When Caring is Not Enough

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The authors, editor and publishers have, as far as is possible, taken care to confirm that the information complies with the latest standards of practice and legislation.

When Caring is Not Enough

Examples of Reflection in Practice

edited by

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Val Chapman is Director of the Centre for Inclusive Learning Support at the University of Worcester. Her work in the area of Disability/Equal Opportunities in HE in the UK was recognised in 2004 by the award of a National Teaching Fellowship, and in 2005 by the designation of her Centre as a partner in the LearnHigher Centre for Excellence in Learning Teaching (one of 16 Higher Education partners). From September 2006 to 2007, she also held a UNESCO funded Chair in Special Education at Qatar University alongside her UW responsibilities.

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Val has published quite widely and has presented at numerous conferences, frequently as an invited speaker, both in the UK and overseas.

Tony Ghaye *Cert Educ, BEd (Hons), MA (Educ), PhD*
I am a positive psychologist and have worked at the interface of healthcare and practice improvement for much of my life. I am now the Director of Reflective Learning International, a social enterprise that promotes and delivers a special kind of strengths-based reflective practice. In my working life I have been fortunate in being able to work with and learn from a very wide range of professionals, such as nurses, GPs, social workers, police, probation officers, therapists of various kinds, teachers and coaches. I have also had the privilege and challenge of working with individuals, organisations and communities in the Third World, mainly in East Africa. This experience has energised my commitment to inter-professional learning and multidisciplinary working to help to improve what we do, with and for others. I am the founder and Editor-in-Chief of the Routledge Taylor & Francis international and multidisciplinary journal called *Reflective Practice*, which publishes six issues per year.

Josephine Hamilton-Jones *BSc (Hons), Tech, PhD*
I grew up in Sheffield, South Yorkshire, in an academic, music and sports-orientated environment. I gained a degree in Mathematics and its Applications at University of Wales Institute of Science and Technology, Cardiff, in 1983 and completed my doctorate in 1987, considering the strategies used to solve battle equations and employing these methods to solve equations in epidemiology. With a young family, I moved into further education and lectured in mathematics, computing and information technology at several colleges around the country, rising to management level. Since 1994, I have been an examiner, mentor and tutor in quantitative methods for the National Extension College to home and international students studying degrees through distance learning.

I returned to Higher Education in 1997 to pursue my research interests in simulation, modelling and the use of IT for teaching and learning. I lecture in Information Technology and Computer Modelling at University College Worcester.

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Since qualifying in 1985 I have gained a wide range of nursing experience in a variety of fields. As Matron of a Hospice I believe that there needs to be strong nursing leadership to empower my staff to give high-quality nursing care. I studied for my MSc at University College Worcester. My interests are in critical reflective practice, effective communication, patient autonomy and interdisciplinary teamwork, maintaining that you need all of these aspects to ensure that patients receive the most appropriate care and staff reach their full potential.

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Having qualified as a Registered General Nurse in 1980 and Midwife in 1983 I worked within various areas, including intensive care, gynaecology and care of the elderly, rehabilitation and acute medicine until entering nurse education in 1989. I have worked as a Senior Lecturer and faculty Head of Quality Assurance within Birmingham City University and currently as Senior lecturer at the University of Worcester. I took three years out working with street children and delivering medical services to villagers in remote villages in the Amazon in Peru before returning to the UK and continuing with my career in healthcare education. My teaching responsibilities have been with post-registration nurses undertaking diploma, degree and masters courses in nursing and collaborative community care Masters course for healthcare workers. Specialist areas of interest include care of the elderly, reflective practice, competence in practice, critical thinking and professional issues.

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I worked in the Endoscopy Unit at the Alexandra Hospital in Redditch. Prior to this I worked for 18 months on Endoscopy at Heartlands Hospital in Birmingham. My present post involves the provision of therapeutic and diagnostic gastroscopy, colonoscopy, bronchoscopy and ERCP for both in- and outpatients. The work involves the physical and psychological preparation of patients, providing assistance to the medical staff and the recovery and advising of patients before discharge. I am involved in the day-to-day management of the unit, ensuring the smooth running of the lists and planning for unscheduled procedures. My interest in training and teaching has enabled me to develop an in-house training plan for use on the endoscopy unit and to be actively involved in the training of staff new to the unit. I find the post a challenging one and hope to be able to develop my role of nurse, manager and teacher.

Helen Taylor ***BSc (Hons) Nursing, PGCE, RGN***
I read for a degree in nursing at Leeds Polytechnic, with a registered nurse qualification. I retrained as a secondary school teacher, specialising in biology and integrated science, at the University of Bristol. Until recently I have been combining researching for a PhD with part-time nursing. While studying for my PGCE I developed an interest in child health and health education in schools. I am married with two small sons and live in Worcestershire.

Acknowledgements

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Introduction

Sue Lillyman and Tony Ghaye

Healthcare literature provides us with a wealth of information and examples of how reflection can be used within our clinical practice. Many authors over the past two decades have identified how it can be used to develop practice (Loughram, 2002), improve critical thinking (Teekman, 2000), build new theories (Korthagen and Lagerwerf, 2001), justify practice (Ghaye and Lillyman, 2010), change and enhance practice (Johns, 2004), help us to develop a level of self-awareness (Ostermann and Kemp, 1993), learn through practice (Burnard, 1988; Jarvis, 1992; Coutts-Jarman, 1993; Johns, 1995) and celebrate our practice (Ghaye, 2010). For the majority of healthcare professionals it has also become a professional requirement for practice. Therefore in this second edition of the book *Caring Moments* we have tried to include those examples of practice from a variety of settings where people have used different approaches to reflection that help to capture some of the aspects noted above. We have, however, also altered the title to *When Caring Is not Enough* to emphasise a commitment to caring as well as a questioning of it, and so emphasise the value of reflection in everyday practice.

We can see how we can make sense of our practice by including different examples of practice and using different approaches to reflection by linking three ideas together. These are reflection-on-practice, the meanings of the term *discourse*, and the use of story and experience. In Chapter 2 the stories in this sense are value-laden stories. They have also been stories told mainly through a qualitative medium. But in Chapter 11 we use numbers to make the point that we can develop a storyline in very different ways – ways other than in words alone. Chapter 11 also serves to make the point that we all have preferred ways of creating a story. Creating it with numbers and words is not everyone's preference, but it is arguably a very important one with the developing healthcare technologies in the new millennium. In this book we have not exploited poetic, visual, musical, still and video forms (Prosser, 1998), 3D modelling and other art-based forms

(Pratt and Wood, 1998), verbal and nonverbal processes, concept mapping and so on. We have suggested that we need the courage to explore them, as all of these can, for certain individuals and groups, be important catalysts to help make sense of practice. They are media through which we can express ourselves and something with which we can work and engage. We have also made the point that the story that is produced, as well as the process of story-making and telling, are important. Additionally, and in the first book in this series (Ghaye and Lillyman, 2010), we learnt that merely having experience is not enough. What counts is what we do with it. In this book we hope that we have shown what can be done with experience set out in a story form. Learning through reflection is paramount here.

A number of things might usefully be considered by those wishing to engage in reflective writing of the kind presented in this book. These have been set out in the first chapter.

Quality care: an elusive idea?

Redfern and Norman (1990) suggest that quality care is the right of all patients and that it is the responsibility of the nurse who delivers it. It is through the chapters in this book that many of the characteristics and qualities of care are illuminated. To understand this better we have invited each author to 'frame' their thinking and contribution by focusing their attention on the selection and exploration of what we have referred to as a 'caring moment'. This has been further developed in Chapter 3, where the connections between caring moments and critical incidents are discussed. Sadly, 'good quality' care within a healthcare setting is often only defined by its absence. Arguably, therefore, there is a need to identify what is meant by good quality care for the individual, group and organisation. This will include reference to its clinical, professional and political dimensions. The concept of quality care, according to Benner (1996), can be traced back to Socrates (469–399 BC) and Hippocrates in (460–370 BC) where the latter tried to move folk wisdom into a significant art of healing. The earliest written health records, according to Marr and Giebang (1994), were in the Babylonian Empire circa 1700 BC where sanctions were described for providing poor quality healthcare, and later through Florence Nightingale (1859), who introduced the idea of caring for patients by putting them in the best environment for nature to act upon them. Henderson (1960) suggests that nursing care should be done for the benefit of the patient and that care is administered to assist the patient to health or a peaceful death. Care is not just related to cure. It is a much more complex idea than this. The contributions to the book illustrate this vividly.

Caring is identified by the World Health Organization (1996) as an important part of nursing practice. Among other things they note that care needs to be understood in terms of relationships, for example with an individual, family or community. These views of care are demonstrated throughout the various chapters. Care is also associated with the notion of 'helping'. Helping includes creating a climate of healing, providing comfort, establishing a relationship and committing oneself to this relationship through that nursing care. Williams (1998) takes this further in his attempt to identify what we mean by 'quality nursing care' and suggests that it relates to the perceived degree to which patients' physical, psychological and 'extra care' needs are met. He suggests that physical needs are identified in relation to the lack of personal independence in daily physical function. Psychological needs relate to the supportive role assumed by the carer, including communication, providing information and being the patient's advocate. With regard to 'extra care needs' he suggests that this is difficult to define, but is concerned with the personal touch administered during the period of care.

Astedt-Kurki and Haggman-Laitila (1992) argue that some of the attributes of care are to do with nurses' attitudes, time for discussion, individualism, listening, showing interest in, feelings and understanding of the experiences of their clients/patients. These attributes are developed further through the various chapters in the book. We should note that Phillips (1993) suggests that caring is a value-laden enterprise and that the intention of that care is often confused with achievements of the care. It is not the evaluation of care *per se*, but the means by which the individual draws on his or her knowledge, skills and attitudes to deliver that care, that identifies the values held. In other words, the caring values are evident in and through healthcare practice. Practice therefore needs to be understood as values-in-action.

Caring *vs*. cure

The role of the nurse or professional allied to medicine often identifies the role of 'caring' with emotional connotations, whereas the role of medicine is often associated with a curing function. Holden (1991) asks if the medical profession does not care for, and the carers not cure? He notes the origins of the word 'care' and points out that it actually originates from the 11th century French word for 'cure'. He therefore questions if they should be seen as two separate identities or more appropriately in a more complex, interactive and holistic relationship? The important issue here is how healthcare professionals view their role, the emphases within it and the extent to which they feel able to live out their caring values in their practice.

Conclusion

The specific role that reflection plays within the delivery of a quality care service is demonstrated throughout this book and other related books (Ghaye and Lillyman, 2010). Reflection assists the individual in identifying and nourishing good practice. It can help us develop realistic action plans that serve to work at aspects of practice with the intention of trying to enhance and improve what we do. Reflection can also help us understand the difference between what we wish to do and what we are able to do as we try to care for our patients/clients. It can give us a better sense of self in relation to others, and the organisational contexts within which our practice is embedded. This book takes the notion of a caring moment as the essence and focus of healthcare work. The contributions describe different moments and use reflective practices to explore and make more sense of each one. In this way thinking and practice are helped to move forward. Without this reflective process we are doomed to relive the experiences and mistakes of the past. We enslave and imprison ourselves rather than provide ourselves with opportunities for enlightenment and empowerment.

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CHAPTER 1

Creating a caring moment

Tony Ghaye

Finding something significant to write about

This is more easily said than done. Practice is often so complex that it is difficult to disentangle one thing to focus upon. Alas – and all too frequently – the focus becomes that part of our work that we feel less happy about, which needs 'fixing' and fast. This has given reflection a bad name. While it is understandable that many of us reflect on things like this, reflective practice is not only about putting right the things that are perceived to be wrong! This is a serious danger. We should also spend some time reflecting on the good bits, the things we are pleased about, right now. If we fail to do this, what is good and right today may become less attractive tomorrow. The reason for this is simple. We work within a dynamic and fast-changing healthcare system. Therefore we cannot confidently assume that what is good today will be good tomorrow. Conversely, some less good and worrying things of today can become less significant and worrying in tomorrow's world. When creating a caring moment (a story) to learn from, we should consider at least two basic kinds: stories of celebration and stories of reconstruction. Both are stories that need to be created and should be heard. Both are stories that precipitate action, but action of different kinds. The first requires the kind of action that tries to nurture, preserve and nourish all that is good in that particular caring moment. The second requires the kind of action that has to try to improve (reconstruct) the existing situation as depicted in the story. Simply writing down a caring moment is not enough. Caring moments require us to act. Caring alone is not enough.

Allowing ourselves to be creative

Creating a caring moment is (or can be), as the phrase suggests, a creative experience. In one way this can be described as moving from something known (or something we claim to know) – that is to say the chosen aspect of practice – to something as yet unknown (practice retold in story form). For most people

'being creative' can bring with it some anxiety. But this need not necessarily get in the way, especially if you find yourself working with a skilled reflective practice facilitator.

Resist being stifled by conventions

Storying can be stifled by literary conventions. In my experience, some healthcare workers are more preoccupied with this than with seeing it as essentially a process of communication and learning. They worry more about their spelling, sentence construction, and writing in the first person (using 'I' and 'we') than anything else! I am often asked 'Do you really want me to write it like an essay?'. For some, these are real anxieties that often touch upon some deep-seated and pervasive difficulties about writing, about how to write and about positioning ourselves clearly within our own story. In this sense they have to be respected. Conventions are important. They need to be understood and used, but in the appropriate context.

Place the emphasis on communication

What we say and how we say it matter. Arguably creating a caring moment reflects a desire to discern and assign meaning to our work. So it is understandable that we might ask the question, 'What makes a "good" caring moment?'. They might have the following qualities. I have deliberately stated each one in a positive manner. A caring moment is:

- **Recountable**: This means that a chosen practice event (significant incident) can be identified and reasons given for its choice – that the events in the incident can be presented in some way and put in some kind of sequence to form a story line. We may recount alone or co-write. This is where storying becomes a collaborative experience.
- **Told in a particular way**: Not only do choices have to be made about what is told but also about how the story is communicated. It may be done amusingly, angrily, sarcastically, provocatively, suspiciously, confidently, hesitantly and so on. 'Stories are important only as told' (Cohler, 1991, p. 182). We may tell them to ourselves and/or to others. We may read our story out aloud, on our own, or in a group (to an audience) and with the help of others. We may draw upon some other media (see above) to help us tell our story. I would argue that the use of caring moments in helping us reflect-on-practice (therefore learning from them and trying to move forward) requires an 'optimistic orientation' .This means that by telling the story we give ourselves a chance of adding meaning to our lives, of establishing our 'preferred story' and, through persistence and curiosity, seeking out and constructing an 'alternative story'.

- **Followable**: A good story is one that can be followed. This is often a complex task and not as straightforward as it might sound. We may claim our story is 'followable'. Others may disagree. Striving to make ourselves understood seems rational and logical. But many of us can never claim that we know ourselves in a complete, coherent and uncomplicated way. We have many 'selves', not one self. We have fragmented stories to tell, not fully knowable ones. We often have to strive to make connections. These are often not clearly apparent. We need to work out the difference and the links between the extra-ordinary (exceptional) and the ordinary. For a story to be followable it needs to have some kind of coherence about it. Sometimes this is not easy to establish. I am also making an assumption that the storyteller actually wants the listeners (audience) to follow the story.
- **Likely to affect its audience**: This is also a tricky quality with a number of parts. In presenting our caring moment (telling our story) we need to have some idea of the effect we are trying to create, or that it might create, with its audience. However, 'If one's self-image depends upon how others react, it seems natural that narrators would want their audiences to understand and agree with them. Therefore most storytellers emphasise only those experiences and reasons that their audiences find plausible' (Rosenwald and Wiersma, 1983; Tolman, 1991), 'they tell their stories in genres that their audiences are likely to recognise' (Harding, 1992; Modell, 1992) and 'they explain away whatever their audiences might find inappropriate' (Ochberg, 2000, p. 110). The caring moments that we choose to recount and communicate do not just fill us (the audience) in on clinical events. They should not be seen merely as people telling us about themselves and what they have done. The act of telling can also be seen as a way in which teller tries to create a relationship (of a particular kind) with the audience. But I said this was a tricky quality. The assumption I am making is that talking through a caring moment might be seen as a way of 'making connections' (with practice, with other colleagues, with the audience and so on). It might also be seen as a way of keeping us at bay. Language and the way we use it can do this. This dual quality of 'inviting the listener in' but also of 'pushing the listener away' is important to understand, especially in the context of clinical supervision (Ghaye and Lillyman, 2007). We should not accept the simple idea that everyone tries to make their story 'followable'. Some who present their story may not expect or even want their audiences to understand them. They may not wish their audience to understand them in the same way as they claim to understand themselves. They may think it foolish or inappropriate to present a clear and transparent story, particularly if they

have any kind of doubts about the motives of the audience. But there is also something else that touches upon the connected qualities of a caring moment being 'followable' and affecting the audience.

- **Likely to affect the storyteller**: We have tried to stress through the books in this series that reflection, of one kind or another, done in particular ways, can be upsetting, 'dangerous' and unleash a torrent of frightening feelings that can be overwhelming for those who are participating. Reflective practices may well be important, but it is important that they are done well. On the other hand, reflective practices such as storying can be therapeutic and emancipating. I am describing strong feelings here. For some the reflective experience then may be regarded as a cathartic one. Reflection can unlock human potential.

Give the therapeutic, emancipatory and empowering effects of storytelling a chance

The therapeutic benefits of storytelling were noted in the nursing literature more than 60 years ago (Bacon, 1933). More recently Banks-Wallace (1998), in discussing the emancipatory potential of storytelling in a group (which she called 'Sisters in Session'), outlined six possibilities. These were that storytelling helped to provide:

- **Contextual grounding**: The story provides a context that helps to position or locate ourselves in the world. The context influences how we see ourselves and others, the choices we make and how we act. The context is like the canvas and frame upon which we paint a picture of practice.
- **Bonding**: In her research with women of African descent living in the Seattle-Tacoma region of the USA, she claims that bonding with other group members was the most important function of storytelling.
- **Validation and affirmation**: The stories that were shared and the reactions of the group (audience) were an important means of women validating themselves and their reality. 'Validation of negative aspects often was a prerequisite to being able to critically examine their lives and make decisions regarding necessary changes. Stories affirming joy and goodness... were uplifting and energising' (Banks-Wallace, 1998, p. 20).
- **Venting and catharsis**: Using storytelling to vent emotions was important to the group. 'No one ever really talked about the "heaviness" of the topics being discussed. There were only a few times when someone cried.... Many cathartic stories focused on the pain and frustration associated with living in the US as a woman and person of African descent' (Banks-Wallace, 1998, p. 20).

- **Storytelling as an act of resistance**: This is the role that stories can play in exposing, challenging and confronting dominant structures, discourses, myths and stereotypes. It is a way in which, through the stories we tell, we can resist and critique the dominant storylines. These may be the storylines that come from males, medics, management, government ministers and so on.
- **Education**: The communication of caring moments (stories) can, over time, be a way of creating a special kind of practical wisdom. This is eloquently described by Tschudin (1999, pp. 14–15):

> Telling stories is essential in reflective practice. What is important, however, is that we listen to the essence of what the person is saying rather than to what we want to hear. The patient who says, 'I am scared of this operation' is not heard if she gets an answer like, 'You'll be alright; this sort of operation is routine here and you have a good surgeon'. The patient needs to tell her story of fear: what the fear is, when it started, why it started and where it has led her. In stories of human suffering, we need to hear not so much the practical details as the untold and perhaps not yet understood meaning. In doing this, we are carrying out the essential work of any ethic: being receptive, relating to the other and responding in the most fitting way. In listening to others, we are sharing and expressing that we are 'with' them. In sharing, we become equal, and this allows us to be moral.

Caring moments are value-laden moments. Creating caring moments reflects our use of two kinds of values: our espoused values (what we say we do in our work) and our values-in-action (what we actually do). These are often not congruent. We say one thing and then end up actually doing something else. Sometimes we are not good at living out our values in our practice. So, creating a caring moment is not enough. Telling the story and listening respectfully to it are not enough. Acting upon it in some appropriate way might be. Just saying that we care is not enough. We have to act in a manner congruent with our espoused caring values. In short, we have to be prepared to learn something from each caring moment that is recounted to us. This might be about ourselves, each other, our patients and clients, treatments, the contexts in which our practice takes place and many other things.

Hopefully this book shows that creating and reflecting on each caring moment is not like trying to repair a faulty machine. Creating a caring moment – telling, listening and learning from it – is not finding out what has gone wrong and then setting about trying to repair it. The whole exercise is not about correcting deficits, inadequacies and malfunctions within us, the team we may be a part of and the

organisation for whom we work. The process should be viewed more positively and optimistically than this. Creating and reflecting on 'caring moments' should be undertaken with patience, persistence, deliberation and delicacy. The learning that may arise from reflective practices, of one kind or another, needs to be given the chance to breathe and emerge. This might usefully be done in the spirit of 'co-exploration' (Monk *et al*., 1997).

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