researcher."<sup>214</sup> The aim of phenomenological analysis is to "construct an animated, evocative description (text) of human actions, behaviors, intentions, and experiences as we meet them in their life world."<sup>215</sup> It focuses on describing essential themes; it is "a thoughtful, reflective grasping of the special significance of this or that particular experience...bringing into nearness that which tends to be obscure."<sup>216</sup> Anderson summarizes, claiming the intent of phenomenology is "not to build grand theories of nursing but to understand the lived experience of people."<sup>217</sup>

However, to discover the meaning of human experiences, some analysis is necessary. Guidance as to how this discovery can be accomplished is provided by Oiler.<sup>218</sup> Oiler suggests that analysis begins when the researcher reads all descriptions to obtain "a feel for them."<sup>219</sup> During this reading, researchers attempt to hold in abeyance their presuppositions about the phenomena so that the phenomena can be seen as they are, not as they are reflected through preconceptions.

Next, from each source, significant statements and phrases are identified, and meanings are formulated from these. The meanings are organized into themes which are displayed as a description of the experience. Uncovered themes provide the essence of the experience. To achieve validation, the researcher returns the descriptions to the participants for feedback.<sup>220</sup>

#### Multi-dimensional analysis

I followed the Oiler process and eventually designed a multi-dimensional analysis of the data. One part of the analysis does not necessarily

follow another in a step-wise manner, rather each is important and somewhat independent of the others. While each analysis makes an important contribution to the overall understanding of exceptionally competent nursing practice, one can appreciate an individual analysis for its own unique characteristics.

The first analysis was provided by the participants themselves as they shared their memories and comments with me. They offered personal reflections and meaningful insights on their descriptions of events. As the nurses wrote their stories and talked to me, they would often say, "What I learned from this was..." or "I think I did this to..." As the study progressed, the nurses reflected on their own descriptions and actions, and shared these with me, thus providing me with additional understanding. To me, this was valuable analysis provided by the participants themselves.

A second analysis was achieved by weaving together the stories, quotations from conversations, and field notes — arranged by themes — with the scholarly literature on each topic. This combination of what was seen and heard, with what has been published on these themes, provides the reader with an additional perspective.

A third component of understanding, the hermeneutical analysis, was reached through the writing of short original poems. As a researcher reviewing the materials, I thought about the essence of each story or observation. To communicate this essence in a concise and meaningful way, I wrote poetic interpretations. The poem is a way of communicating meaning without imposing extensive structure on the data. I agree with Ellis and Flaherty who say, "While any literary form imprisons lived experience...without some form or structure, it would be impossible to convey any experience."<sup>221</sup> Poetry provides succinct, yet dense, analysis. It is a means by which a researcher can communicate meaning received from the data. As van Manen suggests, poems are powerful means of sharing human experience because they do not require summaries. In his words, "The poem itself is the result.... To summarize a poem, to ask for

the conclusion of it, would destroy the result.... The poem is the thing."<sup>222</sup> Poems are able to communicate both the details — including the tacit, unspoken — and the emotion of an experience within the limitations of words.

As a side note, as I have disseminated the findings of this study to nursing audiences, it is often the poems that people respond to in positive way. Many ask for copies of the poems because, in their words, "They speak to me," or "They touch my heart."

The thematic analysis is the most obvious dimension of the multi-layer analysis. The stories, transcripts, and journal entries regarding observations were analyzed thematically. The emergent themes from the data were revealed using a process Mitchell and Jones called "thematising."<sup>223</sup> Through reading and rereading the data sources, I eventually settled on the major themes that are within the data set. As part of the analysis process, Owen's suggestion for identifying themes by using three points of reference — recurrence of ideas within the data (ideas that have the same meaning but different wording), repetition (the existence of the same ideas using the same wording) and forcefulness (cues that reinforce a concept) — were employed.<sup>224</sup>

The final dimension of analysis is left to you, the reader. By reviewing the verbatim words of the participants and the analysis of the researcher, you will form your own insights about exemplary nursing making the analysis more complete and personalized.

This multi-part account, I feel, is close to the nurses' realities. It is designed to capture and communicate the sublime, unstructured, and non-verbal, as well as the more obvious themes.

### Trustworthiness

Qualitative research requires means for assuring standards of rigor. I believe that what readers need regarding trustworthiness is to know what I did as a researcher that would increase their trust in my ability as a researcher. Several actions were taken to ensure trustworthiness. For example, the nurse participants reviewed some of

their own interview transcripts and field notes written on observations involving them. Written and verbal feedback and additional insights were offered by the nurses on these occasions. Two of the nurses reviewed drafts of the findings and stated they believed the insights represented their experiences.

Additionally, each method of data collection served as an opportunity to supplement the others. During the interviews, I was able to confirm my observations by sharing my findings and asking the nurses for clarification and further details. The interviews also provided a chance to discuss the analysis of the data as it was beginning to unfold. The narrative exchange netted stories that confirmed what I had been observing and hearing about during the interviews and what I had seen during the observation phase.

I also presented my preliminary findings to a small group of oncology nurses who were not involved in the study. These nurses commented that I was “getting the real picture” and “seeing exactly what was going on.” The final findings have been disseminated to nurses across Canada and internationally. The feedback I have received from these audiences gives me confidence that this portrayal of exceptionally competent nursing is accurate.

Other strategies used in this study to increase data trustworthiness included keeping the nurses’ comments verbatim and in context, tape-recording and transcribing interviews, using a research journal to record decision points in the research process, and using multiple data sources that confirmed one another. Prolonged engagement at the study site also enhanced credibility of the data. Data collection for this study took place over a period of 14 months, from May, 1992, to June, 1993.

This study is not meant to be replicated or generalized. It would be impossible to replicate because I studied a particular group of people at a particular time. Further studies of exceptional nurses would add to this body of knowledge; however, this study was designed to stand alone in the distinctive contribution it might make.

There are many considerations related to the use of self as a research instrument and the influence on data trustworthiness. Qualitative research requires the involvement of the researcher in this way. I was concerned initially that having been an oncology nurse for nine years prior to starting this project might negatively influence the quality of the study. Lipson notes that the quality of the data is influenced by the informant's perception of the researcher.<sup>225</sup> For example, the researcher's age, gender, culture, and profession may influence the amount, candidness, and honesty of the data. There was congruence between the participants and me on most of these factors. As a result of my experience as a cancer nurse, I was familiar with the role; yet, because I had not worked at the study site, I believe I was removed enough to be able to view it afresh.

Aguilar proposes that familiarity enhances ease of entry for the researcher because there is a common understanding of language, procedures, and experience. This can result in a more accurate account.<sup>226</sup> My comfort level on the unit, and consequently my ability to relate in a relaxed manner with staff and patients, was increased because I was familiar with the oncology milieu including the jargon, sights, smells, and emotion. To be a nurse, you need well-honed interviewing and observational skills which were directly transferable to my role as a researcher.

Another consideration in the use of self as a research instrument involves the researcher's own personal style, issues, values, and biases. Aamodt writes that the researcher's own ideas will pervade the research whether the researcher wills it or not, so therefore the best approach is assessment and acknowledgement of self prior to, and during, the research process.<sup>227</sup> Lipson observes that a beginning point is for the researcher to acknowledge these potential influences by describing his or her own background, giving the consumers of the research an understanding of where the researcher is "coming from" so they can make a judgment about the possible influence of the researcher's history.<sup>228</sup> Lipson contends that the researcher's biases

should not be considered a limitation but should instead be capitalized on as a rich source of data and avenues of learning about the setting.<sup>229</sup> Further, Lipson emphasizes that researchers must have self-awareness to minimize the negative impact of their underlying personal landscape on the research process.<sup>230</sup> Interestingly, although self-awareness is important for good fieldwork, doing fieldwork also helps develop self-awareness as it brings you face to face with your own values. In an attempt to reveal some of my possible values and biases to readers, Chapter 2 includes some of my more poignant memories of working as an oncology nurse, plus reflections from my recent experience.

### Assumptions

The assumptions of this study are compatible with the philosophy of phenomenology. It is assumed that meaning is a central concept in that it mediates human interactions. People are not merely reactive organisms; rather, they think about, and are deliberate in, their actions. I assumed that the nurses shared their honest perspectives. Finally, I assume that the essence of a phenomenon can be understood, described, and shared — and, indeed, that there is such an entity as exceptional oncology nursing practice.

### Delimitations and limitations

One important boundary for this study is its focus on nurses who specialize in oncology. This can be viewed as a strength in that it concentrates the research on an in-depth investigation of this group. A further delimitation is related to the number of respondents; in this study, the sample was eight nurses. Perhaps it would have strengthened this study if I had spent more time with each nurse. Although the literature on qualitative research counsels that the researcher may conclude data gathering once the point of “data saturation” is reached, I am not convinced that data saturation ever really occurs. Within this particular study environment, there were many aspects

of each interaction, and the elements were constantly changing. As long as I was exposed to the nurses who were meeting new patients daily, I was gaining enhanced — or perhaps new — understandings of exemplary nursing. However, given the reality that every study has to one day come to a formal end, data collection was limited to 14 months.

I realize there will always be explanations and ways of viewing these data other than those I have put forward in this book. As a researcher, I am limited by my abilities to perceive and communicate the meaning of experiences observed and discussed. I invite you to take what I have offered and to go beyond what I have done to venture alternative, or perhaps more insightful, understandings of exemplary oncology nursing. The data is presented in a way that it is available for remining.

### Ethical considerations

This research method carries with it many ethical considerations as I entered the nurses' worlds and sought to discover and report personal and intimate thoughts and experiences. It was a privilege to do so, and I made every effort not to abuse this. A fundamental principle guiding this research was that of beneficence, which encompasses the maxim: Above all, do no harm. With this in mind, I structured my design with the objective that no one concerned would be harmed or exploited, and so the potential of the benefits of the study would outweigh any risks. In consultation with the participants, we decided that the knowledge to be gained would have potential utility for many nurses and patients. The nurses also said that they would experience benefits such as increased self-awareness and enhanced self-esteem from participating and being labeled an exemplary nurse.

The informants and I discussed the possibility that participation in the study would change them and the way they provided care. We anticipated that reliving their meaningful nursing moments in the narrative exchange might cause them some personal distress.

To temper the potential harm, I made sufficient time to talk and debrief the nurses at various times. I was careful not to exploit the nurses' time by asking for too much. If I sensed that they needed solitude, I gave them space — physically and psychologically. If I noticed that any nurse was uncomfortable being observed to the point that it might impact the quality of care she provided a patient, I simply left the scene. I did not want any patient to be denied an act of compassion because the nurse was uncomfortable with me watching the encounter.

Formal ethical approval for this study was granted by a university research ethics board. All participants in the study signed an informed consent form. All data collected were securely stored and identifiers removed. The original data were destroyed following analysis. While confidentiality has been carefully guarded, total anonymity is never possible. The nurses who participated are known to each other and to me. I can link each participant with data associated with that participant. However, to facilitate anonymity to some extent, all examples have not been attributed to a specific respondent. Rather, sometimes comments, observations, and stories have been interwoven to provide an integrated picture of exemplary nursing practice.

I spent time preparing myself for field research, anticipating possible ethical situations that could arise and formulating what I thought would be appropriate responses. What would I do if I saw a nurse providing what I considered unsafe care? How would I respond if a patient in serious need asked me for help I couldn't give as a "volunteer"? What would my response be if a nurse I was observing asked for my help beyond my designated scope of practice or advice? By talking with the participants openly about my role before starting the study, these occasions were rare. My observer-as-participant stance also reduced the occurrence of these situations.

I also deliberated about how much I should disclose to informants about myself. My concern was that it was unjust to ask the nurses to share so much about themselves with me without disclosing something

of my situation. Where was the point where sharing my own stories would increase the connection between us, and therefore candidness and depth of the interviews and narrative exchanges — and where would it interfere? Following the advice of Young and Tardif, I intentionally shared some of my own relevant experiences at appropriate moments in each relationship.<sup>231</sup>

Another ethical consideration was the need to be true to the nurses in the study — to record, interpret, and convey their feelings, thoughts, and actions accurately. I believe that, through ongoing verification with the nurses, accuracy was achieved. Reporting the findings in the nurses' own words and giving the nurses power to withhold any particular comment, story, or experience from the final research data was also important.

Finally, I deliberated whether ethically I had the right to even attempt to capture, understand, and communicate to others something so complex as human attitudes and behaviors. Would any attempt to discuss, describe, and share such actions and attitudes be so simplistic that a wrong would be done? Nursing is so intimate — should it be made public?

I anticipate that a variety of people can benefit from the findings of this study. Although my attempts to unravel the intricacies of exceptionally competent nursing practice and to transpose my understanding into words can be at best limited, I believe it was worthwhile to try.

This appendix described the design of the research study and the methodology on which it was based. Specific details of study participants, data collection procedures, and data analysis approaches were described. Techniques for maintaining data trustworthiness, the assumptions made, the delimitations and limitations of the study, and a discussion of ethical considerations were included.