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Hynes, Geralyn; Coghlan, David; McCarron, Mary

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# Developing Practice in Healthcare: The Contribution of Bildung to Negotiating the Tensions among Practical, Professional and Organisational Knowing

Geralyn Hynes, David Coghlan, Mary McCarron

Action research provides a framework for developing practice in healthcare. While developing practice typically implies a combination of patient centeredness, quality improvement and change, conflicts arise in how concepts such as patient centredness are defined. Developing practice invites attention to positionality and engagement with policy directives, trends in clinical care, and other disciplines each with their own language stratification reflecting particular sets of values and beliefs. Our process of engagement is value-based, requiring attention to different and often conflicting languages or worldviews. We understand practice development as responding to different calls from the system, our individual disciplines, patients and changing discourses in healthcare, each exerting different pressures at different times. This paper describes an action research project aimed at developing nursing practice through engaging with two conflicting philosophies of care. We illustrate the contribution made by a particular understanding of Bildung to engaging with positionality, different voices in healthcare and the context of care in a complex environment. Bildung, as self-cultivation, invites engagement with *other* as an underpinning for developing practice beginning with first person inquiry. The idea of Bildung drew attention to the local moral world of nursing and the experience of dual citizenship. Dual citizenship reflected engagement with conflicting care philosophies and notions of evidence.

**Key words:** Bildung, practice development, action research, cooperative inquiry, nursing, palliative care, COPD

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## 1. Introduction

Action research in healthcare is sufficiently well established as to have, to date, warranted two systematic reviews (Munn-Giddings, McVicar, & Smith, 2008; Waterman, Tillen, Dickson, & De Koning, 2001). Much of this activity reports on practice development activities where nurses in the main seek to improve the quality of care through changing practice with stakeholder involvement. The clash of cultures between that which is driven by what Pederson and Olesen (2008) refer to as a diagnostic and fault-finding culture on the one hand, and a collaborative dialogue or 'deeply reflective earnestness' (Kirkeby, 2009:70) on the other, bring particular challenges to healthcare-based action research. In theory, the rhetoric of clinical judgement and decision-making, and integrated inter-disciplinary care speaks to the arguments raised in this journal on the relevance of phronesis (Eikeland, 2006; Kirkeby, 2009); respectful othering (Johnsen, 2010); and practical knowing (Coghlan, 2010). These have in common a focus on different kinds of knowledge to be made explicit in action research.

The purpose of this paper is to illustrate the contribution made by a particular understanding of the idea of Bildung to engaging with positionality, different voices in healthcare and the context of care in a complex environment. The paper is presented in three sections. In the first, we discuss the idea of practice development in healthcare. Drawing mainly from the nursing literature, we present a working definition for developing practice. The second section describes a project aimed at developing nursing practice to address the palliative care needs of patients with advanced chronic obstructive pulmonary disease (COPD). COPD is a common condition that for some patients may progress to advanced stages necessitating frequent admissions to hospital for management of often life threatening exacerbations. In the third section, we explore the idea of Bildung, which provided a reflective lens to make sense of positionality, context and competing worldviews as issues which rippled through the project. Ultimately, this project hinged on making explicit the local moral world of nursing in which nurses negotiate a sense of ideal care with everyday compromises in practice in the harsh environment of Irish hospitals today. We finish with what we see as the potential contribution of Bildung to respectful engagement with other in developing practice in healthcare.

## 2. Developing Practice

Practice development in healthcare has come to imply a combination of quality improvement, changing practice and being patient-centred (Clarke & Wilcockson, 2001; Garbett & McCormack, 2002; McSherry, 2004). In published accounts of practice development, differences lie in how these attributes are defined and the weighting given to each.

Patient centredness is rarely defined or explored as a concept in itself in the current debates on the nature of practice development. Yet, there are clear differences between a view of practice development that seeks to assert influence on the system, and one looking to respond to the system such as need for information booklets. In the former instance, nurses might engage in pushing the boundaries of practice that reflect their challenging the system to provide care that better reflects their patients' needs. In the latter instance, nurses may seek to meet with criteria set by the system in policy implementation e.g. provide patient information on an aspect of care or service delivery.

The point here is not to diminish the value in either case, but rather it is to question the explicit intended meaning of the term patient centeredness, the philosophy underpinning it, and the basis for driving practice development. In all cases patients may be at the centre, but the method and purpose of patient involvement is less clear. Claiming patient centeredness may confer legitimacy on a practice, by symbolising conformity with current norms and standards relating to patient care. In this way, legitimacy might be considered as related 'not to actual efficiency or effectiveness but to the ability to *symbolize* efficiency or adherence to other social norms'(Lotia & Hardy, 2008, p. 370). This highlights the importance of rendering visible the nature of patient centeredness in a given practice development project.

Developing practice invites attention to positionality and engagement with policy directives, trends in clinical care, and other disciplines each with their own language stratification reflecting particular sets of values and beliefs. In action research, positionality is described by Herr and Anderson (2006) as that which describes the researcher's position or stance with participants. Position in this sense can range from the action researcher researching into her own practice to one in which she is an outsider involving insiders in her project. The idea of positionality offers the researcher a way of gauging the strength of participation and reciprocity within a project.

Our process of engagement is value-based requiring attention to different and often conflicting languages or worldviews. Admission and discharge criteria based on health informatics or bio-medical parameters may conflict with individual patients' illness knowledge and experience. Thus, for our purposes, we understand practice development as responding to different calls from the system, our individual disciplines (in this case nursing), patients and changing discourses in healthcare each exerting different pressures at different times.

Positionality brings a more critical and more multi-level engagement with this idea of practice development such that as we respond to different calls, we are also called upon to examine our own situatedness and relationship with other. How we engage with those calls and pressures, the scrutiny we apply to them and consequent choices and decisions we make in patient care both influences and is influenced by our evolving professional knowledge and language, and the values and beliefs underpinning them. In other words, the process by which we recognise and draw on different voices within healthcare such as those of the system including policy and management; professional disciplines; and patients provides the historical-politico-socio-cultural context to our knowledge and practice development, and disciplinary identity. The point here is that our clinical practice develops against a background of tensions that arise from often competing worldviews. Practice development is thus an intensely political affair in which choices are made on the privileging of certain worldviews over others.

A focus on bio-medicine, performance measures including preordained normal ranges for bed stays, bed occupancy rates, and admission and discharge criteria become the parameters within which care might be judged. The lived experiences of illness and care delivery are acknowledged but are less significant in how the service judges itself (Vikkelsø, 2007; Wong, 2004). For nursing, with its claims to holism, such choices in privileging different forms of evidence reflecting particular worldviews challenge the discipline's sense of identity and allegiance to the lived experience of illness (Frank, 2004).

### *Action research as a framework for practice development*

In Ireland and the UK in particular, action research has provided a framework for developing nursing practice (Munn-Giddings et al., 2008; Waterman et al., 2001). The focus on practice and practice-based knowledge development, engagement with different forms of knowledge and attention to participation with reference to power and voice all provide rich ground for exploring our responses to different calls being made on our practice. Participation in action research invites scrutiny of the interplay and power differential among different disciplines each with its own knowledge and value base; the different and often competing narratives inherent in the acute care environment and engagement with different voices. Thus, participation may at once both give voice to different groups not least patients, and generate knowledge through opening a conversation with narratives, disciplinary groups and stakeholders.

Where practice development initiatives frequently stem from requirements imposed by the system to address policy, guideline or protocol changes, an action research approach enables a critical stance to be taken, and examination of practice-based knowledge development that arises. Our project arose from a combination of policy requirements and nurses' experiences of unmet care needs of patients who were dying from chronic obstructive pulmonary disease (COPD). Similar to other countries, a national palliative care policy launched in 2001 stated that palliative care at an appropriate level should be available when needed to all patients irrespective of their diagnosis and age. The policy also required that all healthcare professionals engaged in clinical care should be competent and willing to provide at least basic level palliative care. However, patients with advanced COPD continued to experience unmet palliative care needs, a point that was made repeatedly research reports (Elkington, White, Addington-Hall, Higgs, & Edmonds, 2005; Fraser, Kee, & Minick, 2006; Gardiner et al., 2009; Gysels & Higginson, 2011; White et al., 2011).

One of the authors, GH, is a nurse with experience in respiratory nursing education and practice. Through her involvement with respiratory nursing education and professional association, GH was aware of and engaged in conversations about growing concerns among respiratory nurse specialists of unmet care needs of patients with advanced COPD. This led to collaboration between her and a respiratory nurse specialist which resulted in the development of an action research project proposal based in the nurse's hospital.

## 3. The project: Developing nursing practice to address palliative care needs of patients with advanced COPD

Palliative care is an approach that seeks to improve the quality of life of patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering (World Health Organization, 2002). The concept of suffering is important here as it recognises pain as being physical, emotional, psychosocial and spiritual or existential. Thus, a bio-medical focus on management of conditions such as COPD that addresses exacerbations as discrete events with an emphasis on pathophysiological changes may be at odds with the idea of pain in palliative care. There is an increasing body of work in medical, nursing and sociological literature that highlights suffering in chronic illnesses such as COPD (Kleinman, 1988; Williams, Birke, & Bendelow, 2003).

Patients with advanced COPD typically experience severe breathlessness on minimal exertion and increasingly frequent admissions to hospital. Acute exacerbations are treated aggressively and patients may ultimately become dependent on oxygen support at home and unable to perform basic activities. In policy reports (Brennan, McCormack, & O'Connor, 2008; Global Initiative for Chronic Obstructive Disease, 2010; National Clinical Guideline Centre, 2010) COPD is understood in terms of burden on healthcare through a focus on repeat emergency admissions to hospital, longer than average bed stays in hospital and high usage of services. Evidence-based guidelines for management of COPD present a bio-medical focus with little, if any, attention given to the notion of suffering. Thus, there is a dichotomy between palliative care policy and the current management of COPD.

GH, as an informed outsider, collaborated with the respiratory nurses in a hospital to develop a proposal to address palliative care needs of patients with advanced COPD. There was no tradition of multi-disciplinary team meetings or case conferences in the hospital. Though different professional disciplines worked closely together, this did not extend to interdisciplinary engagement.

The hospital was a busy acute general hospital serving a large rural and urban population. There were two respiratory nurse specialists who worked across the hospital providing specialist support and following up patients in outpatients (OPD). The mainly respiratory medical ward had two clinical nurse managers (CNM) overseeing a team of nurses. The hospital was also developing its palliative care services when our proposal was being developed. This included the establishment of a palliative care team working across the hospital seeing patients on a consultancy basis.

The proposal developed over several meetings with the two respiratory nurse specialists (RNS) in the hospital. For these RNS', the proposal needed an emphasis on initiating changes in practice that would be supported by the management and medical teams. For this, the RNS sought from the project evidence of care needs that would be meaningful to managers and doctors. In other words, the evidence needed to stem from research approaches with which the managers and doctors most strongly identified. Thus, the project proposal was built around the intention to promote palliative care needs of patients with COPD through evidence from widely accepted health status measurement instruments, and developing nursing practice to address this evidence.

Ultimately, the project was designed with two phases. The first aimed to identify palliative care needs through 26 patient interviews (GH) using well validated instruments to measure the health status of patients with respiratory conditions. The second phase was a co-operative inquiry as a form of action research involving respiratory and palliative care nurses, and a nurse researcher (GH). Co-operative inquiry is one in which 'all participants work together in an inquiry group as co-researchers and co-subjects' (Reason & Heron, 2008:366). An inquiry group usually comes together to address a shared concern or interest. The CI groups engage in cycles of action and reflection in a systematic approach to developing understanding and action.

The aim of our co-operative inquiry was to make sense of respiratory nursing practice, and explore how care needs, identified in phase one, might be addressed.

### *Patient interviews*

For GH, the use of health status measurement was problematic at two levels. Firstly, the reductionism of health status measurement conflicted with the notion of suffering. Simply put, reducing disease impact to elements or domains as defined by health status measurement denied the notion of suffering or pain as reflecting the integration of the physical, emotional, psychosocial and spiritual or existential experience. Secondly, the use of instruments limited the voice of the patient in the inquiry. This was research on, rather than with, people. Moreover, the instruments were pre-determining an understanding of disease impact, and so limiting the subjective expression of suffering.

The interviews were undertaken when patient participants were at their most well and in their homes. The health status instruments that were used included the St George's Respiratory Questionnaire and the Hospital Anxiety and Depression Scale. Both are designed to be self-completed. However, GH visited patient participants in their homes and offered to read out the questions. This was intended to ensure that the questions were read out literally rather than shortened or re-interpreted by well-meaning family carers.

An unforeseen and welcome consequence of this process was the degree of control that participants asserted over the questions. In addition to the yes/no and likert scale responses required by the instruments, participants narrated stories recounting life experiences thus elaborating their replies. The interviews were recorded and these stories were integrated into the findings. The stories recounted participants' meaning making from their illness and its impact on their lives often attributing causes to the harsh environment of Ireland in the 1940s and 1950s. Typically, this man began work as a farm labourer at the age of 13:

> For 7 days, I done that for 6 year[sic]. I was driving as a young lad. My wages were 21 shillings a week in all weather. I worked away in all weather I had about 2 miles to go to get home

He remained a farm labourer but his work became mostly to do with tillage including spraying crops and harvesting with no protective clothing or face masks. Others attributed their present condition to previous work in various factories where they were exposed to a range of irritants. These accounts included the lack of available work and therefore having little choice over types of work, and the lack of knowledge during those times about the risks associated with exposure to materials. One participant worked first with talcum powder and later with glue, both of which are now recognised as irritants. In these accounts, COPD was more than a result of exposure to irritants; rather it was a consequence of a hard life:

> And sometimes I ask myself did I do right, did I do wrong on someone during my lifetime. I wouldn't discuss that with everyone……………. But I worked terrible hard..... I was often out till 11 o'clock at night milking cows after doing a day's work….

The findings from these interviews can be summarised as having illustrated high symptom burden, poor quality of life and the interplay between living with severe breathlessness and suffering. For participants, severe breathlessness dominated their lives in the obvious physical and social sense. However, in their stories, they recounted living in fear of breathlessness, extreme isolation and loneliness, grief and loss, and dependency on others.

### *Cooperative Inquiry*

Co-operative inquiry (CI) is aimed at generating knowledge about human experience through action and joint reflection. Emphasis is given to participation and interplay of reflection, experience and action (Heron, 1996; Heron & Reason, 2001). Nurses from the respiratory ward, the hospital palliative care nurse specialist (PNS) were invited by GH to form a CI group with the respiratory nurse specialists (RNS). The group was comprised of three ward-based nurses, one PNS, two RNS and GH. One ward-based nurse later with-drew from the group (she moved on to another nursing post) and the two remaining nurses from the ward were both clinical nurse managers (CNMs).

The co-operative inquiry group met over a 17 month period. Notes were made (GH) from each CI meeting and circulated in advance of the next meeting. Themes from the previous meeting were revisited and agreed at the start of each meeting. At 10, 16 and 17 months, a summary of the inquiry process and emerging themes to date were circulated by GH and explored at a group meeting.

The CI findings illustrated two contradictory facets of respiratory nursing practice. In the first, respiratory care was disease-oriented and underpinned by organisational dictates of what constitutes 'normal' care in terms of bed management, admission and discharge procedures, appropriate time per patient consultation in the outpatients' department and documentation procedures. Disease-oriented care meant focusing on patho-physiological markers and practice routines emanating there from. Typically, criteria for admission and discharge from hospital, and patient assessment in outpatients reflected a focus on a patient's oxygenation levels and related equipment and measurement. Similarly, levels of infection and other patho-physiological markers were a basis for disease-oriented care.

In organisational terms, the hospital was constantly under pressure to provide beds for patients in need of hospital admission, and manage waiting times for those who required outpatient care. Patients were often discharged home with little notice and limited support because of bed shortages. In these instances, criteria to discharge were based on patho-physiological markers with limited if any reference to illness-oriented needs. For the respiratory nurses and other team members, care was provided at a fast pace with limited scope for engagement with patients' illness-oriented concerns or experiences. Thus, not surprisingly, there were difficulties in responding to patients' fears, or needs for conversations about death and dying. The initial co-operative inquiry meetings were focused on the establishment of disease management protocols aimed at supporting clinical decision making in relation to procedures such as non-invasive ventilation. This focus was in line with disease-oriented care, risk management and an emphasis on standardisation of work procedures and practices.

In sharp contrast, the second facet of respiratory nursing was the close relationships built up with patients as their condition deteriorated and their hospital admissions increased in frequency. Shortly before the third CI group meeting, a much loved patient died. Discussion centred on her death, events leading up to it and a sense of loss. Questions opened up about failure or reluctance to have death and dying conversations with patients and relatives.

> N1
> Families: do you know if they could bring up the issues, also because they run as far from it all the time as we do, so I think it's like between all of us like the patient, family and staff: we all run away

All the respiratory members of the group had developed close relationships with this patient. Though the patient had required repeated admissions to hospital in her final year, the issue of concern for the group was that there had not occurred with her a conversation about death and dying. Within the group, moments were recalled when the patient had indirectly invited such conversations but without response from nurses. The focus of the subsequent co-operative inquiry group meetings turned towards making sense of respiratory nursing practice in the context of acute medical care which members saw as at odds with their relationships with patients.

> N1
> It's like when I meet someone or they say Oh I know your mother, and it makes them feel at home.
>
> N2
> I suppose if you make an effort to see what life is like. You'd notice in OPD like if you give the time, or you make the effort for time, they will remember and come back, whereas if it doesn't go that right you know you rush someone you get the feeling the next time that you didn't really give them enough time you know. They do let you know don't they
>
> N3
> You can tell by their expressions that you haven't built up a relationship.

In between admissions, these patients attended respiratory clinics, and were supported by the respiratory clinical nurse specialists. The nurse/patient relationships built up over time gave rise to knowledge of individual patients' illness experiences. Patients recounted stories that reflected their illness experience in terms of emotional, social, cultural and life world meaning. This illness awareness represented background knowledge or knowing the person as distinct from knowing the patient or case (Liaschenko, 1997). However this knowing the patient or illness knowledge developed from informal or ad hoc conversations with patients. It was knowledge that stood outside formal engagement with patients, documentation, ward rounds and multi-disciplinary team meetings.

> N1
> If you tell that to someone outside of COPD they'd laugh. They just wouldn't get it
>
> N2
> Well I didn't document it. There's nowhere you could put it
>
> N1
> You'd be embarrassed to document it
>
> N2
> Yeah you'd be thinking how can I put this down in a medical way?

### *Re/presentation of patients*

Acknowledging a disease/illness dichotomy in nurses' relationships with patients drew attention to different ways patients are re/presented. In documentation and clinical conversations, nurses addressed biomedical markers, and were reductionist or disease-oriented in their talk. Typically, patients' needs were described in terms of symptom control and treatment self-efficacy. This was at odds with nurses' illness knowledge of a patient derived from conversations about life events, struggles to maintain everyday routines with increasing disability and loss. Conversations such as these illustrated suffering. Attending to these conflicting re/presentations drew attention to engagement with conflicting philosophies of care but privileging that of acute care.

The idea of re/presentation highlighted the need to articulate and act on illness-oriented knowledge of patients' experiences and meaning making. In the acute care environment, attempting to privilege illness-oriented knowledge was an attempt to re-describe an understanding of care and the practice environment. In seeking to privilege illness-oriented knowledge, the respiratory nurses were engaging with the notion of suffering and attempts to embed palliative care within acute care.

### *Local moral world of nursing*

In the co-operative inquiry, members articulated the gap between our (and society's) ideal nursing selves in relation to an ethical framework, and the moral experience of living with compromises and harsh reality of care delivery in the current Irish healthcare environment. Ideal nursing care gave way to care practices driven by pressures of staffing levels, time pressures, ward routines, bed shortages, need to discharge patients quickly with little notice etc. Examples were aired of being aware of patients' wish to speak about their fear, but failing to meet this wish or diverting conversations towards safer territory. These examples illustrated the divided world and self in everyday practice. Inability to sit with distressed patients was explained away as evidence of system limitations, reflecting reasoned justifications that may be based more on reactive selves against fear of exposure to uncertainty when facing the suffering of another. Confronting 'reactive selves' drew attention to self-formation/development as practitioners, as a basis for developing practice. In other words, engagement with the competing narratives of everyday practice was contingent on individual personal development that included, but went beyond, skills development.

## ***Findings as engagement with Other***

Earlier, we defined developing practice as responding to different calls of the system, profession, patients and discourses. For GH, responding to calls through an action research lens highlighted issues of positionality, power and voice. Thus, responding to calls inevitably invites engagement with *other*. In the development of the proposal, the RNSs regarded their capacity to effect change in practice as limited unless reasoned and supported by the kinds of evidence that are privileged in medicine. For GH giving voice to the RNSs' concerns and experiences conflicted with her wish to give voice to patents' experiences.

Participants' expanded responses to closed questions invited a different perspective of health status measurement. Typically, one dichotomous question, getting washed or dressed makes me feel breathless, would lead to stories illustrating moment by moment planning that this everyday task required because of severe breathlessness. The stories invited a counter to the reductionism of health status measurement, and a means to bring participants' lived experiences of COPD into the project. For participants, their COPD could be contextualised or made meaningful as part of their 'life story', through linking their condition to poverty or early adult experiences. Health status measurement in COPD does not seek out how patients make meaning from their illness; yet, for these participants, this was important. Giving voice to participants' stories, while still capturing the health status data, allowed different ways of understanding COPD to emerge.

In the early co-operative inquiry meetings, GH was confronted with members' initial reactions to the group's purpose, ie the need to put in place guidelines and protocols and focusing on treatment interventions. These included the use of non-invasive ventilation, pharmacological management and referral to the specialist palliative care team. The idea of suffering as described earlier was not addressed in these early meetings, but rather the respiratory nurses wished to improve referral rates to the specialist palliative care team, so that patients who appeared anxious or wishing to talk about their illness could be referred on. In other words, suffering could be reduced to discrete elements including pain, communication needs, anxiety etc.

Recent discussions in action research literature have highlighted paradoxes that can surface when seeking to create conditions or space for opening conversations towards mutual understanding (Arieli, Friedman, & Agbaria, 2009; Ospina, Dodge, Foldy, & Hofmann-Pinilla, 2008; Wicks & Reason, 2009). These have in common the gap between the initiating action researcher and other group members in terms of understanding of action research, positionality and experiential knowledge of the issue being addressed. For GH, a similar gap surfaced at different levels including:

1. Understanding of palliative care as underpinned by a different philosophy of care to that of biomedicine in acute care. GH believed the group needed to develop an understanding of palliative care before determining how

palliative care needs can be addressed. The respiratory nurses were concerned with the immediacy of practical problems relating to end of life care.

2. Exploring the accounts of patients and importance of their illness experiences as integral to understanding suffering and unmet palliative care needs. GH's broad vision for the group to examine practice, in the context of the findings from patient interviews, was at odds with the focus of the initial meetings.
3. Developing nursing practice as needing to focus on essentially nursing care. The early focus on decision-making was as much a focus on medical as nursing care, since doctors carried the responsibility for prescribing including initiating and stopping treatments.

Fundamentally, attending to the paradoxes of participation requires engagement with different perspectives and specifically contextual understandings of the issue at hand. However, for GH, members' initial responses were also potentially silencing the suffering accounts of patient participants and therefore their voice in the inquiry process. The paradox of participation presented an added moral dilemma of engaging with, and giving voice to, different voices, some of which were not represented (in a physical sense) in the group.

Later on in the co-operative inquiry, recognising palliative care needs meant engaging with a different understanding of patients' COPD experiences, an understanding that was already present in members' accounts of informal interactions with patients. The palliative care nurse specialist in the group described these informal interactions as reflecting basic palliative care. However, since they were not formalised in any sense, there was little scope for incorporating palliative care into care planning. Not only did care practices reflect the dominance of biomedical and other reductionist markers of COPD management, they also reflected a silencing of other understandings of COPD and suffering, and of the nurse patient relationships in advanced COPD. Thus, addressing unmet palliative care needs became more about how to give voice to and then privilege these understandings.

For GH, developing nursing practice to address palliative care needs of patients was a process of engagement with *other* rather than one which required the development of a new set of competencies or skills for practice. This is not to deny the importance of skills and competencies, at however basic a level of palliative care, but rather to highlight the significance of *other* in this project. Our understanding of developing practice as responding to different calls required a way of understanding engagement with *other*. For GH, the idea of Bildung provided such an understanding and lens to guide all stages of the project and engagement with the paradox of participation in the early co-operative inquiry group meetings.

In the following, we explore the idea of Bildung which provided a reflective lens to make sense of positionality, context and competing worldviews as issues which rippled through the project.

## 4. Bildung

Bildung is an ancient term that has evolved but continues to refer to self-cultivation through engagement with other. In its modern meaning, Gadamer devotes some time to this theme in his work Truth and Method (Gadamer, 2003). Through Bildung, learning takes place through cultivating the inner life that forms through conversations with others, drawing on past history, recreating the self and seeing the world differently (Gadamer, 2001, 2003):

> To recognise oneself in the alien, to become at home in it, is the basic movement of the Spirit whose being consists only in returning to itself from that which is other (Gadamer, 2003, p. 14).

Seeking out and engagement with *other,* or bringing *other* back to self, is a process of continually developing self or that self.

The individual's understanding of the world is built upon that which went before. Rendering conscious the assumptions upon which the individual understands the world is integral to self-formation or self-cultivation that is Bildung. Through the process of Bildung, the individual learns to move out from and to bring back to the self, differing views of the world through conversations with e.g. other professional groups, patients, discourses and cultures. Thus, one's sense of citizenship in the world develops, in the context of relationship with other.

In bringing back these differing worldviews to the self, there is formation of the self that stands apart from the narrow experience of being *a nurse* or other healthcare professional. This moving towards experience of encounter and engagement with what is other is, as Gadamer puts it, looking to the alien and returning to the self from the alien. The essence of Bildung is this alienation or difference and, crucially, returning to the self. That is to say it is recognising other diverse (or alien) ways of viewing the world, and bringing these back to one's own self. Thus, Bildung in its modern meaning may be viewed as self-cultivation linking the self to the world in an animated interplay (Løvlie & Standish, 2002).

### ***Bildung as ever-developing self***

Bildung thus, reflects a process of engagement and self-criticism when facing different and often alien perspectives, an ever-developing self. It is a dialectic, between the possible and what appears as the limits of the possible, in a given professional or social culture. The relationship between self and the world is a necessary opposition that generates interplay. Bildung does not come from gaining competencies, but rather grows out of an inner process of formation and cultivation (Gadamer, 2001, 2003). As such, Bildung constantly remains in a state of Bildung; the endpoint is a constant process of self-formation and cultivation. Thus, Bildung reflects a historical spirit; all that we receive is absorbed and preserved in an on-going interaction with other or difference.

This also raises questions such as in what cultural tradition and how is the self conceived in this interplay between self and world (Masschelein, 2004). Gurze'ev (2002) develops this idea with a view of Bildung that seeks out a self-cultivation that is in a constant dialogical relation with others. In other words there is a counter to any possible dominance or alternative dominance in practice. So, in this sense where Bildung seeks the alien or other; it is the promise of a dialogical way of life of seeking out and engaging with difference. In practice development terms, Bildung invites a dialogical approach to the different calls of system and profession being made on the practitioner. Developing practice becomes a dialogical response to different calls being exerted on the practitioner and informing her own practice development.

The distinctions between Bildung on the one hand, and education and professional development on the other hand, include the interplay between the practitioner and her professional discourse. At the heart of this interplay lie the 'imperatives of organised reason' (Prange, 2004, p. 505) whose authority is organisational demands and the ensuing professional competencies. The focus is on self-formation from a purely technical competency basis that is situated within the evolving requirements of institutions. There is a gap between one the one hand, the nurse's ideal of the nurse, for example, as one of providing individualised patient centred care in all its complexity, and, on the other hand, the professional and service institutions within which the nurse must operate. Bildung promises an interplay between self and any such gap by inviting attention to this gap between self and different calls of system, profession etc in practice development.

For GH, the early need to acknowledge the importance of health status measurement despite its dominance over other kinds of evidence drew attention to the need to engage with different voices, irrespective of how dominant they are. This was even while seeking to give voice to the more silenced forms of evidence or illness and practice experiences. Put simply, as initiating and lead action researcher, her positionality could be framed in the context of her relationship with *other,* where *other* reflected different world views, experiences and voices in the project. Her support for health status measurement was neither yielding to a dominant perspective of patients' needs nor forfeiting the need to seek out different perspectives of illness experiences.

The idea of Bildung offered GH a reflective framework from which to recognise and engage with multiple and often competing discourses and worldviews in the patient interviews and the cooperative inquiry. While recognising that some perspectives and forms of evidence are more dominant and often silence other worldviews, developing practice seems contingent on engaging with all rather than alienating any one of them. In other words, viewed from a Bildung lens, developing practice invited a seeking out of the more silent voices (such as those reflecting the lived experience of COPD) while also hearing those that are more dominant such as that of medicine. Taking these worldviews as other, Bildung offered a way of engagement that seeks to converse with all.

Despite its clear boundaries, health status measurement opened up conversations about living with COPD when GH met with participants. What might have been a round of interviews with closed questions became a rich process of engagement in stories about everyday experiences. An integrated data analysis approach was undertaken, in which the scores obtained from the questionnaires were integrated with the stories. This was intended to continue the dialogue between the scores and stories in reporting the findings to the hospital and in particular, continuing to engage different professional groups with different ways of understanding illness experiences.

### *Bildung and positionality*

Positionality in action research brings a focus on one's position or stance with other (Herr & Anderson, 2006). This is made complex when the researcher must attend to her own position or stance compared with multiple others. Positionality invites a continual assessment of the strength of participation and reciprocity within a project. A key aspect of positionality is that it is not a fixed stance, and neither does it necessarily move in linear fashion; rather, there is a focus on multiple perspectives and mobile subjectivities, of forging collaborations and alliances and juxtaposing different viewpoints (Wolf, 1996, p. 15). Through a Bildung lens, positionality might be examined by the means by which the researcher moves towards reciprocal collaboration while also seeking out differences in perspectives. In this sense, the aim towards collaboration is not one of homeostasis or some kind of merging of views but rather continually seeking out difference or *other*.

Distinctions between voice and control in the research process are made complex by the fact that those in control decide whose voice is represented (Gaventa & Cornwall, 2006; Ospina et al., 2008). Voice in the inquiry will largely determine what knowledge is generated. Voice in this sense may depict stakeholder representation, and how those targeted by the inquiry determine their right to have a say in what knowledge is generated about them (Ospina et al., 2008; Reason, 2006).

In our project, we recognised the healthcare environment as a complex melting pot of voices in which the voices of different professional groups, disciplines/specialists, managers, support staff and patients intersect positivist and constructivist understandings of hospital/organisation life and illness. The value attributed to health status measurement by the respiratory nurses in the proposal development did not mean simply that this form of evidence was preferred and privileged by them. Rather, they recognised the institutional privileging of health status (positivist) evidence over other forms.

Thus, our understanding of voice included and extended beyond stakeholder representation to address the hospital narratives that reflected the privileging of some ways of knowing over others. For example, for patients who are admitted to hospital with acute exacerbations of advanced COPD, the focus of assessment and treatment is on the bio-medical: blood oxygenation levels, infectivity etc. The narratives built up about individual patients then centre on their biomedical profiles in assessment and management. These narratives are reductionist since COPD is reduced to the sum of various measures. In the same way, the organisation narratives of hospital life may be built upon narratives of efficiencies and effectiveness that are formed from measures such as throughput of patients, lengths of stay etc.

In the patient interviews, participants recognised these narratives, and engaged in conversations about oxygen saturation, treatments and lengths of stay in hospital. In the co-operative inquiry, engaging with competing and unequal narratives lay at the heart of the themes that emerged: the re/presentation of patients' care needs and the local moral world of nursing. In other words, the voices of different and often conflicting narratives rippled through the project planning and roll-out. Representing the respective *voice* of nursing or patients gave way to the different voices of life with COPD with which patients and nurses engaged and privileged on a moment by moment basis.

## *Action points*

At the start of our co-operative inquiry, the group identified the need for guidelines and protocols for end of life care. Palliative care was viewed more as care that should be provided by the specialist palliative care team. This reflected the usual responses in everyday acute care to clinical challenges namely, reducing the problem down to the sum of its different elements and addressing these with the acute model of care. Our co-operative inquiry ultimately led to a different response as follows:

1. The group moved towards a view of care for patients with advanced COPD that incorporated patients' experiences of living with the condition. In other words, the group saw palliative COPD care as part of everyday acute care. This represented a shift in understanding of palliative care, from that which was the business of a specialist team, to that which was part of every respiratory nurse's role
2. A stronger relationship between with respiratory nurses and the specialist palliative care team was forged resulting in increased patient referrals for specialist palliative care support and presence of a palliative care nurse in the respiratory ward.
3. Attempts to introduce greater emphasis of care needs beyond the patho-physiological through patient assessment and recording concerns in patient documentation.

At the end of the project period, though referral rates to the specialist palliative care team had increased, there was less success in achieving greater emphasis on responding to, and integrating palliative care needs within, the wider respiratory medical team.

Nursing practice development in the acute care environment is often linked with education typically relating to new ways of working, new guidelines, standards or procedures. Bildung moves beyond this interpretation of education in the sense of normalisation or socialisation (Gur-ze'ev, 2002) to that of self-cultivation and autonomy of self but always in terms of relationship with other. In this sense Bildung addresses citizenship and moral world.

In this co-operative inquiry, practice was characterised by a duality in which there was denial of personhood with limited acknowledgement of illness experiences at a formal level in contrast to the knowledge of individual patients' illness experiences at an informal level.

This reflected dual citizenship between responsibility to the hospital system with its attendant disease-oriented worldview and responsibility to our knowing the person relationships with patients and calls for a more illness-oriented care. Dual citizenship is a moral endeavour bringing an outsider status to both the acute hospital world and the illness-oriented 'knowing the person' worldview. The point here is the import of and responsibility to attending to each however conflicting they are. Dual citizenship to the acute care environment and illness-oriented worldview is not an endpoint but rather a process of constant engagement with different perspectives.

## Conclusion

At its core, developing practice within an action research framework is about engagement with other where other refers to the individual and, different worldviews, horizons, knowledge, skills and experiences. However, the paradox of participation that has been identified within the action research literature highlights the challenges for lead or initiating researchers in addressing voice and control in the early stages of a project.

We drew on an interpretation of Bildung to reflect on the foregrounding of the initiating researcher's dynamic positioning in unfolding events and sense–making processes. Bildung invited a rendering explicit the relationship between engagement with *other* and knowledge development. This drew attention to voice as extending beyond a stakeholder view towards the multiple perspectives (voices) with which different stakeholders must engage in a shared world. Bildung brought to the idea of developing practice, a seeking out of different and often conflicting voices, when responding to the different calls of system, profession, patient etc.

## References

Arieli, D., Friedman, V. J., & Agbaria, K. (2009). The paradox of participation in action research. *Action Research, 7(3),* 263-290. doi: 10.1177/1476750309336718

Brennan, N., McCormack, S., & O'Connor, T. (2008). Inhale 2nd Edition: *Ireland needs healthier airways & lungs - the evidence* (2nd ed.). Dublin: Irish Medical Organization.

Clarke, C., & Wilcockson, J. (2001). Professional and organisational learning: analysing the relationship with the development of practice. *Journal of Advanced Nursing, 34(2),* 264-272.

Coghlan, D. (2010). Interiority as the cutting edge between theory and practice: A first person perspective. *International Journal of Action Research, 6(2-3),* 288-307.

Eikeland, O. (2006). Phrónêsis, Aristotle, and action research. *International Journal of Action Research, 2(1),* 5-53.

Elkington, H., White, P., Addington-Hall, J., Higgs, R., & Edmonds, P. (2005). The healthcare needs of chronic obstructive pulmonary disease patients in the last year of life. *Palliative Medicine, 19*, 485-491.

Frank, A. W. (2004). *The renewal of generosity: Illness, medicine, and how to live*. London: The University of Chicago Press.

Fraser, D. D., Kee, C. C., & Minick, P. (2006). Living with chronic obstructive pulmonary disease: insiders' perspectives. *Journal of Advanced Nursing, 55(5),* 550-558. doi: 10.1111/j.1365-2648.2006.03946.x

Gadamer, H.-G. (2001). Education is self-education. *Journal of Philosophy of Education, 35(4),* 529-538. doi: 10.1111/1467-9752.00243

Gadamer, H.-G. (2003). *Truth and method* (2nd revised ed.). London: Continuum.

Garbett, R., & McCormack, B. (2002). Focus. A concept analysis of practice development. *NT Research, 7(2)*, 87-100.

Gardiner, C., Gott, M., Small, N., Payne, S., Seamark, D., Barnes, S., . . . Ruse, C. (2009). Living with advanced chronic obstructive pulmonary disease: patients concerns regarding death and dying. *Palliative Medicine*, 0269216309107003. doi: 10.1177/0269216309107003.

Gaventa, J., & Cornwall, A. (2006). Power and knowledge. In P. Reason & H. Bradbury (eds.), *Action research.* Concise paperback edition (pp. 71-82). London: Sage.

Global Initiative for Chronic Obstructive Disease. (2010). Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease (Updated 2010). Retrieved from http://www.goldcopd.com/GuidelinesResources.asp?l1=2&l2=0

Gur-ze'ev, I. (2002). Bildung and critical theory in the face of postmodern education. *Journal of Philosophy of Education, 36(3),* 391-408.

Gysels, M., & Higginson, I. (2011). The lived experience of breathlessness and its implications for care: a qualitative comparison in cancer, COPD, heart failure and MND. *BMC Palliative Care, 10(1),* 15.

Heron, J. (1996). *Co-operative inquiry research into the human condition.* London: Sage.

Heron, J., & Reason, P. (2001). The practice of co-operative inquiry: research ‘with’ rather than ‘on’ People. In P. Reason & H. Bradbury (eds.), *Handbook of action research* (pp. 144-154). London: Sage.

Herr, K., & Anderson, G. (2006). *The action research dissertation*. London: Sage.

Johnsen, H. (2010). Scientific knowledge through involvement - How to do respectful othering. *International Journal of Action Research, 6(1),* 43-74.

Kirkeby, O. (2009). Phronesis as the sense of the event. *International Journal of Action Research, 5(1),* 68-113.

Kleinman, A. (1988). *The illness narratives: Suffering, healing and the human condition*. New York: Basic Books.

Liaschenko, J. (1997). "Knowing the patient?". In S. Thorne & V. Hayes (eds.), *Nursing praxis: Knowledge and action* (pp. 23-38). Thousand Oaks, CA: Sage.

Lotia, N., & Hardy, C. (2008). Critical perspectives on collaboration. In S. Cropper, M. Ebers, C. Huxham, & P. S. Ring (eds.), *The Oxford handbook of inter-organizational relations* (pp. 366-389). Oxford: Oxford University Press.

Løvlie, L., & Standish, P. (2002). Introduction: Bildung and the idea of a liberal education. *Journal of Philosophy of Education, 36(3),* 317-340. doi: 10.1111/1467-9752.00279

Masschelein, J. (2004). How to conceive of critical educational theory today? *Journal of Philosophy of Education, 38(3),* 351-367. doi: 10.1111/j.0309-8249.2004.00390.x

McSherry, R. (2004). Practice development and health care governance: A recipe for modernization. *Journal of Nursing Management, 12(2),* 137-146.

Munn-Giddings, C., McVicar, A., & Smith, L. (2008). Systematic review of the uptake and design of action research in published nursing research, 2000-2005. *Journal of Research in Nursing, 13(6),* 464-477.

National Clinical Guideline Centre. (2010). Chronic obstructive pulmonary disease: management of chronic obstructive pulmonary disease in adults in primary and secondary care Retrieved from Available from: http://guidance.nice.org.uk/CG101/Guidance/pdf/English

Ospina, S., Dodge, J., Foldy, E. G., & Hofmann-Pinilla, A. (2008). Taking the action turn: Lessons from bringing particiaption to qualitative research. In P. Reason & H. Bradbury (eds.), *The Sage handbook of action research: Participative inquiry and practice* (pp. 420-434). London: Sage.

Pedersen, C. H., & Olesen, B. R. (2008). What knowledge–Which Relationships? Sharing Dilemmas of an Action Researcher. *International Journal of Action Research, 4(3),* 254-290.

Prange, K. (2004). Bildung: A paradigm regained? *European Educational Research Journal, 3(2),* 501-509.

Reason, P. (2006). Choice and quality in action research practice. *Journal of Management Inquiry, 15(2),* 187-203. doi: 10.1177/1056492606288074

Reason, P., & Heron, J. (2008). Extending epistemology within a co-operative inquiry. In P. Reason & H. Bradbury (eds.), *The Sage handbook of action research: Participative inquiry and practice* (2nd ed., pp. 366-380). London: Sage.

Vikkelsø, S. (2007). In between curing and counting: Performative effects of experiments with healthcare information infrastructure. *Financial Accountability & Management, 23(3),* 269-288. doi: 10.1111/j.1468-0408.2007.00429.x

Waterman, H., Tillen, D., Dickson, R., & De Koning, K. (2001). Action research: A systematic review and guidance for assessment. *Health Technology Assessment (Winchester, England), 5*(*23),* iii.

White, P., White, S., Edmonds, P., Gysels, M., Moxham, J., Seed, P., & Shipman, C. (2011). Palliative care or end-of-life care in advanced chronic obstructive pulmonary disease A prospective community survey. *British Journal of General Practice, 61(587),* e362-e370.

Wicks, P. G., & Reason, P. (2009). Initiating action research: Challenges and paradoxes of opening communicative space. *Action Research, 7(3),* 243-262. doi: 10.1177/1476750309336715

Williams, S. J., Birke, L., & Bendelow, G. A. (eds.). (2003). *Debating biology: Sociological reflections on health, medicine and society*. London: Routledge.

Wolf, D. L. (1996). Feminist dilemmas in fieldwork. In D. Wolf. *Situating feminist dilemmas in fieldwork* (pp. 1-55). Jackson: Westview.

Wong, W. H. (2004). Caring holistically within new managerialism. *Nursing Inquiry, 11(1),* 2-13. doi: 10.1111/j.1440-1800.2004.00199.x

World Health Organization. (2002). National cancer control programmes: Policies and guidelines. Geneva: WHO.

## *About the authors*

Geralyn Hynes is a lecturer in Nursing at the Faculty of Nursing & Midwifery, Royal College of Surgeons in Ireland, Dublin. She is a Fellow of the Faculty of Nursing and Midwifery. For this project, she held a research fellowship with the Health Research Board (Ireland).

David Coghlan is an Associate Professor at the School of Business, Trinity College Dublin, Ireland and is a Fellow of the College. He is currently on the editorial review boards of: Journal of Applied Behavioral Science, Action Research, Action Learning: Research and Practice among others. Recent books include Doing Action Research in Your Own Organization (Sage, 3rd ed. 2010) and Collaborative Strategic Improvement through Network Action Learning (Elgar, 2011). He is co-editor of the 4 volume set, Fundamentals of Organization Development (Sage, 2010).

Mary McCarron is Dean of Faculty of Health Sciences, Trinity College Dublin, Ireland and is a Fellow of the College. She is principal investigator for the Intellectual Disability Supplement to The Irish Longitudinal Study on Ageing and other research projects that address cost and quality of life issues in dementia care, and end of life care.

*Authors' addresses*
Dr Geralyn Hynes
Faculty of Nursing and Midwifery
Royal College of Surgeons in Ireland
123 St Stephen's Green
Dublin 2
E-mail: ghynes@rcsi.ie

Prof David Coghlan
School of Business
Trinity College Dublin
Dublin 2
E-mail: dcoghlan@tcd.ie

Prof Mary McCarron
Dean of Faculty of Health Sciences
Trinity College Dublin
Dublin 2
E-mail: mccarrm@tcd.ie