Curiosity, Knowledge and Liberty.

Exploring the Lived Reality of Curiosity in Nursing Practice.

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

This study set out to explore the lived reality of epistemic curiosity in nursing practice in the NHS. It adopted a narrative, post-structuralist approach to inquiry, which included researcher ethnography as integral to the method. In depth, un-structured interviews were conducted with six currently registered and practising NHS nurses, across two U.K. NHS Trusts. Purposive sampling was adopted. Data was collected utilising an innovative rhizomatic approach over a six month period May – October 2013. Interviews were audio-recorded and transcribed verbatim. Twenty hours of un-interrupted, depth data was obtained and thematically analysed.

The thesis suggests a nursing narrative on curiosity which is socially constructed, with curiosity acting as a liberator and antecedent to reflexive knowledge correspondence and construction. Nurses viewed their engagement in curiosity as a key asset for melding the various sources of knowledge required for the provision of person-centered care. However, curiosity is also lived within the tension afforded by organisational compliance discourse, which demands engagement with prescriptive, formulaic forms of knowledge and a felt dismissal of the need for professional nursing knowledge and curiously crafted practice. Acts of resistance to dominant organisational compliance discourse are evident, as nurses engage in curiosity on a moral but covert basis, in an attempt to preserve epistemic truths, subvert and circumvent compliance and prescription and thus exercise professional freedom. Concerns are raised as to 'knowledge lost', which may be generated from covert curiosity practices. Nurses lament a lack of discourse on curiously led practice, resulting in perceptions that curiosity is significantly compromised as a critical motive to engage with professional knowledge correspondence, practice improvement or innovation initiatives.

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Preface

This thesis has been crafted by a curious mind - a mind that has been socialised to break the rules of convention, to be different, to mindfully look up from that which 'is', take it apart, imagine alternative possibilities and re-construct that which once was, to something that could be. The mind is mine.

Whilst I may (arguably) own my mind, I have, by virtue of engaging with it to write this thesis, opened up the folds to expose its intricate, sometimes contradictory and ever complex composition. I have learnt that I cannot escape its contradictions, or its complexity, because that is the nature of a curious mind. It slices through time and seeks to make one notice how they are engaged in the world at any given moment, between 'being there' and 'getting there' (Hurren 2000:2). A curious mind encourages one to dance between the lines of the folds, to move backwards and forwards, inwards and outwards across our known texts and the discourses which have shaped those texts – so we may think again; and perhaps shape a more equitable world, albeit open to further de-construction and re-construction (Freshwater 2002a). Such a movement is the main purpose of post-structuralist writing (Rolfe 2000). I invite you into that movement through the presence of my curious mind and the post-structural writings my curiosity has helped to produce.

The narrative that you will find within these pages has arisen from my own experiences as a nurse and educator. The curious mind I depict above has led me to question some deeply held assumptions I have had about my own curiosity and the impact the nature of it has had on those with whom I have come into contact. Looking at my own world and the world of others through a curious lens has led me to examine the contemporary context of healthcare and the discourses which signify who can and cannot speak. The process through which I have travelled has enabled a better understanding of the ways in which curiosity is enabled, inhibited, contested and re-

worked. Taking a post-structuralist stance has called me to think differently about that which I may have taken for granted and has challenged any arrogance supported by such licence. Through the acts of studying, exploring, asking, hearing, interpreting and finally representing, I have written my way to (a current) understanding and making sense. I now offer my writing for public reading and for scrutiny as I link theory, practice, personal, professional and the experience of others dialectically and deliberately, into what I hope is a coherent composite and new understandings.

Although my writings are presented with form and are structured to give one a sense of linear progression from a particular beginning point, to a chosen point of closure, I have endeavoured throughout the text to scatter linearity to points of distortion, from which one may 'look up' and enter other spaces (Freshwater 2002a:109). The point I wish to make in the doing of this, is to illustrate the convoluted journey which curiosity evokes and through which I travel. The journey of curiously crafted research to me has not been a linear process, but takes many twists and turns. It also moves between the abstract and the tangible. The text represents those abstract and tangible labyrinths I have travelled through and includes art, poetry and literature. I have been curious to know how I may represent key points, essences, thoughts, reminders, moments of incongruence, moments of clarity, reflections and feelings in a different, perhaps more poignant way, than is usually the norm. The text is also written with differing fonts which also seek to illustrate the moments and positions from which I write. To provide a guide for the more structured reader:

Blackadder ITC (font 20) represents thoughts which have sliced into my moments whilst writing or represent concepts or reminders which are addressed at later points.

Reflections between supervision sessions are written in Calibri (Body) Font 11 Italics

Reflexive thoughts during my writing of the thesis are written in Bradley Hand IT Font 11.

Poems, quotes and extracts from literature are written in Andalus Font 11

Direct quotes from the academic literature are written in Arial Font 11 italics

Quotes from study participants are written in Agency FB font 11

A description from childhood is written in Times New Roman Font 11

There are also key players on the stage who I mention by first name in the body of the text:

Philip – Dr. Philip Esterhuizen, PhD supervisor

Liz – Dr. Liz Walsh, PhD Supervisor

Dawn – Professor Dawn Freshwater – PhD supervisor

Immy- Professor Immy Holloway- Academic and author of Narrative Methodology texts.

I leave the narrative herein in the capable hands of the reader, in full knowledge that once you have it, I cannot take it back. I have confronted myself in it which has at times been difficult, but is something I had to do. Never the less, there is a vulnerability in the exposure of revelation, not just on my own part, but also on the part of the nurses who took part. Their courage to speak out, even under the caveat of anonymity, has led me to places of revelation and brought about an in-depth piece of work, which will hopefully influence others to think differently.

In a mercurial world of paradox

Where plethoric realities play

Is the mind without walls

Where curiosity and creative thought is free

Is our world broken into fragments by modes contrived

Where the stream of reason has not lost its way in the sands of tiresome habit

Where the veils of perception are lifted

Where knowledge emerges from the depths of our truths

Where the key to our future has been crafted.

Are we are led towards resistance

Into that place of liberty

To grasp the grains of wholeness to make our world awake

Or do we seek to hide again, our knowledge behind the veil?

A poem inspired by Rabindranath Tagore – 'Where the Mind is without Fear'.

Curiosity

Oppression

Fear

Emergent Emancipation

Hope

Reflective Interventions

Forever Becoming

Reflexive Action

Transformational
Knowledge Integration

Chapter 1

Unfolding Curiosity

The previous diagram is a conceptual representation of my thinking, which was conceived in the first week of beginning my PhD studies and was constructed from my experiences of working with nurses in various practice contexts. Underpinned by an appreciative approach to inquiry, my role was to facilitate them towards a reflective journey of knowledge extraction, integration and reflexive application. The goal was to enhance their ability to explore current practice, validate best practice, identify gaps and undertake action for improvement. Curiosity, exploration, learning and development were central to the work.

Through multiple encounters with these nurses over a five year period, I began to note a lack of curiosity and deliberative thinking and very little evidence of activities which would suggest reflective integration of knowledge sources into practice. On an anecdotal basis, I began to openly explore this perception with the nurses I worked with, all of whom were situated in various National Health Service (NHS) contexts across a wide variety of client groups. Their narratives suggested a reticent, fatalistic and defeatist approach to everyday practice and practice improvement. Considering the corporate NHS embrace towards practitioner led innovation and improvement and my own views that practice should be curiously wrought, their views raised a potential paradox for me to consider curiosity in more depth. I also presented my perceptions at the RCN International Research Conference in 2011. Stories from practising nurses and academics at this conference, along with reflective discussions with my supervisors, prompted a deep exploration of my own 'curiosity' experiences, alongside that of others.

My personal journey with curiosity began at a very early age and has continued throughout my career as a nurse and educator. I hold the view that the mind of an individual or collective is a naturally occurring curious entity. It is reflective and reflexive

and has the power to curiously integrate knowledge sources towards an architectural whole, whereby the self and conjointly one's practice is enabled towards 'forever becoming'.

Whilst these beliefs have informed my own practice, with curiosity being an intrinsic and relentless driver, there have been times where such aspirations have been violently challenged and shaken to the core. My whole sense of reality and existential well-being has often been threatened, as my curiously discursive self has failed to find voice or have it heard. My ambitions and commitment to contributing to reflexively applied knowledge-whatever its form, has oftentimes been inhibited, arrested; or in really dark times - punished.

In my own experience, the act of exposing curiosity and voicing linked thought has the power to shift ones position from a private place of safety to one of public exposure; carrying with it an opportunity of awareness raising, participatory learning and shared meaning making or conversely, a high risk of ridicule, isolation and consequential thought suppression. Arising from this is the question as to whether curiosity is supported as a collective social and cultural constructional norm or is viewed more as an inherent individually exclusive trait, considered foreign to, held out-with and excluded from being embraced within the collective mind. However, there have been times when, supported as a nurtured journey of discovery and sculpted through the dynamics of learning, I have been awarded the hope of catharsis to unlock and elicit transformative creativity, which has been a catalyst for emancipatory thought, reflexive action and innovation in practice.

Having been invited to wander on to a stage where clinical teams play out their daily dramas in an effort to improve patient care, a sense of curiosity has arisen as to the nature of the architectural forms employed within their acts of developing practice, and the role that the presence or absence of individual or collective curiosity, thought exposure and discourse, has upon it. Viewed through the lens of the practitioner and in

hearing their voice, their clinical world presents itself an unfathomable, complex field of play where permanent 'white water' resides to create states of critical and reflexive inaction, stagnation and perceived oppression. The notion that practice and personhood is 'forever becoming' through exploring and voicing curiosity, identifying insight, describing discovery and sculpting episteme, is seemingly suppressed within institutionally created silence, where any attempt to challenge given knowledge is perceived as pollutive, unsafe and open to recrimination.

In reality, suppression may be a manifestation of inhibiting discourse and may sit side by side with an emancipatory open form, whereby figments of hope and oppression co-exist as constructive and destructive discourses at any one given place in time and space, where compliance and innovation exist together at the edge of chaos, as emergent catalytic properties. However, curiosity not expressed may be held as pure thought and once voiced, has the potential to be consumed by the fire of a seemingly oppressive system and be stopped in its tracks, or it can be exposed in curiously wrought action to be nurtured and given credence to become a validated part of the journey of knowledge, practice transformation and forever becoming.

The challenge I have set for myself for this research is to uncover these veils of perception as related to curiosity in nursing, and work towards building an architectural whole. In an attempt to build 'wholeness' (although I'm not so sure this can ever be done in the entirety the word itself aspires to – I shall come to this later), I have chosen to adopt a narrative approach to inquiry. Narrative inquiry purports to be a fundamental scheme to link contextually situated personal accounts of motives, experiences, events and actions of individuals into interrelated aspects of an understandable composite (Holloway & Freshwater 2007a, Polkinghorne 1998). It also extends its potential to highlight complex and contradictory elements and layers of meaning, to create a rich archive for understanding how personal, relational, social and political realities are being constructed (Tamboukou 2008). Additionally, narrative approaches to research encourages and inspires researcher reflexivity - to look through the lens of curiosity to

reveal contradictions, gaps, fragmented and incomplete sketches of the self – to be aware of the emergence of self, as power and knowledge are embodied in the production of narrative and in their effects (Squire et al 2013).

Within this essence of reflexivity, I am aware that my own experiences and beliefs have influenced my work and thinking thus far. So, before I can step toward offering a narrative of curiosity in nursing, I am beckoned to attend to the voices and spaces which have shaped my own curiosity. I feel this is important as I believe that my own narrative on curiosity is the entry point to opening up the problematic of curiosity in nursing practice. Furthermore, insights from my reflections seek to raise the ways in which my identity, beliefs and life-course have, I think, been curiously wrought. The intent is to encounter multiple texts from within my own practice and prejudice, with the view that I am unable to transcend my own history and *'situated embeddedness'* (Polkinghorne, 2007:483). In sharing these insights, I seek to provide the reflexive scaffold for narrative rigour, congruence and authenticity. That is, I am first led to offer an auto-ethnographic exploration of self-knowledge and uncover my own social and political narrative in relation to curiosity, and make use of these in order to better understand and re-present the curiosity narratives of fellow nurses. By means of an auto-ethnographic inclusion, I bring about an outward, inward, backward and forward movement, which displays my experiences through multiple levels (Smith and Sparkes 2008). The outward brings forth my social and cultural text, the inward brings forth my feelings, moral disposition and my aesthetic text, the backward and forward represents my temporal text, across past, present and future (Clandinin and Connelly 2000).

Whilst the intention to foreground the ways in which curiosity has shaped my experiences, I am mindful not to position myself as omniscient and distance myself from being in an ethical relationship with the participants. As Clandinin and Murphy (2009) suggest, narrative researchers are part of the phenomenon they study, situated within a world that they have helped to create. As a researcher, I am situated within the research puzzle and process and therefore have an ethical relationship with

participants and their texts. As a nurse and as an educator in nursing, I also have a common background and professional history and familiarity with my research participants, who are all nurses. All of these things set me within a co-created relationship them. Therefore, I can re-present the partial, contextually dependent lived reality of the participants, with an informed but complicit understanding of their professional gaze. The caveat to this however, is that a co-created relationship does not allow a '*God's eye view'* of the *'intimate workings of a participants mind'* (Clandinin and Murphy 2009:601).

'I lay listening and thinking of the night animals and secret lives. Of impressions. And the stories we weave, so frequently embellished in the telling. Of the layer upon layer of camouflage we paint on, creating our facades with such practised skill that the brush strokes go mostly unseen.' Deon Meyer (2011) – from his novel – 'Trackers'

Until now, the depth and breadth of the impact of my curiosity has been hidden. It has not been made explicit. The veil which covers its riches and secrets and through which it also hides, has only just begun to lift. I have only recently allowed my consciousness to awaken to the energies that curiosity has provided across my life and career and consider how multiple discourses, from a variety of sources and contexts, have directed and shaped these energies. The way that I understand energies is anything which provides personal significance (Freshwater 2005); with significance understood to be that which is both signifier and signified (Derrida 1976). That is, in the Derridean sense, curiosity has form and meaning. In this present moment, curiosity, for me is a powerful, insidious force. It creeps into my evolving being with a myriad of lessons within its folds. It is a complex instrument, which plays an unstructured symphony. The composition is paradoxical - elusive and tangible, silent and cacophonous. It breaks

with convention and conforms to custom. It is whole and fractured, hedonistic and eudaimonic. Thus, the form and meaning which curiosity elucidates for me is mercurial. Contained or liberated, the inherently itinerant nature of curiosity can simultaneously construct, de-construct and re-construct my life world.

As I open up the voices and spaces which I think have shaped my curiosity, the conceptions of my curious self are unpeeled and my perceptions of reality, as seen through the lens of curiosity, become exposed. These conceptions and perceptions are my constructions. They are architectured through personal history recall, resulting in a self-portrait. The beckoning hand entices me into a reflexive way of being to scrutinise and critique my perceived reality. That is, to move back and forth as I question and am curious about how my curiosity, as derived from my experience, is interpreted and expressed across my own text and across the texts of fellow nurses. For, there never is, as Freshwater (2005:313) attests, '*a single, cosy interpretation'* of a text. Nor, I would add, is there only one text to challenge and contest in isolation, but a raft of texts and practices which have meaning in relation to one another across time lines (Alvesson and Skoldberg 2009, Freshwater and Rolfe 2001). Within such a reflexive process, an empathic dialogic takes place, whereby meanings of truth become interpretations through constant inter-textual interaction – through a nodal dialogue with the texts at play, which include one's own (Polkinghorne 2007). One bears in mind however, that meanings of truth derived from inter-textual interpretation are always a matter of perspective (Polkinghorne 2007). The claim for any one truth depends upon explicating an awareness of influences and assumptions and justifying ones positional stance (Holloway and Freshwater 2007a, Polkinghorne 2007).

Although the reflexive stance that a narrative of the self brings to research practice is useful in uncovering, critiquing and understanding one's perceived reality, (Freshwater and Rolfe 2001, Riessman 2008) and in placing the researcher as integral to the study (Taber 2010, Trahar 2009), the reflexive nature of narrative inquiry has been labelled as being narcissistic, impotent, pretentious and self indulgent (Freshwater 2005, Lynch

2000). At worst, personal researcher narratives that form part of narrative inquiry have been cast aside as mere seductions *'to elicit admiration or sympathy',* or they stand accused of being mindfully evasive or mindlessly escapist: of being a '*flight from self knowledge'* (Paley and Eva 2005:92). Whilst Freshwater and Rolfe (2001) do contend that all texts are fabrications of the truth, they also argue that truth is socially constructed and should be subject to deconstructive re-writing and contestation.

My curiosity is best described as a journey. It is a journey which has taken me through light and darkness, emancipation and oppression, and is one I am still travelling. The road of understanding still opens up before me. Although I have earlier declared an attempt to know myself, with a promise to weave these self-insights and revelations within the tapestry of this thesis, I am reminded to care that I am constantly constructing myself. Whilst I may be able (or not), to assert what has 'made' me; my 'being' is a work in progress.

Therefore, the truth of who I am and my perceptions of reality, as sculpted through curiosity, are situated within given points in time. My truths and perceptions are always incomplete and constantly on the move. My sense of self and my position in the world have been and are being shaped by experiences. These experiences take place in contexts; contexts which are institutional, economic, political and social; each one of which, is I believe, '*draped in a discourse'* (Veyne, writing on Foucault 2010:48) or series of discourses.

For Veyne (2010), Foucault's notion of discourse comprises a collection of historical formations or discursive practices, through which people elucidate meaning, interpret the actions of others, discern degrees of and allegiance to importance, power and prestige. According to Veyne (2010), Foucault viewed discourses as subconscious forms of knowledge, maps of what people do and think without realisation; until such a point in time arises when the transient nature of human affairs contests one form of discourse, only for another to take its place (Veyne, 2010).

Whilst one might be led to believe that such genealogical forms of knowledge (despite their inconstancy), have cybernetic power to prescribe, rather than creatively and purposefully design personal strategy and action, I am mindful, as Foucault (1972) attests, to simultaneously confront and challenge any given order, and move into a virtual unknown; into moments of invention and potential emancipation. However, such moments of invention have the potential to raise methodological surprises. Surprises which may prove difficult to inhabit as their forms become '*continents of thought beyond the horizon'* (Pefanis, 1991:138, cited in Lather, 1993:687). Within such an elusive frame, I am of a similar mind to Bauman (2000:29) in that my agency and power in my post-structuralist world are '*unfulfilled project[s]*'. That is, as I strive for the reality or illusion of emancipation and growth, with agency and power as their vital ingredients, I am subject to forces of fluidity, surprise, interruption and incoherence. My agency and power are thus in a state of *'constant transgression'* (Bauman, 2002:28).

So, as I begin my personal reflections on curiosity, I stand on shifting sand. Guided by a post-structuralist reflexive stance, I hope to fracture the vessel which contains my curiosity texts and allow them to seep and pool. Adopting a reflective gaze, the form, meaning and hidden contradictions which are inherent in my text (s) may be revealed (Freshwater 2002a). In doing so, I set out to frame my prior knowledge and beliefs in readiness to encounter, interpret and re-present the curiosity experiences of fellow nurses.

Chapter 2

Emergent Curiosity

'In the secret place the child can find solitude. ... something positive grows out of the secret place, …. something which springs from the inner spiritual life of the child. ……the secret place remains an asylum in which the personality can mature; this self-creating process, this standing apart from others, this experiment, this growing self-awareness, this creative peace and absolute intimacy demand it -- for they are only possible in alone-ness' (Langeveld 1983 :17).

I can hear the children in the school playground, adjacent to my garden, practising for their end of summer term games. A relay race is in progress. Shouts of encouragement for team mates getting to fever pitch, climbing ever higher; reaching a crescendo as the finishing line is breached. The air is packed with that wondrous energy of abandoned excitement, which childhood embraces so well.

My mind wanders ……..…

I loathed end of term sports day. The fact was, I averted any attempt to be included in sports, end of term or otherwise, and went to great lengths to come up with avoidance strategies. A culmination of years of coming last or letting the opposition get the ball, and facing ridicule from fellow pupils, left me feeling that I had no place in sporting activities. I was never 'picked for the team' and dreaded being in that line up as team captains chose their players. One by one the line went down. I remained. I felt deeply humiliated. Side-lined was a concept I lived.

End of term school report circa 1969: 'Could try harder'.

Despite trying, sport was something I did not understand. I could not fathom the rules or the strategies employed. I remember asking the sports mistress what the purpose of 'games' was. On being dismissively told not to ask foolish questions and feeling highly

embarrassed by the public reprimand, I took myself off into the woods at the back of the school grounds. Whilst there, I remember thinking that if I could really understand what it took to be good at sports, what the rules and principles were, then I would try my hardest to be better. I would do this often. Just go off somewhere to be alone and try and work things out. I would become totally absorbed into a questioning, sense making realm of mind.

Diversions from my original purpose were common. I took journeys into a magical world of imagination and wonder; seeking faces in the trees and animals in the clouds. To Hove (2011), wonder is not just a passive state but a reflective act, which inspires our interest and urges us to respect that which it reveals. By bringing us to a place of being-in-the-world, wonders' influence tends to be one of priority, where it marks a beginning to unfold further and be followed or explored.

Being absorbed in that space, I often failed to hear the bell calling me to lessons. My reverie was often broken by being forcefully dragged into another reality by an authority figure. I was constantly rebuked and physically punished for being 'out of bounds', of being itinerant, of having 'my head in the clouds' and whilst in lessons, of not focusing on the task in hand. One particular escapade resulted in a missing child report and a police search. The high anxiety this invoked in my parents and teachers must have been unimaginably painful. 'Defiant', 'rebellious', 'lacks attention', 'dreamer' and 'could do better', were constants on my end of term reports.

However, my periods of alone-ness and escape also meant that I could be curious from a distance, within a place of safety from which I could emerge better prepared. Like Langeveld (1983), van Manen (2007) suggests, our silent moments of encounter with ourselves, are pre-formative phenomenological experiences, which give significance to the meanings that influence us, even before we are aware of its formative value. As we direct our gaze to the space where meaning resides, we drift towards sculpting knowledge which is more pathically informed (van Manen 2007). My reflective

encounters allowed me to attend to my own internal discourse, to 'feel' and internalise my understanding. It was a discourse steeped within an ever unfolding process of creating and making sense of my world. It was a secret world; a private eudaimonic space to which invitations were rare and discerned.

Conversation with Philip, circa 2013 – 'You have a tendency to keep us all at arms length – you don't let us in.'

Whilst I could manage and satisfy my curiosity and attempt to devise learning strategies in this way, its solitary nature took its toll. The energy expended in striving to learn – to do better - was exhausting (and still is), and the act of going into my own asylum of peace and understanding, kept others at a distance and brought about a self-generated isolation. I would not let others know what was going on inside my head, until I understood first.

Going back to the sports…

Through months of observation (from the boundaries of the woods, or literally on the side-lines; having faked letters from my mother that I could not play netball/tennis etc. due to sore ankles/knees etc.), I eventually came to understand that the person who knew most about the rules of the games was the referee. I worked out that if they knew when somebody had made a mistake or foul, then they must also know the 'right' ways of the game.

So, when physical excuses were beginning to wear thin, I volunteered to be a referee. This meant I would have the sports mistress next to me on the side-lines explaining the rules of the game and pointing out where faults had been made. I began to understand the key principles, to be able to analyse how the winning team won through adopting

teamwork and strategies. Not only did I now begin to understand what it was all about (netball at least), I also had somebody there to ask questions of, guide my thinking and glean knowledge in real time. I could make sense in, of and from action. I could be openly curious, internalise and 'live' learning this way.

On reflection, there was an associative symbolism in having an expert authority figure on the side-lines with me; a referent type of power perhaps, which, by association, I could draw motivation and inspiration from. There is also the possibility that it was also an unconscious attempt (or ulterior motive) on my part, to communicate a message to my fellow pupils; a message that I was no longer the powerless outcast, but was gaining in credibility and authority. I could now stand on the side-lines and apply my new knowledge with a badge of legitimate power, with earned respect.

The reality of everyday life proved that my way of reflexive learning was just not possible all of the time. I could not always take control of my own curiosity and learning. I was subject to 'normalising' institutional and social sanctions which, as Berger and Luckmann (1966) suggest, are objectivizing realities, resistant to temptations at re-definition, having pre-determined patterns of conduct and habitualised actions. I am beginning to understand, over 40 years later, that perhaps I did not reciprocate such action and resisted definition by disengaging from lessons and subjects which did not facilitate my curiosity and sense making. Asking questions was seen as impudent. Whilst I understood the language of English, French[1] and biology for example, the formulaic of maths, chemistry and physics were nonsensical to me. Here, I needed to ask the questions, to de-construct the origins of that language in order to understand and engage with it. 'Impudence personified' is a label I was often given to wear. Questions were dismissed as didactic pedagogies prevailed. Formulas

[1] I excelled at French in particular – winning the 'Concorde de Diction Français' UK national award for public recitals of French poetry for 9 consecutive years from age 7-16. In my final year I was asked by my teachers not to enter the competition 'To give others a chance of winning'. I still entered and won.

were explained once. If you did not catch the essence of understanding at that point, then you became lost, as I did. I still cannot do fractions.

Final year school report circa 1979: – 'Is unlikely to do well in a professional field.'

When I reflect back on my childhood days, my experiences of curiosity were somewhat dichotomous. Although (in my mind), my formal education did not embrace the curious child within, I was socialised into an environment where the quest for meaning, a thirst for exploration and discovery and a wont to learn were positively encouraged. From my earliest childhood days, I would be enticed to marvel, question and engage with that which surrounded me. According to Engel (2009), childhood should be filled with curiosity to provide an epistemic framework within which to explore and master experiences. It is suggested that children learn more and retain information for longer when activities are designed to spark their curiosity, and they have opportunities to explore answers to their questions (Renninger et al 1992). For me, this was especially true.

My Father in particular was a rich source of learning. Encouraging questions and enabling learning were his raison d'être. He held a premium on education and knowledge application. I would emerge out of journeys into the mountains with him, having lived an ordnance survey map. My curiosity became embodied. We would walk the contours. As they became ever tighter, my legs felt the increasing steepness, along with an emerging feeling of relief that, as the contours on the map were merging to form a single black point, I knew the summit was close – and along with it, our sandwiches.

I began to be curious about how I might get my sandwiches that much quicker (or rather, reduce the mileage and effort), and took to pre-reading the maps to discern degrees of climb. I identified different locations. On the pretence that it would be a new place and new experience, I suggested alternatives to my Dad. He knew the ruse, but

played along. I learnt to listen for the sound of the river as a marker to follow ('if lost - the river will lead you to a pathway, farm, road –---- eventually'). I was inquisitive about why trees had different bark and leaves. Dad would explain, name the trees and then ask me what they were, when we were next in the forest. We would also spend many an hour listening to classical symphonies, whilst he asked me to name their creators. He said music would give me energy. I could identify Tchaikovsky, Wagner, Holst and Handel by age 5. Likewise with art, the books would be opened and I would be able to name the artist from the picture exposed. We would go out into the snow for picnics taking with us the poems of Matthew Arnold[2].

Weary of myself, and sick of asking
What I am, and what I ought to be,
At this vessel's prow I stand, which bears me
Forwards, forwards, o'er the starlit sea.

'Ah, once more,' I cried, 'ye stars, ye waters,
On my heart your mighty charm renew;
Still, still let me, as I gaze upon you,
Feel my soul becoming vast like you!'

These were the times that I remember my curiosity enlivening my soul. My curiosity was unencumbered and free. Not judged or measured.

However, it was not always the case that my spirit of curiosity brought such joy. I remember receiving the complete Encyclopaedia Britannica as my main present one Christmas, at about age 7. I cannot really say I took that particular gift with grace, when a doll which cried real tears was on the retail toy shelves. I was sorely disappointed. My disappointment was coupled with an internal state of expected anticipation. The doll must surely appear. I would get it later. At the point of final realisation, I hid my feelings in an attempt not to appear un-grateful. Or perhaps it was placidity, a wanting to please or a desire to attract approval. In reality, all four states of being were most

[2] An extract from the poem 'Self-Dependence', by Matthew Arnold 1822-1888.

likely at play. I guess that the nature and form of my curiosity and enthusiasm for learning, gave licence to the thought and action behind the gift of the books. The premium on curiosity and learning evidently had a price.

Dad also imbued a sense of deviance. Forays into disused gold mines were a weekend pastime. Prohibited entry signs and warnings of danger were simply ignored. Dad's view was that if you applied your awareness, intelligence and analytical ability, any situation was manageable. Tapping the side of his temple, he used to say: 'Pay attention and use your noddle'. In Dad's book, 'noddle', was an abstraction for using your knowledge and intelligence in a reflexive way. On reflection, I guess my Dad taught me to integrate mindfulness with my curiosity – to become mindfully curious[3].

These ventures into risky and potentially unsafe activities also brought forth a challenge to power and authority within me– a kind of Foucaldian resistance and liberation, albeit anxiety provoking. Dad believed in breaking the rules to explore and learn. He did not distrust curiosity and its potential dangers, but like Engel (2009), saw it as vital to intellectual growth. When it came to exploratory learning there were no such words as 'cannot' or 'fear' in his vocabulary. I still bear the scars from climbing over barbed wire to gain entry into one particular mine. The far reaching hand of panoptic power and authority had left its mark. I should have taken note of its reach.

My home life was fairly unconventional, as compared to that of my peers. During my early childhood years, my parents travelled extensively overseas[4] and wrote long letters home. These letters contained the most vivid descriptions of the people and places they had visited. I remember a particular line my Father wrote about Rio de Janeiro, saying how incredibly beautiful it was; yet he depicted hardened edges, with abject poverty standing alongside incredible wealth. He was emphatic in his writing, that when I was older, I must travel to see these things and learn about other people

[3] I will address mindfulness and its relationship with curiosity later.

[4] My Father was a marine engineer and was at sea for periods of up to 6 months at a time. My Mother more often than not travelled with him. My brother, sister and myself spent the times they were away with my grandmother and aunt.

and places. A world of adventure, mystery and exoticism came alive from those pages. They took me into a world of wondrous imaginings and stimulated my curiosity to learn more about the life of others (although I probably did not realise it in these terms at that time). However, I do think those pages, and more like them, as they travelled around the world, influenced a desire within me to live and work abroad - to 'feel' and live those pages for myself. I opted to spend 11 years living and working in North Borneo, shortly after I qualified as a nurse.

'……. driven by fascination: being swept up in a spell of wonder, a fascination with meaning. The reward offered…. are the moments of seeing meaning, …seeing into the heart of things…. toward the regions where meaning originates, wells up, percolates through the porous membranes of past sedimentations – and then infuses us, infects us, touches us, stirs us, exercises a formative effect.' (van Manen 2007:11).

Seen but not heard.

I think the influence of those letters was quite profound on my being and becoming, as was my parents' return home, which was no less fascinating. The house was, often than not, filled with guests from far off places; the atmosphere aromatic with spices from their gastronomic experiments; our ears assaulted by multiple languages. We were rarely allowed to socialise with our guests. My mother had a mantra when guests were around: 'Children should be seen, not heard'. So, I would go back into my secret space, sit silently on the stairs and absorb the alchemy of difference and eclecticism. Looking back, I cannot quite decide on whether these episodes brought forth ideas of romanticism at their best, or whether it was a compensatory space, one which I inhabited as a result of enforced distancing, which my mother did so well. Had my curiosity become romanticised? Or was it a space I retreated to, to give attention to myself? Quite honestly, I do not know. Whatever the truth, my curiosity was under constant stimulation and gave me a life-force, upon which I thrived. Questions abounded: 'What was over the sea? How could I get there? What would I find?'

‘What made the clock ‘tick-tock’?’

It is perhaps my curiosity about the clock which remains the most prominent in my mind; not least for the consequences that my curiosity could bring about.

The clock stood majestically in pride of place on the mantle-shelf, its silver gilding and gentle chime called invitingly to my curious mind.

Tantalised and dragging forth a chair, I stood facing the object of my fascination.

‘How do you tick-tock?’ thought I.

Tiny fingers fiddled and cajoled until the pieces came away.

A most intricate sight lay before my eyes.

Mesmerised, I became lost in the magic as the wheels and cogs danced delicately around and whispered their language of time.

‘What makes you all dance?’ thought I.

More pieces came away.

The clock spring, a tricky devil, flexed into the air and disappeared.

The dance stopped. The whisper became silent.

‘I’m in trouble.’ thought I.

I was right and there were numerous similar instances. My brother’s prized traction engine is still missing a few parts to this day. The list of labels became longer. Add ‘destructive’ to ‘impudent and defiant’. A penchant to take things apart and attempt to re-construct them, to delve into things I did not understand, drove me towards finding answers and making sense. Nothing unusual in that, one might think, as many children

are absorbed into pastimes of discovery and exploration, which often take them into troublesome realms.

My problem however, was that although I knew that the consequence of my curiosity could lead to emotive responses in others, reprimand or punishment, the desire to question and learn often punctured the protective shield of fear and containment. That is not to say that I did not spend many an hour banished to my room, or a week without my pocket-money. I certainly did. I also felt great remorse at having irreversibly altered the beauty of delicate craftsmanship, and the compromise this brought to the pleasure of others. I did evoke sadness and anger. But, I was embedded within a powerful discourse of curiosity, eclecticism and learning. My curiosity had become embodied and enabled. Cocooned within the walls of familial bonds, degrees of latitude were likely remotely negotiated and granted. Something which I probably knew at an intuitive level and more than likely took full advantage of.

Thus, a sense of security - a blanket of protection - enfolded my curious child to a determined extent. It would not be until the early stages of my nursing career that my sense of security with my curiosity would be seriously threatened. The blanket would be removed and the rules of engagement with my curiosity would change.

Rules of Engagement

' ……. and wards are healthy or unhealthy, mainly according to the knowledge or ignorance of the nurse. Are not these matters of sufficient importance and difficulty to require learning ….. and careful inquiry, just as much as any other art?' (Nightingale 1859:75)

Although I did not appreciate it at the time, I entered nursing at an exciting juncture of its development as a science and as a professional discipline[5]. In the late 1970's and early 1980's grand theories and conceptual models of nursing began to emerge in earnest. Nursing scholars asked key epistemological questions and began to de-construct the elements of nursing as a means to articulate a sound knowledge base (Alligood 2013). The intent was to capture the purpose of nursing and generate knowledge which would be deemed characteristic of professional identity (Murphy et al 2010). A shift in nursing practice from an instrumental, task based approach to a knowledge focus with patient centrality, was core to theoretical and paradigmatic development (Alligood 2013). In short, nurses had become curious about nursing.

At nursing school, I was introduced to the 'Nursing Process' (Orlando 1961) – a cognitive framework for nursing practice, which promoted thinking and decision making in a structured way (Orlando 1961). It utilised patient focused, holistic assessment based on 12 'Activities of Daily Living'[6] (Henderson 1961, Roper et al 1980) and was implemented widely in UK nursing practice in the early 1980's. The nursing process and its theoretical influences demonstrated a pluralist approach to knowledge integration in nursing practice, drawing on multiple sources of knowledge from across several scientific disciplines (Murphy et al 2010). Working with the nursing process, nurses had to demonstrate knowledge integration and competent skills application

[5] My date of entry into nursing was 1981

[6] The Activities of Daily Living (Roper et al 1980), were constructed '*to help people to prevent, alleviate, solve or cope with problems (actual or potential) related to activities of living* (maintaining a safe environment, communication, breathing, eating and drinking, elimination, washing and dressing, controlling temperature, mobilisation, working and playing, expressing sexuality, sleeping, death and dying). *Knowledge and skills of nurses included the physical, psychological, sociocultural, environmental, political, sexual and spiritual underpinnings of the 12 activities of living'*. Source:Murphy et al 2010:19.

through reflexive practice (Alligood 2013). With the patient as the central actor, the interaction between nurse and patient had depth and meaning. This relational and holistic way of thinking and practising was quite a departure from the medically influenced, instrumental approach to nursing which was prevalent prior to the 1980's.

I spent my initial 12 weeks in nursing school being indoctrinated into the theory and practice of the 'Nursing Process'. For me, it was a gift. It was curiosity in epistemic form and appealed to my penchant for reflexive learning. I engaged with it wholeheartedly.

After the mandatory 12 weeks, and with my tutors' emphasis of '*pride in the profession of nursing*' ringing in my ears, I ventured out in my crisp new uniform, looking forward to three years of promised curiosity in action. Unfortunately (for me at least) our tutors had failed to mention that, whilst all wards we had been allocated to had committed in principle to adopt the Nursing Process, many were still in a transitional phase of adoption and some ward Sisters had refused point blank to engage with it. Throughout my nurse training, I experienced a mixture of all three situations and on many occasions, some wards would adopt it partially or wholly, dependent upon who was in charge of the ward on any given shift.

Research studies examining the nature of change in nursing practice from the early 1980's and into the 1990's, highlight these paradoxical tensions. Dartington (1994) noted that those ward sisters who did support the principles and practices of the nursing process were sufficiently tolerant of change to institutionalised practices, that curiosity, capacity for thought and intimacy with patients was encouraged. Conversely, some viewed this new approach to nursing as idealised, labelled their more liberal peers as eccentric (Smith 1992) and regarded the nursing process with indifference and suspicion; or as a deadly contagion which needed containment (Dartington 1994). Many nursing contexts persisted in keeping the dialogic nurse-patient interaction at a

distance; with communication preferably being superficial, and practice kept functional to the orientation of instrumental care (Macleod Clark 1983).

The reticence of some senior nurses to engage in new ways of nursing resulted in a transference effect for students (Dartington 1994). Being subject to a dominant discourse of distanced instrumentality, student nurses became anxious and reluctant to engage in more meaningful nurse-patient interactions (Dartington 1994, Savage 1995). In these restrictive contexts, their voice in the creation of holistic, relational practice became silenced, whereas in more liberal contexts students had presence, imagination, influence and voice (Dartington 1994). Their perceived reality was thus one of paradox. Student nurses' expectations and efforts to provide curiously wrought, knowledge based care, could be simultaneously compromised and facilitated. Practice was forged dependent upon the prevalence of the discourse at play and the perceived realities such discourses created (Smith 1992, Dartington 1994).

'…….Finding our feet is an unnerving business which never more than distantly succeeds'. (Geertz 1993:13)

My personal experience as a student nurse reflected these paradoxical realities. I had to adopt a constant awareness and vigilance as to who was doing what on any given ward, in order to orientate myself into new realities and manage the tensions contained therein. Along with observation, it was often the case that I asked about the 'rules of engagement' from fellow students who had previous experience of a particular ward culture, or questioned nursing assistants who would, more often than not, provide the detail of 'what Sister likes and does not like' and 'how things are done around here'. Even then, questions and answers would be surreptitiously mouthed, eyes would dart about nervously; heads would be down, as if concentrating on the task at hand and then raised fractionally, scanning for potential danger. What might be construed as

idle chit chat could get you into a whole heap of trouble. All were wary of the potential wrath that may come your way from Ward Sisters who had remarkable visual and auditory acuity.

As students, we would all congregate in the nurse's home lounge after a shift and recount our experiences of the day. Learning which way different ward Sisters liked leg bandaging done or which lotions to use on which type of wounds or whether you could ask questions or spend time talking to patients, was a means of survival. Likewise, word got around quickly of which students had been reprimanded that day and what they had purportedly done wrong in Sister's eyes. Forms of intransigence and degrees of 'drastic-ness' were shared. A 'telling off' on the ward counted as less drastic, as compared to being called into the School of Nursing to be 'disciplined'. Being disciplined was at the high end of the draconian scale. You would, by means of assimilation and discernment, resolve never to repeat the same mistakes. This was particularly useful as a student nurse who was frequently required to gain a broad variety of nursing experiences and move from one ward to another at six weekly intervals. You stored up other peoples lessons for future reference and used them mindfully. It was our version of Wikipedia and Facebook© combined. As a student nurse in a position of subordination, with your future reliant on attracting positive evaluation, being mindful of the prevailing worldview of the incumbent authority seemed a smart thing to do. As Menzies Lyth (1959) suggests, one begins to understand the required modes of functioning and behaving in a setting, through gleaning intelligence from insiders. Understanding such functioning enables one to set up psychological defense mechanisms to help contain anxieties and come to terms with enforced new realities (Menzies Lyth 1959).

My tendency to be curious and learn the rules of engagement through whatever means was available, served me well for the most part. All of my placement reports[7] reflected high opinions of my ability, willingness and quickness to learn and future potential, to

[7] Bar one, which I will come to presently.

the extent that I was asked to apply for Staff Nurse positions on many of the wards I worked on. I was often asked to teach more junior nurses and on several occasions, developed learning materials for use on the wards. When developing these materials, I learnt to use my curiosity to de-construct what I already knew to make knowledge accessible to others. Perhaps my previously destructive attempts at de-constructions, had become constructive after all.

I became confident with my curiosity to the point of asking how we might develop new ideas to improve practice. This way of approaching nursing in the early 1980's was quite a novelty[8]. Whilst on placement on a paediatric ward, I began to notice that one set of parents in particular who had a child on permanent artificial ventilation, showed an interest in the technical aspects of the care we gave. It occurred to me that it could be possible to teach and train the parents to care for their child and keep them at home. I put this idea to the ward Sister, who agreed to support me in developing a care pathway for these children and their parents. Working with her, the Consultant Paediatrician, the Paediatric Anaesthetist and one of the Paediatric Tutors, I learnt as much as I could about the topic and developed a competency based training programme, linked to a care pathway.

Although I did not know it at the time, the ward Sister took this development further and rolled it out to children undergoing chemotherapy. I was to learn only a few years ago that the concept of 'Hospital at Home' for children, as it became known, had subsequently been adopted across the region. During my time in North Borneo, I also took this idea and the learning I had gleaned from it and, again with others, developed a 'Hospice at Home' programme for terminally ill cancer patients. I cannot take sole credit for the outcomes of my curiosity here. If I have learnt anything about my curiosity over the years, it is that it cannot thrive without a climate of support and

[8] The notions of nursing development, evidence based practice and nursing innovation did not come to the fore of nursing practice until the late 1980' and early 1990's – source Page & Hamer (2002).

encouragement. In these two examples, like minded others, with a spirit of inquiry and learning were central to collective success.

Learning from and with others and engaging with my curiosity in a reflexive, mindful way, as my Dad had imbued all those years ago, was seemingly beneficial. It gave me the power to process and to understand differing worldviews, innovate and work with most eventualities. I no longer stood on the sidelines. I felt seen and heard.

Although I was not aware of 'mindful curiosity' as a theoretical construct at the time, my understanding of its impact and application to life events, has only just begun to take shape. My mindfulness in this present moment, reminds me to digress slightly and draw on the benefit of current research on curiosity to provide some insights into 'mindful curiosity', as promised. It is also worth noting here that no research has been conducted on curiosity in nursing or healthcare (my search strategy can be found in appendix i), and so insights are derived from the complex, incomplete and emergent body of literature that makes up the current knowledge base on curiosity.

The literature is complex, incomplete and emergent due to the fact that there have been many attempts across the last 55 years to empirically define, describe and measure curiosity and determine its nature, qualities, features and benefits (Boyle 1983, Loewenstein 1994). Up to the present decade, there is acknowledgement across the scientific community that the research on curiosity is subject to 'conflicting conceptualisations' (Reio et al 2006: 121), remains 'under theorised' (Guthrie 2009:65) and 'understudied' (Kashdan & Fincham 2004:482) leading to research which is 'redundant and isolated' in parts (Reio et al 2006:121-122) and on the whole, research on curiosity is rather 'messy' Guthrie (2009:65).

Part of the problem, according to Loewenstein (1994) and Kashdan and Fincham (2004) is due to the range of different disciplines that have attempted to study, measure and explain curiosity in terms of their discipline specific, pre-existing theoretical frameworks. The majority of research on curiosity has been conducted by

behaviourists, educationalists and psychologists, has focused upon experimental studies to continue theory development. However, attempts to develop theories of curiosity have been replete with complex issues due to its inherent abstract facets, therefore current research tends to focus upon and undertake experimental factor and construct analyses (Loewenstein 1994, Guthrie 2009). Despite the 'messiness' of current research, some interesting and valid insights may be drawn from the existing body of knowledge, which could have direct relevance to nursing practice. Refleting back to the subject of 'mindful curiosity' and its role in developing strategies to manage changing realities, the work of Kashdan et al (2011) is perhaps relevant here.

Based upon the hypothesis that mindfulness can be leveraged by curiosity, to respond receptively to existential threats, Kashdan et al (2011) undertook a quasi experimental study to assess whether attitudes of curiosity coupled with mindfulness, would result in non-defensive reactions to threatened worldviews. The work drew on a synthesis of the work of psychologists Bishop et al 2004, Hayes et al 2006, Niemiec 2010, who suggest that one is mindful by being openly observant, receptive and attentive to what is happening in the present moment, with mindfulness operating as way of being which is inquisitively focused on the novel or unfamiliar. An orientation of curiosity with mindfulness seeks to appreciate and learn from what is new and unfamiliar, even when uncertainty and anxiety prevail (Silvia and Kashdan 2009). The study concludes that in a given present, mindful curiosity helps individuals to openly explore and engage with differing worldviews, practices and situations, by enabling cognitive flexibility, context sensitivity and adaptive states of being and behaving (Kashdan et al 2011).

Please report to the Senior Tutor's office immediately.

Whilst this correlation between curiosity and mindfulness may be true, theoretically at least, Kashdan et al's (2011) research did not address the possibility of sudden reality shifts and the effect this has on curiously discerned ways of being and adapting. That is, even when individuals may engage their curiosity with mindfulness, the rules of

engagement as determined by those in positions of authority can be rendered inaccessible or can change, without prior indication. One then finds the process of understanding some worldviews as illusive, like trying to catch a moonbeam.

I remember one particular incident which illustrates my own unsuccessful attempt at fishing for moonbeams very well. It was 6 months into my final year as a student nurse. With only 6 months to go, I felt the finish line and a great future as a nurse was in sight. I had just completed an early shift on an acute medical ward, my last but one placement, and returned home. I had been home for about ten minutes, when the phone rang. It was the staff nurse on the ward saying that a message had been left for me to report to the Senior Tutor in the School of Nursing immediately. Images of the draconian Likert scale came immediately to mind, along with a real confusion as to why I might have been summoned. I tried to scrabble with the contours of my memory to try and identify some recent travesty. Nothing. I had no idea why he wanted to see me and there was no opportunity to climb into that secret space to become prepared.

When I arrived there was just him in his office. He presented me with litany of complaints from the Sister in charge of the ward I was currently working on. I had been on the ward for 5 weeks at this point. The complaints ranged from failing to give a patient their tablets and challenging her decision to stop a blood transfusion. Her first recommendation was that these were serious professional misconduct issues and I should be dismissed immediately. Failing this, she demanded that I should re-sit all my medical theory and practical examinations, and undertake an additional and extended medical placement. This would mean that my registration would be delayed by approximately 6 months. She made an annotation that this complaint be kept on my records and submitted to the General Nursing Council in the event of my eventual registration, and that she would prefer that this extra placement not be on her ward.

I was devastated, confused, utterly dumbfounded. I could not for the life of me understand what was going on. I had absolutely no recollection of the events she listed

and I felt that I had had been doing quite well on her ward. Neither her, nor any of her senior staff had given me the slightest indication that anything was amiss with my performance. In fact, this particular Sister had praised me a couple of weeks before on the care and attention I had given to a terminally ill lady.

My saving grace came through the measured and considered approach the Senior Tutor took. We talked about how the Sister might have construed some of my actions and he gave me the opportunity to reflect back on events. It transpired that I had indeed not given a patient her tablets. This patient was the lady who was terminally ill and could not swallow. I had explained this to this particular Sister, who was giving out the drugs at that time. She still handed me the tablets. I respectfully returned them to her some time later and enquired about alternative forms of drugs. I asked if it was possible that we might be able to administer something via a different route. With regard to the blood transfusion, she had told me to stop this even though the patient had only had two of the three units of blood he had been prescribed. As this particular patient had no observable contraindications to stop the transfusion, I was curious as to why this Sister has asked me to stop it. I remember thinking at the time, that due to her years of experience, she must know something that I did not and so wanting to learn, I asked her the question why.

With all of this taken into consideration, the Senior Tutor duly took the letter of complaint, tore it up in front of me and put it in the waste paper basket. He looked at me, with an understanding gaze - the like of which emanates from those who have wisdom running through their veins - and he very gently explained to me that, in his assessment, I had, through my own curiosity and willingness to learn, unwittingly challenged this Sister beyond her level of tolerance. He went on to say that, despite our own best intentions, there will always be those who interpret our actions differently, to protect or maintain their own power and agency. An act of independent thought on my part, evidently posed a threat to a worldview of dependence on and deference to a

given authority. The far reaching hand of panoptic power and authority had now extended its reach.

I guess this was my first, but sadly not last, experience of what has been more recently termed as 'horizontal violence' - an iniquitous practice common in nursing, which dances pollutively with power, demands compliance and seduces individuals into insidiously determined norms (Rittenmeyer et al 2013). For those like me, who naively breach a tacit code, punishment comes in its most destructive form. I would never have been able to catch this particular moonbeam.

When I look back on this particular event, something quite profound happened to me. Despite the opportunity for reflection and the understanding and wisdom of the Senior Tutor, I could not resolve the feelings of injustice I felt or the lack of integrity I perceived this ward sister to have. In that one moment, a sliver of my spirit had been sliced at cthonic depth. My curiosity had been silenced. I became afraid of the power that my curiosity could bring about in myself and in others and spent the remaining 6 months of my nurse training in fear. It was a fear so deep that it often rendered me impotent. I was no longer the confident student, but halting, anxious and wary. I contained my curiosity within an internal vessel and I carry this one to this day. I became aware that although my curiosity could enhance my nursing, it could also significantly compromise it. I realised that my curiosity had the potential to end a career that had barely just begun. It was a new reality.

Out of the night that covers me,
Black as the Pit from pole to pole,
I thank whatever gods may be
For my unconquerable soul.

In the fell clutch of circumstance
I have not winced nor cried aloud.
Under the bludgeonings of chance
My head is bloody, but unbowed.

Beyond this place of wrath and tears
Looms but the Horror of the shade,
And yet the menace of the years
Finds, and shall find, me unafraid.

It matters not how strait the gate,
How charged with punishments the scroll.
I am the master of my fate:
I am the captain of my soul.

Invictus
William Ernest Henley 1849-1903

My narrative on curiosity is the story of an embodied spirit which thrives and evolves on inquiry and reflexive learning. Knowledge generation and its integration into the world of nursing which I inhabit at any given time, is at the core of my ambition. When set free, my curiosity releases an aspiration to go beyond that which is and determine that which could be. Bringing forth a wellspring of emancipatory action which cavorts with insubordinate and impish transgressions, curiosity is an epistemic dance which has choreographed my life to date. Whilst many of my experiences arising from my curiosity have been positive, some have agitated my world and the world of others. I realise that whilst curiosity may bring about a desire for something to be 'other', it can also bring about ontological turbulence in the process of its desire. It can, as Benedict (2001) suggests, disrupt catalogues of thought, violate realities and liquefy identities. Curiosity in my world is paradoxical.

When I look back over my life and career, I am not able to resolve all of the issues that my curiosity has invited and carry them with me, although I have been more able, through experience, to read the rules of engagement that much better. What I do know is that nursing and the teaching of it is a catalyst for my curiosity. In finding vehicles for this catalyst, I have gravitated to places and into roles that embrace my curiosity – at least on the surface. I cannot say my moves have been conscious choices. They have, in the main been opportunistic, based upon a language which resonates with my curious energies. Perhaps I am drawn to people, contexts and discourses that espouse curiosity and which speak to my soul and entice me into a series of new realities.

But is there a caveat - a price to pay for such indulgence? The shifting sands of concomitant realities which curiosity can invite, might just leave me chasing an identity and a reality that is forever out of reach. Led by the discourse of curiosity and its

promise of reaching *'continents of thought beyond the horizon'*[9], along with that elusive shape which some call wholeness, it begs the question of whether I am truly the captain of my soul.

However, I do think that my curiosity takes me into an internal dialogue which pays focused attention to the paradoxes it observes. It is a dialogue with those paradoxes which arise within discourses, that perhaps takes me on that search for wholeness; to find as Bohm (1980:188) describes, the 'implicate order of things' – the harmony that my spirit and soul craves. Curiosity though, demands action. It contrasts from its close cousins, imagination, interest and wonder which although, as attested to earlier, may be pre-formative reflective acts (Hove 2011), if they are not followed by curiosity, they stay as momentary states (Kashdan and Silvia 2009). The centrality of this action is knowledge – its exploration, generation, integration and application. Curiosity is a reflexive act and epistemic in its intent (Kang et al 2009). This architectural form is at the core of my current work to help fellow nurses explore and improve practice and is, I suspect, bound to my quest for wholeness.

Although it has become clearer through these reflections, that there is almost certainly a self indulgent motive to my curiosity, the work which enables it is undertaken in dialogue and action with others, and I would like to think that it is upheld at the level of the collective; that it is participatory. It is through this participatory, dialogically reflexive approach and paying curiously mindful attention with nursing colleagues, that challenges to engaging with curiosity in nursing practice have recently arisen and this is the subject to which I now turn.

[9] Pefanis, 1991:138, cited in Lather, 1993:687

Chapter 3

Curiosity in Context

'Or is it that some Force, too wise, too strong,
Even for yourselves to conquer or beguile,
Sweeps earth, and heaven, and men, and Gods along,
Like the broad volume of the insurgent Nile?
And the great powers we serve, themselves may be
Slaves of a tyrannous necessity?'[10]

Location: An NHS Trust or two, somewhere in England – circa, 2006-2009. Prior to beginning PhD.

I could sense something was amiss as soon as I walked into the room.

Sat around the large conference table were fifteen or so clinical team leaders, whom I had arranged to meet for a six month follow up meeting. I knew them all well. I had been working with them for just over two years and they had been very adept at and successful in engaging their patients, carers and teams in a variety of co-created, clinical improvement projects. As mentioned in my introduction, curiosity was a central motivator in their knowledge journey. Working with this reflexive process, they had completed groundbreaking work by developing an innovative toolkit to improve professional practice. Our plan for the day was to celebrate their successes, reflect upon current practice and develop an on-going practice development strategy for each team, for the next 12 months. Considering the fact that their work had been recognised nationally as an exemplar of best practice[11], they had much to celebrate. Yet, on this

[10] Extract from Mycerinus, a poem by Matthew Arnold 1822-1888

[11] A reference which supports this claim can be provided to examiners on request. It is not supplied here as it would clearly identify this team. As all University of Leeds PhD theses are published on line and are therefore publically accessible, a definitive reference is therefore omitted for ethical reasons.

occasion the high energy, drive and motivation which I had experienced with them on previous occasions, was absent. Initial greetings were insensate. Interpersonal interactions stilted. Their energies inert. Something was clearly wrong.

In trying to open up a reflective dialogue with them, I told them respectfully what I had sensed and invited them to respond. One by one, slowly at first, the team leaders described their current world of work and the impact it was having on them and their teams. I started to listen.

Collectively, they presented a portrait of constant rupture to a world they once knew and understood, leaving them feeling lost in a vortex of upheaval and resigned to a fate yet to be determined. Daily life, in their words was like 'being on a rollercoaster', 'being lost in fog', 'pushing jelly uphill' and 'being in permanent white-water'. They talked of being in relentless cycles of change, the nature and form of which constantly shifted, along with the demands it placed upon them. They said they were exhausted by it.

One community based team had been told that their case loads would be increasing to double the amount of patients they could assess and that their base would be re-located. The new location was an additional twenty miles further than their current client locality. Practitioners were concerned about how they would physically manage to increase their case load whilst having extra distances to cover. They decided to get together and devise a better way of working so they might comply with the new requirements. Having spent many hours, mostly in their own time, to re-organise their daily operations and come up with a workable solution, managers then told them that the plan to re-locate them would be subject to a further review. Since they were first told of the re-location, four reviews on the issue had been conducted. The team leader said that her staff felt like they were 'constantly hanging in mid air' and that patients were becoming increasingly anxious as to the future of their care.

Despite this teams' reputation for rigorous accountability and effective governance of their clinical innovations, they also felt coerced into accepting dictated ways of working.

The recent introduction of a plethora of pre-determined clinical protocols, guidelines and pathways was, according to the team leaders, ' going back to task based practice', with one commenting: 'We *(nurses* – my italics) have gone back a hundred years'. The clinical leaders also felt that their ability to work in partnership with their service users and co-produce practice relevant to contextual need was being compromised.

Referring to work the teams had done in the past two years to develop multi-disciplinary, integrated care plans and pathways, (which they had also designed with their service users and third sector colleagues, to promote continuity of care), one clinical leader said these had recently been discarded by the Trust and replaced with fourteen separate care plans. Notwithstanding mountains of documentation to complete, she said this now meant that their time was spent asking patients scores of questions, many of which were irrelevant to their condition or situation and carrying out pre-determined tasks. She also added that in her view, this new way of working meant that patients were being unnecessarily re-admitted to hospital, as specific needs were not being met and co-ordination across services had been compromised.

When she told managers that she and other clinical colleagues could see problems arising, managers told them that, considering that the Trust was now being paid against its pre-determined activity[12], the new protocols and care plans made for better data sources to measure contractually set performance targets. The manager also added that they should just 'get on with the job' and leave any operational problems for managers or the corporate Service Improvement team to deal with.

Seemingly under close surveillance and control, clinical leaders bemoaned a world which spoke of local ownership, critical thought and innovation. They could see their

[12] The NHS Plan – a key NHS policy document of the New Labour Government - July 2000, introduced the Government's intention to link the allocation of funds to hospitals to the activity they undertook, known as' payment by results'. This reformed financial system offered incentives to reward performance, support reductions in waiting times for patients and make the best use of available capacity. The system of payment by results was first implemented in October 2002 and staggered across the NHS over the next 5 years.
Source:
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH_077259

curiously wrought ways of working becoming erased. One team leader explained how recent funding for a research project had been rescinded by the Trust. They had been working with care homes to reduce unnecessary use of psychotic medications for elderly patients. The plan was to generate evidence and then develop protocols for the appropriate use of such medicines. The Trust felt that it was not in their remit to deal with drug issues arising in care homes.

The teams had, it seemed, become resigned to feeling beleaguered, with no glimpse of a way out of their current reality. Some had reached a point of despair. They had attempted to engage their managers in discussions on their perceptions of the impact of enforced change on patient care and on the motivation and morale of their co-workers. Managers, they said, refused to engage in critical discussions on the rationale for change or its method of implementation. It appeared that they too, according to the clinical team leaders, were subject to 'ruthless pressure and scrutiny' to make efficiencies and progress measurement of distantly prescribed performance measures and outcome targets.

Despite my attempts to remind them of and celebrate their successes and encourage them to look at possible ways forward, they were very reluctant to engage in any form of reflexive dialogue. I sensed no tangible inclination from them to pause, be curious and learn in, with and from their experiences. It was as if, in a short time, this dynamic group of nurses, so proficient in clinically led, quality improvement had voluntarily become infantilised. The dejection and impotence in the room was palpable.

'*Paradoxically, even when governments are giving clinicians autonomy, it can feel like interference'* (Traynor 2013:125).

Had this been an isolated incident, I might have thought it a passing phase, a temporary and context specific transition. However, the narrative began to repeat itself

across the country. Without exception, every clinical team I visited over the next 2-3 years had a similar story to relate.

One team in particular called me to cancel a meeting we had arranged to develop a client centered philosophy of care, specific to the specialist needs of their discreet client group. They stated that their NHS Trust had sent out a directive to all nurse managers instructing them to phase out any nursing models and philosophies currently in use. Nurses in this Trust had been utilising a model of care known as 'Primary Nursing' - a model and philosophy of care based on the principles of a therapeutic alliance between nurse and patient, with the focus being on nurse led organisation of care, which reflected accountabilities for patient centeredness (Savage 1995). The Trust, it transpired, was under pressure from government policy to demonstrate standardised practice and had developed a generic nursing assessment, which was to be used for all patient groups. The assessment had apparently been designed without the input of clinically based nurses, and was structured to reflect a series of quality indicators such as infection control, environmental cleanliness, drug administration and patient satisfaction.

The same Trust, the team leaders told me, had also issued a moratorium on all reflective practice and clinical supervision sessions, saying that nursing time would be better spent in conducting set audits to measure quality outcomes and meet organisational discharge targets. The latter apparently had an emphasis on freeing up bed space on the wards, to promote increased patient throughput in the system and improve patient waiting times. One ward sister told me that she had approximately twenty three separate audits that she had to complete and submit to senior managers on a monthly basis. Time for practice related issues and leading the team in improvement work were lamented – seemingly lost in a myriad of surveillance activity.

'We welcome innovation and local ownership….. (there is a) shared desire across the NHS for more freedom and less monitoring……..Clinicians and managers play a

key role in enabling change and improvements to services. This is clearly recognised in the NHS Modernisation Agency's work supporting and developing leaders at all levels in the NHS' (NHS Modernisation Agency 2003)

In another Trust, clinical team leaders had been told to stop all development work, as the Trust was to introduce a new efficiency initiative developed by the NHS Institute for Innovation and Improvement. Known as the 'Productive Ward: Releasing Time to Care Programme™', this initiative, based upon evidence from work undertaken on the production lines in the Japanese car industry, was designed to enable more efficient and effective ways of working (Morrow et al 2012). Whilst many practitioners said that in principle, they could see its worth, two separate teams related their experience of it as a 'ridiculous waste of time', 'not very well thought through', 'not practice focused or intellectually stimulating' and 'not inclusive of patient views'.

For example, in two areas, despite staff protests to the contrary, managers determined that to save staff time in walking to and fro', shelves could be put above patient beds to hold sundries such as gloves, hand sanitising gels, tissues etc. and in another, equipment and patient note trolleys could be moved from their current locations behind the nurses' station into the main ward corridors. The outcome after all the changes had been put into effect was that in the first example, patients complained that they felt unsafe with shelves above their heads, fearing that items could drop on to them. All the newly constructed shelves were subsequently removed. In the second example, patients who had mobility problems found they could not use the hand rails on the main ward corridor due to the obstacles created by the trolleys. Two patients fell whilst trying to navigate their way to the ward toilet. All trolleys and equipment were subsequently re-located to their original positions. Although many staff felt that their initial perceptions of the programmes' usefulness were vindicated, they said that due to a recent Trust directive to roll out the programme across all wards and departments, they felt they had no alternative but to engage with it.

On one occasion I received a phone call from a clinical leader who asked my advice on how she might motivate more of her staff to become involved in clinical improvement work. Sensing there was more to the phone call, I asked what had prompted her to focus in on the issue of staff engagement. She related a situation with her team whereby many of them were undergoing changes to their job specification, skill mix and roles[13], which for some was negatively affecting their seniority grades and their pay. As a result, she said, team members were de-motivated and reluctant to engage in any kind of development or improvement work as they now considered this as discretionary activity, out-with their newly specified roles and revised job descriptions. In trying to bolster their motivation and encourage their involvement in development work, two staff members had reported her for bullying and she had received visits to her office by Trades Union officials. This lassie was absolutely confounded. Only a few months previously, she said, her team had won a Trust award for their outstanding teamwork and contributions to improving patient care. It was she said, 'Crazy. Why should I bother? It's like the whole world has suddenly gone mad'.

"The evidence never seemed to matter to those in power, who had already made up their minds and did what people typically do when their worldview is threatened by new data: they attacked the messenger."

Sol Luckman 2014: *Snooze: A Story of Awakening*

[13] During the Labour Government 1997-2010, reforms to the NHS included a review of pay and skills for all staff except doctors and dentists. Known as 'Agenda for Change', all staff had to undergo a job evaluation. The NHS Job Evaluation Scheme was purportedly a means of rewarding people by measuring their job-related skills, knowledge and responsibilities. A detailed assessment of each post was undertaken using the Job Evaluation Scheme which determined the correct pay band for each post, and so the correct basic pay. Many jobs were evaluated nationally and used for matching posts to new pay bands.
Source: http://www.dhsspsni.gov.uk/agenda_for_change.pdf

‘One of my colleagues was invited to speak at a national NHS conference where he presented a paper on his views of the reforms and how he thought they were negatively affecting his staff and compromising care.

Shortly afterwards, he was called personally by the Secretary of State for Health.

It was a career limiting, one sided phone call……..

So, you’re dammed if you do, and dammed if you don’t.

The pressure is enormous. More than I have ever experienced in my 30 years in the NHS.

The average time a Chief Executive stays in any post these days is 12 months*.’*

*(*Personal conversation with an NHS Chief Executive circa 2007*)*

Surrounded by the gloom of a forest, Dante wakes up, lost in time and space. Confused, he begins to search for a way out……...

Dante in the Dark Wood.

Etching by Gustave Doré, 1857.[14]

[14] This is a faithful photographic reproduction of a two dimensional public domain work of art. The work of art itself is in the public domain. This applies to Australia, the European Union and those countries with a copyright term of life of the author plus 70 years.

The litany of stories from nurses and more senior NHS staff were disturbing to me. It appeared that the notion of caring practices, reviewed and improved, through reflexive knowledge integration and sculpting episteme, was being compromised. If I were to re-look at my own ideas for curiously wrought practice, then curiosity, it would seem, had been invited into the darkness of Dante's wood.

Yet, despite the perceived oppression and dispossession which emanated from the discourse of clinical team leaders, I was somewhat bemused.

At that time (around 2006/09), NHS policy discourse, although professing measures to improve performance, efficiency and effectiveness, also professed support for clinically led innovation and improvement (Traynor 2013). The combination of these policy measures partly constituted the 'NHS Modernisation Agenda', conceived under a series of reforms to the NHS by the then Labour government between the years 1997-2010 (Traynor 2013). The intent was to make the NHS fit for purpose in a modern world. Under pressure from advances in science and information technology, significant epidemiological shifts and a more informed, analytical and sophisticated healthcare consumer, policy needed to reflect value for money, accessibility, cost effectiveness, efficiency and quality. Many of the reforms purporting these features were becoming embedded and felt between the years 2006-2009 (Mays et al 2011).

As part of the modernisation agenda, millions of pounds (the exact figure is unknown) were invested in clinical leadership for nursing and allied healthcare professionals (Edmonstone and Western 2002). The purpose underlying the emphasis on leadership was to empower healthcare professionals to initiate and sustain improvement and innovation at the patient-practice interface (Kitson 2001, Traynor 2013). Leadership opportunities and more power to effect local level change and develop new ways of working were also offered to nurses in the form of new roles. Modern Matrons, Nurse consultants, Nurse Entrepreneurs and extended roles such as nurse prescribing were all created and were seemingly embraced by the nursing profession (Rivett 2011).

Recognising the potential of healthcare professionals to contribute to a modernising agenda, nurses, who constitute the majority of the healthcare workforce and who were directly placed at the patient care interface, were invited to step up and step forward and position themselves to meet higher ambitions and public rights and expectations; to innovate, improve and develop practice and services fit for a modern world (Modernisation Agency 2003, WHO 2010).

In parallel, the accumulation of a distinct body of knowledge, coupled with the influence of the evidence based practice movement, was also central to popular nursing discourse and its historical drive towards legitimising nursing's professional habitus (Traynor 2007, Tosh 2007). Scholarly activities such as lifelong learning, reflective practice and developing practice in context formed the bedrock of epistemic practices and were perceived to be the golden lynchpin to nursing's unfolding modern identity (Beck & Young 2005). Such discourse emanated throughout the profession and held resonance with a modernising thesis. The work of Giddens (1991), suggests that the distinguishing feature of a groups' modern identity lies in the ability of individuals and collectives to reflexively apply new knowledge and thinking as it comes into the system, thus altering established values, attitudes, norms, practices and forms.

With such empowering discourse, one would imagine that clinical teams would feel liberated to engage with their curiosity and create conditions for communicative action and emancipatory learning. Surely empowering government policy and the label of knowledge rich professionalism gives nurses licence to proceed, to take up the mantle of improvement, be curious and join a liberating movement which promises reward.

"*Whether it's trying to convince others that something is more true, more virtuous, or more desirable, all communication is rhetoric in action.*" Leonard Koren 2003: Arranging Things: A Rhetoric of Object Placement.

Beginning my PhD

I spent most of my time gardening –completely lost in it - preparing it for the summer – nurturing it to bloom and grow into something spectacular. My garden is my sacred space – a place for healing, introspection and reflection. It also feeds my curiosity. I am constantly curious as to the well being of my plants, how they are now, where they are in their phase of growth – why aren't some growing yet? Why are some stronger than others? I am constantly on the look out for the delicate tips of new growth and seeking ways in which I can protect them from the destructive power of the elements and the cats and squirrels. I search the internet and my gardening books to find the best ways to grow my different plants – I am constantly learning and experimenting. I am curious as to how they will thrive and look in the fullness of a bright sunny time. My garden is the place where I am not harmed by my curiosity and I can take risks with what I have learnt and try out new things and be creative – even if I do fall into the pond on occasion. Learning and its application has often been the purpose and drive to my curiosity – to learn and experiment and create something new or anew.

Perhaps nurses too have a sacred space… an existential space…somewhere they go to deal with the everyday- to deal with the destructive powers they perceive to be around them – to find a bright sunny time. Where and how do they try out new things and use their curiosity? Do they feel harmed by it? They tell tales of an environment which depicts aridity – is the NHS a desert for curiosity? Not many tall (or short) poppies can survive in a desert. What are my expectations of practitioners as an educator.. that they should be curious at all costs – any cost? What is that cost? Am I as an educator caught up in that modernising rhetoric? Am I blindly subscribing to and promoting a political and professional ideology which may in fact be at odds with the reality of the nursing world? Am I evangelically sermonising curiosity within Frierian framework as a panacea? What arrogance, if so. Perhaps some insights from the nursing literature and research on curiosity might provide me with some much needed enlightenment ……

On reflection and considering the events and stories which nurses had been relating to me, it may be the case that constant reform and change have had a considerable impact on the form and function of healthcare organisations and on the roles and working practices of the nursing workforce. According to Tosh (2007) and Traynor (2013), boundaries and frameworks of nurses working practices have shifted and become blurred and confusion arises as to clarity around once understood roles. Dominant discourses driven by political and economic mandates have favoured corporately led service improvement, resulting in nursing practice which limits itself to accommodating cost containment strategies (Urban 2014). The semantics at corporate level lead to the perception that staff at the nurse-patient interface are not capable or entrusted to initiate practice change (Page and Hamer 2002). Care pathways, predictive operational processes, care protocols, care quality indicators, efficiency targets and an array of imported organisational improvement programmes have all been implemented. Through compliance to prescriptive norms, it is implied that clinical effectiveness, standardisation, productivity and efficiency are assured as a constant and that knowledge is in an (arguably) static form (McCrae 2011). The suggestion is that nursing practice becomes normalised, as prevailing ideologies dictate the form and function of practice, rendering nursing power to effect change redundant (Urban 2014). Whilst modernising healthcare policy might espouse the widespread adoption of protocols; nursing practice, unsupported by nursing models and theories makes nursing reliant on '*bureaucratically imposed outcomes'* and predetermined standards (Chambers 1998, cited in McCrae 2011:225) and only serves the perverse incentives of administrative masters (McCrae 2011). Reio and Wiswell (2000) point out that many institutions fail to promote curiosity due to control orientations, rather than cultivating environments which support new learning and innovation. Individuals are rewarded for performing to set standards and protocols, rather than for cultivating new ideas and approaches to working practices (Reio & Wiswell 2000). Attree (2005) would agree. Her grounded theory study exploring the perceptions of 142 registered nurses' with respect to their agency and governance of professional practice, noted that the

healthcare reforms which took place in the late 1990's through to 2004, had a detrimental impact on nurses perceptions of their autonomy to govern and determine the nature and quality of their own practice. Professional ideologies and values were in direct contrast to the hierarchical control and outcome oriented NHS management practices, driven by government policy (Atree 2005).

Whilst many quality initiatives and change programmes, such as the aforementioned 'Productive Ward' programme, have undoubtedly contributed to improvements in patient care, models of change and improvement have historically focused upon organisationally identified deficits, at the expense of an exploration and appreciation of existing practice (Walsh & Freshwater 2009). Few improvement initiatives are led directly from and within everyday practice (Page & Hamer 2002). The role of praxis as a unified enabler to integrate experiential, propositional and codified knowledge at the patient-practitioner interface may well be compromised. As a result, corporately led deficit models could be said to lead to a detrimental impact on practice, staff learning and morale and a felt lack of ownership of change processes at the practice level (Walsh & Freshwater 2009). Whilst Leonard & Harvey (2007) and Kedge & Appleby (2010) note the pivotal role of curiosity to enable and own knowledge integration at a local level and make a convincing case to promote curiosity as an enabler of learning, Kashden and Yuen (2007) noted that individuals who were exposed to an environment which failed to challenge their thinking and was unsupportive of curious exploration, performed at a lower level and failed to thrive intellectually. Likewise, in their meta-analysis of research on predictors of intellectual achievement, Schiefele et al (1992) noted the effect of perceived threats toward those who may show a propensity to curiosity.

Further inconsistencies arise in the modernising discourse of the NHS as a whole, as in Giddens' view: `*living in the world produced by high modernity has the feeling of riding a juggernaut. It is not just that more or less continuous and profound processes of change occur; rather, change does not conform to either human expectation or control.'*

(Giddens 1991: 28). Eraut (2004) informed by the work of Schon (1983), describes such conditions of rapid change and complexity as '*hot action contexts'* (Eraut 2004: 258). Within these contexts, Eraut (2002) suggests that attention to and consideration of multiple knowledge sources becomes competitive, due to constantly changing demands. With the pressure for productivity and efficiency prevailing, practitioners may often choose to utilise intuitive and existing forms of knowledge as they are denied the opportunity for reflection and knowledge integration (Eraut 2002). Time is poor, curiosity is inhibited and thinking and practices become stagnated and routinized, leading to quality failures, lack of innovation, increasing risk and plummeting job satisfaction (Eraut 2004). Routinized knowledge of this kind becomes increasingly valueless as circumstances change and knowledge evolves. The propensity to engage in exploration and search for new knowledge or insights through deliberative means, utilising integrated knowledge sources, is significantly compromised or absent (Eraut 1985, 2000, 2002, 2004).

If then, we are to believe that as an unfolding dialectical process, high modernity stimulates ontological and epistemological shifts, enfolded within curiously led, chronic reflexivity (Giddens 1991, Eraut 1985, 2000, 2004), then does a culture of compliance exist to stifle progress, mock the rhetoric of improvement and along with it, erase the need for curiosity? And /or do nurses embrace compliance, silence their curiosity and co-create, reinforce and welcome compliance as a protective mechanism to survive in an environment of perceived marginalisation?

Perhaps all is true. However, experimental studies conducted by Kashdan et al (2004) and Kashdan & Silvia (2009), suggests that curiosity motivates us to leave familiar and routinous practices, even when uncertainty and anxiety prevails, and helps us to extract and integrate experiences and meanings from processes of exploration and discovery. In arguing that those who have a propensity for curiosity are more likely to recognise, pursue and become absorbed in learning and growth experiences, Kashdan et al (2004) in their experimental factor analysis, found positive correlations between

curiosity, exploration and absorption, positive subjective experiences, positive evaluations of the self, the world and the future. Additionally this research found that those who engaged with curiosity, believed goals are attainable and obstacles can be circumvented, with most research participants demonstrating general tendencies to enjoy effortful cognitive endeavour, be open to new experiences and to recognise, pursue, and thrive on novelty and challenge (Kashdan et al 2004). The view that curiosity also enhances feelings of reward and pleasure is a position supported by functional imaging studies conducted by Kang et al (2009), who noted significantly higher activations in the reward circuitry and memory enhancing areas of brain functioning, with study participants who rated highly on epistemic curiosity scales. With such reportedly positive effects, one might think nurses would then engage with their curiosity, regardless of perceived constraints and uncertainties.

With the emphasis on workforce development and innovation in the NHS, one might also think that curiosity may thrive. Whilst there is limited research on the relationship of curiosity to workplace learning, characterised by complexity and constant change, the need for curiously wrought knowledge integration in modern organisations purportedly gives an edge to competitive knowledge economies and is vital for the continuous learning needed in contemporary workplaces (Reio and Wiswell 2000, Leonard and Harvey 2007). As far as individuals are concerned, studies by Perlovsky et al (2010) suggest that the satisfaction of learning something new has a significant pleasure component for subjects. Litman (2008) concurs with Perlovsky et al (2010) and concluded from his experimental study, that those who held a propensity to add new ideas and concepts to their repertoire would be motivated to explore in a diverse fashion, resulting in feelings of enjoyment associated with wanting to improve intellectual mastery, whilst those who reflected curiosity as a feeling of deprivation were more likely to be energised by specific exploration, aimed at solving problems and setting performance oriented goals.

Within such a liberating discourse, consistent with Freirean (Freire 1993) thought, nursing must then have the gift to engage with curiosity, integrate knowledge sources, critically appraise deficits in practice, craft new knowledge and transform its mind-set towards leading improvement and development. Stimulated by epistemic curiosity, the alchemy of learning along with reflexive concomitant action reflects a nursing contribution which is central to its modernising text through scholarship and practice, empowerment and growth. The construction and integration of multiple forms of knowledge maintain nursing's professional identity in its efforts to provide person centered care (James et al 2010). However, Goldberg (2002) notes the possibility that there may be occasions and situations where certain individuals believe that their current situation lacks inherent meaning and individuals may choose to live within the present moment with no desire to change, learn or grow. With nurses exhausted from change, the energy and emotion required for knowledge work may be to effortful. Thus, reticence to expend curious energy may be enacted. Additionally, whilst curiosity may hold the prospect of wholeness and fulfilment, it may also elicit tensions promoting existential and ontological conflict (Goldberg 2002). Contradictions in exploratory behaviours may therefore arise, as nurses struggle with competing realities and seek to maintain a world of practice and habitus which is historically mandated (Traynor 2013, Maben et al 2007).

Although experimental studies in the automotive industry have noted a positive correlation between sustained curiosity and increased job performance, during complex organisational change and workforce transformation (Mussel 2012), instances of feeling of being overwhelmed, stifled and helpless are also reported in the literature. For example, in their grounded theory study exploring the impact of sustained curiosity, Levitt et al (2009) noted that the experience of curiosity could result in great intellectual discomfort when curiosity became too consuming and that inordinate amounts of time would be invested in curiosity, which impinged on other areas of work causing feelings of neglect, tension and worry. Additionally, some study participants relayed that when

their curiosity was not rewarded by learning and knowledge generation, they experienced feelings of anger, fear and helplessness (Levitt et al 2009). To contain the discomforts and anxieties which may arise from tensions arising from reward deficits and the unpredictability of complex change, nurses may thus refrain from engaging with their curiosity, either as a political protest strategy or as a means of protecting a sense of familiarity and well-being.

Whilst most studies on curiosity have focused on theoretical construct analysis and have been conducted out-with contextual frames, Silvia & Kashdan (2009) warn that crucial contextual factors can moderate the nature and extent of curiosity. Deliberative engagement in curiosity rests upon prevailing mental models, world views and conditions that support combined cognitive, social and developmental elements (Silvia & Kashdan 2009). Taking this into account and regardless of recent epistemological and ontological critiques of nursing knowledge and practice (Paley 2001, Nelson and Gordon 2004, Traynor 2007), nursing's propensity to explore and learn, has perhaps been its one consistency (James et al 2010). What has not been in any way consistent is the world in which nursing/caring is embedded and laboured (Maben et al 2007) and the implications this has on enabling epistemic curiosity, the continuing development of nursing practice, praxis and scholarship and ultimately, improvements in patient care and experiences.

"Oh, if only it were possible to find understanding," Joseph exclaimed. "If only there were a dogma to believe in. Everything is contradictory, everything tangential; there are no certainties anywhere. Everything can be interpreted one way and then again interpreted in the opposite sense. The whole of world history can be explained as development and progress and can also be seen as nothing but decadence and meaninglessness. Isn't there any truth? Is there no real and valid doctrine?"

The master had never heard him speak so fervently. He walked on in silence for a little, then said: "There is truth, my boy. But the doctrine you desire, absolute, perfect dogma that alone provides wisdom, does not exist. Nor should you long for a perfect doctrine, my friend. Rather, you should long for the perfection of yourself. The deity is within you, not in ideas and books. Truth is lived, not taught. Be prepared for conflicts, Joseph Knecht – I can see that they already have begun."

Hermann Hesse 1946: The Glass Bead Game

And there lies the rub. Was I now in a space of internal conflict - a moral conflict? Had I perhaps believed that the strengths of a political and professional modernising discourse would be that panacea which provides magical power for clinical leaders to engage with their curiosity even when anxiety and uncertainty prevail? After all, from an objective perspective, with nursing constituting the largest section of the NHS workforce, surely as a collective force in its own right, nursing has the potential to transform clinical care through engaging in curiously wrought practice led learning and improvement. Is that not the whole point of the truth to nursing's professional habitus?

When I reflect back on the time that nurses told their stories, there is a part of me I think which came from an objective paradigmatic place – a place that believed in the rhetoric of improvement and innovation at the expense of a more subjective understanding of their reality at a cognitive level. Was that part of my inner narrative which embraced 'insubordinate and impish transgressions' expecting nurses to follow suit, to resist and challenge the reach of the panoptican and just get on with the business of curiously transforming practice?

And yet……. the critical voices on curiosity and the context within which they play, suggest a world of paradox and dichotomy in which nurses are embedded. A complex symphony plays. Its composition is seemingly so difficult to fathom - simultaneously transforming, liberating, constraining, irking, disturbing – epistemologically and ontologically turbulent. It leaves one in dark and light spaces at any one given time.

After reading the literature and discovering its incongruence and contrariness, had I learnt nothing from my own experience of curiosity across my lifetime - Of curiosity being socially and contextually constructed and within this construction – or constructions, having the power to take me into light and darkness. Was I too bound up in my quest for wholeness to consider the impact of dichotomies on nurses' curiosity? After hearing their stories, was my work, my intentions and interactions with these nurses truly 'upheld at the level of the collective and participatory?' Where was the notion of dialogue, of exchange and reciprocity? Where was my empathy? ……. Had I been putting on a mask? Had I been hiding – as I did with my supervisors- my own internal narrative on the difficulties I had faced with my curiosity and lost contact with the belief that the self is constructed and re-constructed in relation to the context which I found myself within at any given time? Had I once again read the rules of engagement, as told by these nurses, through a lens of liberating rhetoric, at the expense of the challenges and restrictions they faced?

The nurses I had listened to were clearly relating a practice environment which was at odds with political and professional discourse, and yet the implications of a curiously impotent, and therefore an intellectually static nursing workforce was still concerning to me. From a professional practice perspective, I began to wonder if I, as a curious educator, had been caught up in a political, professional and pedagogical ideology which espoused empowerment, liberation and practice transformation.

Considering the paradoxical tensions which curiosity itself holds tight to, questions now arise for me as to whether in fact nurses have a propensity to be curious and undertake deliberative action to integrate knowledge sources and if so, how do they ameliorate such a process within an environment of competing discourse and constant change? Similarly, do contextual conditions created by institutional drivers, boundaries and caveats moderate nurses' engagement in curiosity?

Exploring curiosity in context may enable an understanding of moderating conditions leading to favourable and unfavourable consequences for nurses and nursing practice. The overall question which arises for me now is; within an environment of constant change, conflicting discourse and competing knowledge sources, when and how do nurses engage in curiosity? Within this question, we may better understand the lived reality of nurses' experiences of curiosity, understand the factors which may indicate how curiosity is enabled or inhibited as a mechanism to promote knowledge integration and application and gain some insights as to how nurses might ameliorate processes and practices which impact upon their engagement in curiosity.

Perhaps I had listened, but not opened up a space for them to be heard. It was time for me to find a way to open up that space.

Intermezzo

'She has been warned of the risk she incurs by letting words run off the rails, time and again tempted by the desire to gear herself to accepted norms. But where has obedience led her?' (Trinh T. Minha-ha :264 – in Hurren:48)

Sunday August 18th 2014 – thesis writing

I got up this morning filled with enthusiasm… ready to write again. Two cigs (well, maybe three) and three (four) cups of coffee. Still in my dressing gown.. perhaps I will stay like this all day…. Nobody will know.

I am on my own.

Pete, my beloved, has gone on a trip for 5 days.. so I feel I can forget about the guilt of writing for hours on end, of being lost in a performative space, where quite frankly, he has been marginalised…

an enforced distance?

perhaps..

There.. ….. is that life pattern emerging again?

Or does the act of writing a PhD thesis demand enforced distances.. between what I want to do and what I feel I have to do?

Thinking about enforced distances which I feel research and the writing of it can create.

Perhaps another metaphor comes to play.

Scylla and Charybidis…

I feel caught between them… trying to avoid the methodological rocks and being sucked into a white water vortex… Wanting to navigate through compliance towards liberation and emancipation… to keep moving….. to be 'on the move' .. to get 'there', to become whole.

I feel a tension… of being between spaces…between the creativity within the performance of writing and the compliance of an 'audit trailed, acceptable' academic text…. Dawn and Immy recognise this tension in their book – of the need for PhD candidates to demonstrate an audit trail – to include representations of evaluative processes to determine quality, rigour and appropriateness. Dawn and Immy list ten features and a checklist.

They attest in their 'text' to 'Structure' and yet I declare myself a post structuralist.
It is this 'structure', the 'setting out' of the thesis that I battle with on a daily basis. I have found this immensely difficult to try and achieve. I find a constant pull and push between perceptions of imposed structure and the intertextual fluidity of the creative performance of writing – a new structure, an alternative structure – a **post-**structure – from what is, what has been and what could be?.

Secret space

I had to go out. I had to go into that secret space to think about what I was thinking about, about the nature of my thought and how I might string it together to write in a way that makes sense to me. It seems that once I have grasped the 'truth' it goes some way to being elusive again.
I went out into the garden for a while.
I did get dressed
☺

Chapter 4

Opening the Space

It went many years,
But at last came a knock,
And I thought of the door
With no lock to lock.

I blew out the light,
I tip-toed the floor,
And raised both hands
In prayer to the door.

But the knock came again.
My window was wide;
I climbed on the sill
And descended outside.

Back over the sill
I bade a 'Come in'
To whatever the knock
At the door may have been.

So at a knock
I emptied my cage
To hide in the world
And alter with age.

The Lockless Door - Robert Frost (1874-1963)

I have learnt that curiosity is a complex entity, full of paradox, set within a fluid, eventful world and surrounded by dichotomous discourse. Multiple realities, perceptions and intricacies prevail within its folds. To open up the spaces which may part those veils of perception, explore the folds and reveal how and when nurses engage with curiosity, I

need to set out to open the doors wide enough to enable insights into their intricate world to emerge, to hear the myriad of voices which weave the tapestry of their curiosity narrative.

But, I find myself in Dante's wood- lost in time and space and trying to find a way through into the open space.

The trees are there.. as structures.. they tell me I am in the wood.. so that must be real then…they are solid.. and yet…. Trees have energy. They have life… ……..

Life.

Lived.

Living.

Being.

Becoming……

Going round in circles – as Wanda Hurren puts it……. (Hurren 2000)

Thinking about the research on curiosity, I feel it has no soul. Not enough energy or life in parts of it. I find it stilted – almost contrived. Set within structures that have meaning and yet have no meaning. This notion of structure and post structure may speak to the reason of why I am not enamoured with the research on curiosity. Current research takes life experiences (or not) in a structured, controlled way, as if they represent 'truths' thus the 'reality' of curiosity… maybe I did the same with the nurses I was involved with pre-PhD?

Perhaps when I come to think about it and look at the nature of the research on curiosity, it is derived from an objective scientific place. Whilst the research is attempting to develop theory, test hypotheses and determine construct congruence, it does so through quantitative measurement and has so far neglected contextually constructed lives. The research on curiosity has no soul. I don't mean this in a dismissive or derogatory sense. It is how it is,

although I do think it somewhat contrived (but then, isn't all research contrived?). The lived world of curiosity has yet to be explored.

Interestingly, the major proponent of experimental research on curiosity, Professor Todd Kashdan, has recently published a paper on the ways in which curious people are viewed by their friends, peers and unrelated observers (Kashdan et al 2013). Taking an experimental factor analysis and controlled observation approach and utilising university students as participants (a common choice of participant sampling throughout the curiosity research literature), Kashdan and his colleagues found that those who engage with curiosity often defy established social and cultural norms. The research team noted the need to explore the interactional aspects of the social environment on curiosity. What was interesting to me about this finding was the tone of surprise with which it was presented in the discussion element of the paper. It was as if there was a sudden realisation by the authors that curiosity might be subject not only to social and contextual constructionism, but also to acts of resistance, and that there might after all, be a place for other types of research out-with controlled, quasi experimental scientific studies to enable such capture.

Thought lags behind nature (Deleuze and Guattari 1987:5, cited in Tamboukou 2003 a:29)

I do believe that narrative inquiry is best suited to opening up these spaces. But let us adopt a Socratic spirit and look through a curious lens.

I am familiar with ethnography having utilised it for my Masters research in Borneo. With its ability to explore cultural and contextual issues in situ, ethnography would enable me to adopt participant observation and record contextual and cultural data. This approach might provide insights into the impact of these elements on curiosity. However, this means that I would need to be able to 'observe' curiosity in context. As

curiosity is arguably an abstract cognitive construct, on reflection, it would be difficult to 'observe'.

Whilst I could argue that within ethnography there is the opportunity to conduct interviews and discover what people say about their curiosity, the issue of observation, a central feature of ethnography, is still difficult. One could also say that observing nurses in practice through capturing episodes or events of 'verbal questioning' or 'conversational events' might constitute a form of curiosity, and could be observed. Considering that one of my objectives is to explore how nurses engage with their curiosity, to integrate knowledge sources into practice, undertaking such observation would either mean that I would have to constantly follow nurses around and take part in all of their verbal questioning events or/and follow them in their intimate interactions during patient care. Apart from being intrusive on all counts, this kind of observation might possibly alter the nature of the interaction and the 'curious event or intervention'. Which brings me to another point, how would I as a researcher suppose/define/construct what a 'curious intervention' looked like, so that I might know when I observed it. There is the possibility that I could engage in an interpretive process to formulate categorisations. However, I might find difficulty in escaping these. As Silverman (2013) points out, categorisations may deflect attention away from activities which may be 'uncategorised'. Additionally, if, as is another central premise of ethnography, that ethnographers study 'natural' behaviours (Hammersley 1992), then surely my intrusive presence would alter such 'naturalness'. I think the idea of ethnography on ethical, pragmatic as well as epistemological grounds is probably not a suitable approach.

Another method I could adopt is 'Life-World' research. Life World research has its roots in phenomenology. Drawing from the existentialist works of Husserl and Merleau-Ponty, Dahlberg (2006), posits that in order to understand the relationship between the individual, their context and their wider social world and the meanings derived from

experiences therein, one must consider direct participation in the life worlds of those we study.

The premise behind Dahlberg's (2006) idea of immersion rests upon an embodied understanding of the phenomena that one studies. That is, to actually be a physical part of and experience the phenomenon being studied with those who are experiencing the phenomena first-hand. At an experiential level, one shares, exchanges and lives 'text's, but with a Gadamerian view of seeing things differently, in real time. The value of this approach, according to Dahlberg (2006) is that such depth of involvement has the potential to generate knowledge of meanings in context, which allows access to otherwise inaccessible meanings and patterns. Whilst interviews may provide insights into a world of experience 'lived', Life World immersion provides insights into a world of experience 'being lived' (Dahlberg 2006).

The appeal to me of Dahlberg's (2006) approach is in the potential to immerse myself in the world of nurses to understand their contextualised experiences with curiosity as it is being lived. Such an immersion would provide me with rich insights and revelations into how, in a complex and dichotomous world, they might engage with curiosity to integrate knowledge sources into practice and ameliorate processes and practices which impact upon their engagement.

Note to self: Must order day lilies[15]

However, in studying the approach to Life World research in more depth, similar reasons with regard to 'participation' as highlighted in ethnography apply and would not be feasible. Of additional significance, part of the method employed in the process of doing the research involves 'bracketing', 'stepping back' or 'bridling'. Whilst Dahlberg

[15] A note on day lilies – Day lilies are rhizomes. In botany and dendrology, a **rhizome** (/ˈraɪzoʊm/, from Ancient Greek: *rhízōma* "mass of roots",[1] from *rhizóō* "cause to strike root")[2] is a modified subterranean stem of a plant that is usually found underground, often sending out roots and shoots from its nodes. Rhizomes are also called **creeping rootstalks** and **rootstocks**. Rhizomes develop from axillary buds and are diageotropic or grow perpendicular to the force of gravity. The rhizome also retains the ability to allow new shoots to grow upwards. If a rhizome is separated into pieces, each piece may be able to give rise to a new plant. Source – Wikipedia.

(2006) attests to ‘stepping back’ and ‘bridling’ as forms of critical reflection as meanings come into being, which I see as central to qualitative research and have no problem with, other commentators such as Kakkori (2010) and Hodge (2008) note the need for the researcher to eliminate all political agendas, pre-suppositional and common-sense beliefs of the phenomenon prior to and during the research act(s).

Whilst Hodge (2008) notes that Life World research can be an emancipatory for both researcher and participants, I cannot see how me ‘bracketing’ my values, beliefs and prior experiences of curiosity is either emancipatory or empowering. I view myself as part of the phenomenon under study, which has come about from my own personal experience and professional practice. With a reflexive rather than a ‘bracketing’ approach, I might subscribe to the principles of the methodology. Furthermore, the--participants are fellow nurses and in respect to the notion of ‘sisterhood’ or ‘brotherhood’, where shared understandings of the nuances of nursing practice are common, as they are in many professional fields, if the participants talk takes us to those shared understandings and beliefs in conversation, then I cannot suspend these and not ‘join’ the participants in their conversation. I would not think that an authentic, participative way to conduct research. Additionally, I do see the act of research as political. For me, it is political in the sense that I am concerned with resistance and change and have a message to give to the wider world. The dissemination of my research, say to policy-makers, is a political act and I think is a moral responsibility of any researcher. Whilst there are limitations to all forms of research approaches, I do feel that Life World research would not suit my purpose from a pragmatic, epistemological, ontological, moral and authentic perspective.

Poetic possibilities become present if we engage in critical thinking, include multiple perspectives, making connections between past, present and future, and honouring and respecting self and others whilst we try and make sense of space and place in our everyday living…..(Hurren 2000:73) .

I am wondering whether I am now at a place where my writing, reading of it, re-writing and re-reading (for that happens regularly), has at some level stimulated my mind to consider aspects of methodology? Have I reached that place which Foucault (1972) describes as a virtual unknown, a place which has the potential to raise methodological surprises?

If I am to enable a deeper understanding of curiosity in nursing practice in all of its intricacy, it could be that a narrative methodology would be suitable. According to Holloway and Freshwater (2007a) narrative inquiry is concerned with peoples lived reality, which comes about as a result of their experiences in a socially and culturally constructed world. As such, narrative inquiry is person centered and engages with participant stories as a rich archive for understanding multiple, complex realities within the construction of narrative knowledge (Holloway and Wheeler 2010).

Narratives would therefore have an epistemological and ontological function. According to Sandelowski (1994) narratives are a particularly useful means to discover and generate knowledge situated within the contextual complexities inherent in nursing practice. Although Sandelowski (1994) cautions of a potential danger of narrative knowing furthering the emergence of a new dogma, she notes that narrative is significant due to its unique ability to understand what it is to be human. Narratives are interpretive acts which reveal the complex dimensions which define lives lived (Sandelowski 1994). Similarly, Fisher and Freshwater (2013) believe that narratives are storied ways of knowing and stories told lead to interpretive acts which determine the nature and perception of realities. Whilst the terms ‘stories’ and ‘narrative’ are often used interchangeably with little distinction between the two (Holloway and Wheeler 2010), clarity is put forth by Fisher and Freshwater (2013:203) who understand

narratives to be culturally constructed templates, which act figuratively as guides to '*understand the significance of the stories we hear' …….*and that *…..'narratives are also resources that people draw on to develop their stories.'*

However, narratives are not static but dynamic in the sense that when considered contextually and in relation to prevailing discourses and power relations, they provide a scaffold, an architecture whereby individuals or groups make sense of the past, craft versions of reality, define identities, shape behaviour and enable sense making of experiences (Riessman 2008, Holloway and Freshwater 2007a). As stories are told and re-told, new narratives may emerge generating rupture or disturbance, provoking reaction, adjustment, resistance and transformation (Bruner 2002, cited in Riessman 2008, Fisher and Freshwater 2013).

Expanding on the notion of transformation, Holloway and Freshwater (2007a) and Freshwater and Rolfe (2004) emphasise the power and freedom which narratives can bring to expose and contest received wisdom and taken for granted truths. In this way, narratives do not act as a means of repetition (Frid et al 2000), but enable individuals to reflexively construct their reality, which includes notions of self-hood, power and identity (Holloway and Freshwater 2007a).

*' …in place of an 'ego' enamoured of itself, arises a 'self' instructed by cultural symbols, the first among which are our narratives…' (*Ricoeur 1991:33)

Whilst some narrative theorists challenge the notion of an evolving self, believing in the subject as unified and knowable, other theorists, particularly those from a post-structuralist, constructivist perspective, eschew such an idea and believe in the self as a dynamic entity, forever undergoing constructions (Squire et al 2013). With this latter understanding, known as '*bundle theories of the self',* the self is transformed in time and context through narrative telling and knowing (Holloway and Freshwater

2007a:40). However, it is generally agreed in the narrative literature that such polarising views are unhelpful (Squire et al 2013). The self can be both dynamic and stable, as the self moves with the ebb and flow of a life tide, within the tensions of making sense of and understanding experiences to which the self is subject over time (Holloway and Freshwater 2007a, Riessman 2008, Squire et al 2013). As such, I do not see narrative as means to establish grand truths or edifying features of the self or the world, (Squire et al 2013), but view them as a creative endeavour which establishes uniqueness and moves towards new starting points through past, present and future (Holloway and Freshwater 2007b).

Whilst narrative research appeals to me, it does appear to be a methodological bricolage and has often been described as an historically produced theoretical and philosophical *'blurred genre'* (Squire et al 2013:5). In Squire et al's (2013) opinion, narrative research has been subject to theoretical contradictions and divisions, not only in the realms of what constitutes the 'self', but also in the distinctions made between structure, content, context, language, event and experience. Although arguments rest on how researchers conceptualise and undertake the process of studying the phenomena under question, there is agreement among narrative researchers that it is a multi-level interdisciplinary field whose bricolage lives large (Squire et al 2013). Whilst this may be the case, making sense of it all so there is and understanding of what you are doing as a researcher, why and how you are doing it, does not help a novice researcher – a point of fact noted in the contemporary narrative literature (Riessman 2008, Squire et al 2013).

Going back to the tension, which is a methodological one - Structure and post structure ---- Like Wanda Hurren, I understand there are overarching structures which we are in relationship with, rather like the axillary buds of the rhizome. I recognise that those structures are there (structure). I can still pay attention to them, but I can also let new structures emerge from old

ones (post-structure). But my second tension asks -.If things are in a process of becoming, then do they have something to become from?

My sense making process leads me to thinking …….

The rhizome has nodal structures from which new things can grow… it is in a constant state of becoming – but it is not isolated, but interrelated. It is a product of its own texts – plural - many - a construction not just of language (plants speak through complex energies in order to grow), but of events – elemental and instrumental, time, space, neighbouring plants and its own experience. It has genealogy. It re-writes itself from a text or texts that still exist in the present – a past text that becomes a present one. Even if you separate it, fragment it, chop it, cut it, block its route, it has the power to challenge and resist and 'go off' in a different direction. The rhizome has the ability to shape a new future – post structure. We can then see things as being on the move – of developing new shoots. In my research, this might mean following new lines of thought, but with a respect for the past and present texts which exist as interrelated. In this way, rather like the rhizome, we can write a history of the present from the present, which respects past texts which become and are present, listens to present texts and has a view to a future. A genealogy perhaps. A new text emerges, which is connected and combined.

'……the frontiers of knowledge work rests in the liminal zones where disciplines collide.' (Kincheloe 2001:689).

The mention of a past, present and a future suggests that narrative research has a temporal feature, which brings me back to genealogy. As attested to earlier, narrative research has been labelled as a 'bricolage'. Bricolage is a notion coined by anthropologist Levi-Strauss (1966) and later taken up by Geertz (1988), which suggests that researchers do not bind themselves to particular methods, but adopt eclectic approaches within the research act (Kincheloe 2001). The point of 'bricolage',

according to Kincheloe (2001:689) is to avoid reductionist approaches to research through a recognition that; '....*knowledge is always in process, developing, culturally specific, and power inscribed.'* Within this knowledge dynamic, Kincheloe (2001:689) goes on to suggest that as researchers, we should also be '…*attuned to dynamic relationships connecting individuals, their contexts and their activities instead of focusing on these as separate entities in isolation of one another.'* In Kincheloe's (2001) view, attention should be focused upon how cultural and contextual systems and processes alter lived realities and how individuals and groups engage in processes to challenge and resist power and re-affirm them – *selves* in the world. Within this view, Kincheloe (2001) suggests adopting a perspectivist approach to research, arguing that research cannot be undertaken through prescriptions of method. He opts for reflexive Foucauldian post-structuralist genealogical methods, which set out to consider the ongoing constructions and complexities of culture, context and lived realities (Kincheloe 2001).

However, Lincoln (2001:694) disputes Kincheloe's (2001) position, suggesting that Foucauldian genealogies are a bridge too far for qualitative methodology and that post structuralist genealogies '*are not well laid out as method.'* Whilst this may be true in Lincoln's (2001) mind (and as mentioned earlier, it is the case that narrative methodologists such as Riessman (2008) warn of no methodological or analytical blue-prints in conducting narrative research), those who have undertaken post-structuralist cartographies to craft histories of the present, such as Tamboukou (1999, 2000, 2003ab, 2008, 2010abc, 2013), Benedict (2001) and Hurren (2000) may (quite rightly) disagree with Lincoln's (2001) view.

Tamboukou's (2008) research into women and education and women artists of the 18th Century, particularly highlights the value of Foucauldian genealogies. In her opinion their critical gift lies in their ability to write an history of the present by; '*bringing into light un-thought of contours',* seeing narratives as *'multiplicities of intertextual meaning'*

and 'discursively constructed regimes of truth' and 'active practices of self- formation'. (Tamboukou 2008:102 & 109). In Hurren's (2000) post structural thesis on imagining radical changes to the way in which geo-graphy is thought about and taught, she adds that language, time, structures, texts, non structures, spaces, events, symbols, experiences, all dance together within the territory and the lines of our lived realities and transform them into a version of the future. This 'dance' is noted by Alvesson and Karreman (2000) who in their de-construction of discourse analysis, comment that, whilst post structuralist genealogical methods may be useful in exploring the relations and forces of the power connected to discourses, they do warn of the dangers of a focus on 'power inscribed discourse', which marginalises the socially constructed aspects of individuals and the vital patterns therefrom, which form their narrative and on-going story.

Fisher and Freshwater (2013:204) expand on this argument further and suggest that whilst Foucaldian post-structuralism positions the subject within discourse, it can also be considered as a reflexive mechanism that individuals can apply to deconstruct dominant discourses and '*provide insights into how people subvert and re-configure their own discursive subjugation*'. When applied as a meta-method to research, post-structural reflexivity implies capacity to challenge and resist established dogmas and conceptions (Freshwater and Rolfe 2001). This essence of reflexivity encourages and inspires the researcher to look through the lens of curiosity to reveal contradictions, gaps, fragmented and incomplete sketches of the self – to be aware of the emergence of self, as power and knowledge are embodied in the production of narrative and in their effects (Freshwater and Rolfe 2001).

At the time of my transfer viva, I had thought of post structural discourse analysis as a means to guide the study and analyse the data, but on reading the literature on narrative inquiry and post-structural reflexivity, I re-thought this approach. I did feel a personal resonance with Foucauldian post structural approaches, but did not want to just focus in on 'discourse' per se. Within the framework described above, I felt that the

approach to my inquiry would follow Fisher and Freshwater (2013) and Freshwater and Rolfe (2001), recognising that narratives emerge in contexts saturated by power/knowledge relations and dominant discourses which determine the conduct of individuals and submit them to certain ends or domination. However, such power/knowledge relations also act as active practices of self-formation, with subjective capacities being developed to resist domination, subvert power and exercise freedom (Fisher and Freshwater 2013). The responsibility of the narrative researcher is to look reflexively through the lens of curiosity to weave the nodes of power / knowledge relations, historical and cultural constructions and practices; following new lines and making connections and inter-connections (Tamboukou 2008). Deconstruction of coherence reveals contradictions, gaps, fragmented and incomplete sketches of the self – to be aware of the emergence of self, as power and knowledge are embodied in the production of narrative and in their effects (Squire et al 2008). To enter the spiral of ever deeper insight into the self as researcher, an auto-ethnographic text opens up the dialectical encounter with entry level perceptions as they relate to other artefacts and texts (Smith and Sparkes 2008).

Narrative research which embraces my own self-awareness therefore has the potential to highlight complex and contradictory elements and layers of meaning, to create a rich archive for understanding how personal, relational, social and political realities are being constructed (Tamboukou 2008). With this in mind, I view narrative research as the most authentic way to capture the contextually situated personal accounts of the motives, experiences and actions of nurses, in relation to their engagement with curiosity.

In order to draw on nurses' stories of curiosity in their practice, I invited six nurses from across two NHS Trusts to share their realities and take part in my research. Two nurses hailed from an acute Trust and four from a mental health Trust. The reason for such a small sample size was to strive for validity through information richness, depth and thick description (Holloway & Freshwater 2007a).

Due to the levels of complexity under investigation, a sample size of six was co-determined with my supervisors as a pragmatic approach and optimal number to enable capture of depth data and realistically allow for thick description of the perceived reality of participants. I chose to sample from across two NHS Trusts, not to undertake any form of comparative analysis, but for purely pragmatic purposes. Even though the sample size was small and one would think that recruitment from one Trust would have sufficed, I had 'received' wisdom from several researchers who had recently had problems with recruiting nurses in both of the NHS Trusts I intended to conduct my research within. Taking their advice and following discussions with my supervisors, I recruited from both Trusts with a view that from across both Trusts, I should be able to get six participants.

Reflecting on the issue of split–site recruitment, my decision not to undertake a comparative analysis of the data could be seen as a weakness in this study. However, as I discovered in my analysis, the stories of nurses from across the two trusts held congruence and a comparative analysis would have served no significant purpose.

I did impose criteria for participants to be included in the study. I specified at the time of recruitment that they should be currently practising registered nurses working within the NHS. Registered nurses were classed as those who were registered with the Nursing and Midwifery Council and who were bound by a professional code of conduct, which expects continuing development of nursing practice and scholarship in practice leading to continuous improvements in patient care. Non-registered nurses, e.g. ancillary nurses/nursing assistants were excluded on the basis that they are not deemed to professionally regulated and bound within a similarly demanding professional code of conduct. Student nurses were also excluded from the study on the premise that their part-situatedness within a university learning environment (theoretically at least) promotes epistemic curiosity as a central driver for learning and development and therefore it was assumed that student nurses would, by virtue of their immersion in a

university environment, be epistemically curious. In addition, whilst it is believed that student nurses may be epistemically curious, within the NHS practice environment, they do not, in contrast to registered nurses, have positional vested authority to instigate actual changes in practice.

Recruitment to the study was via purposive sampling. Sampling was not restricted to any specialist group or specific nursing discipline, as I believed that curiosity as the phenomenon under investigation was pertinent to all registered nurses currently practising across all areas of the NHS. However, it is important to note here that I did not recruit from those NHS Trusts where I had held my conversations with nurses prior to commencing my PhD. This was for no other reason than their geographic location was a fair distance from my place of work. I had to consider factors with respect to mutually agreed and available time of the participants and myself, whilst understanding working patterns and the difficulties inherent therein.

Once University ethical and NHS Research and Development approval was granted, all nurses were approached via existing networks. These networks consisted of 3 senior NHS managers. I sent each manager a draft e-mail written by myself as an invitation to nurses which I asked the managers to send out. I provided my e-mail and phone contact details, an outline of the study, a sample of the participant information sheet and consent forms so that they could send these out as attachments to their nurses. It was agreed with the managers, that information about the study and its participation, be generically cascaded across large services, with a request for those who may be interested in taking part, to respond directly to me and not via their managers. This was to ensure confidentiality and to guard against individual identification. Two nurses from one trust and four from another trust responded directly to me via e-mail or directly by telephone with a view that they would like to take part.

I do realise there was a potential issue here with coercion as e-mails were sent out and signed by managers and nurses may have felt pressure to respond positively.

However, I made a point of discussing the issue of coercion with each participant. To do this and to build a rapport with the nurses, I called each one who had shown an interest in participating and arranged to meet them face to face. At this meeting, I explained the research in more depth, provided copies of the Participant Information Sheet, assured confidentiality and arranged dates, times and locations for the interviews. I gained signed consent at the time of interviews. At this initial meeting, I also shared the fact that I was a nurse as a means to establish common ground.

The issue of power/knowledge relationships between researcher and participant and its empathic management is core to narrative research (Holloway and Freshwater 2007b). The emphasis is on a dialogic relationship with participants which sees them as socially constructed, evolving beings, within a process of becoming (Holloway and Freshwater 2007b). Such a relationship, according to Torbert (1991) requires one to be humble, to be mindfully aware in any present moment of another's world-view, to transcend agendas and allow a view of how the present is situated, the past is merging into the present and how the future is emerging from it. Interestingly, the research I spoke of earlier on in my thesis on mindful curiosity applies here and is expanded upon by McEvoy et al (2013), who bring forth the notion of empathic curiosity. That is, the synthesising of mindfulness with an open and curious attitude, facilitates adaptation and flexibility of those who listen, so building and maintaining rapport and bringing forth extensions to certain angles or perspectives of the speaker (McEvoy et al 2012).

From my reflections, specifically with regard to what I considered as a rather objective approach to the nurses I spoke to prior to beginning my PhD, I was mindful of the need to adopt an empathic approach in the conduct of the research itself. It is important that I did not see the participants as mere objects, without a history, a present and without feelings, being 'there' to perform for my benefit and for the greater good of knowledge generation – and yet, I still wanted to approach the interviews through a curious lens. I was thus mindful to adopt an empathic form of curiosity during in the interview process.

I was also mindful of an empathic approach to other aspects of the research design. I had asked the nurses to keep reflective diaries for a period of three months, which they had consented to doing. I bought them each a notebook to write down any experiences on curiosity, which they may have had or remembered post interview. I said I would either collect these personally or reimburse postage to them. I intended to use these diaries as an adjunct to the interviews and as part of the data collected. However, none of the nurses who took part in study kept reflective accounts and did not use these diaries. I did not ask why, but respected their choice.

I was also asking nurses to relate in depth personal accounts on their experiences of curiosity and as I had found from my own experience, the nature of curiosity can be both emancipatory and anxiety provoking and so participants may have related experiences which may have caused problems for them in the past. To ensure all participants' well-being as far as possible, I undertook several steps to help with any anxiety which may have arisen on the part of the participants. My intention was be to be observant, mindful and reflective during interviews, to ensure that if the nature of the conversation elicited challenging memories or experiences and thus resulted in any upsetting emotional reactions, then I had planned to ask participants if they wished to continue or whether they wished to halt the interview. I was happy to honour their choice and where asked, or where a high degree of participant distress may have been observed, I would have halted interviews or asked if they wished to continue the interview at a later time or date, stressing that they would by no means be under pressure to do so. If participants had required the services of counselling, I had made provision to provide them with details of counsellor services. I would also have assured them that if they wished to contact me for counsellor contact details, my contact details were on the participant information sheet which was given to each participant as an e-mail attachment and as a hard copy at the beginning of each interview.

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To capture the complexity of nurses' narratives on curiosity and enable them to share their experience of it in nursing practice, I undertook open form interviews with all six nurses from May – October 2013. I remember being curious prior to the interviews on how best to let them speak and capture the richness in their stories.

My reflections from that time were:

April 2013

My curiosity, it seems, also brings problems. Going back to supervision – conversations centered round my fears of conducting the first interviews, now I have ethical approval. I am concerned that I will be unable to elicit nurse's stories of curiosity – how am I to begin the interviews? What do I say? How can I ensure reliability/validity in the data collected, by not leading the stories of the other and just let them 'speak' (literally and metaphorically)? Am I afraid of my own curiosity here? Am I fearful of what will – or indeed won't, be revealed to me? Am I afraid of the dark side of my curiosity – that which has caused me problems in the past – am I afraid my participants will 'abandon' the central question and go off in a totally irrelevant direction? Do I therefore have a pre-conceived pathway for their curiosity narrative? Is there a prescriptive, directive and objective element in my affect and approach – however manifest? Simple fact is, I don't know – perhaps I am trying to control what is or might be – so there are no surprises – and yet, would that not compromise the whole point of narrative research? – Dealing with the paradox of curiosity is evidently causing personal angst. Yet, the richness that the paradox may bring, however difficult, may be a gift as yet to be presented and unwrapped.

Each interview lasted for approximately two hours or just a bit longer in some cases. Nurses talked until they came to a natural end. There was approximately fourteen

hours of un-interrupted depth data generated from their interviews. Interviews were digitally recorded with permission and were conducted in quiet meeting rooms at the place of work of each nurse. This was their preference. My entry point for the nurses was to pick up on everyday discussions that we had had at our first meeting to re-establish rapport and ask about their day. I re-iterated the purpose of the study, issues of confidentiality and their choice to withdraw if they wished and then once I sensed they were comfortable, I provided a broad entry point for them to relate their stories on curiosity. I simply said: As a nurse in practice in todays NHS, what is your experience of engaging in curiosity. Tell me your story of curiosity in nursing practice.

And they did…..

From the initial question posed to them, the nurses talked and talked. Each one commented after the interview of how therapeutic and cathartic they felt the interview process was for them and how much they appreciated the chance to tell someone 'how it is' in nursing practice today. I felt very privileged to have been a part of their storytelling and told them so.

I didn't pay the fine…….

It was my act of resistance and defiance to the panoptican

But that's another story……

'The nomad intentionally lives without roots; willingly moves from place to place, idea to idea, and concept to concept. Nomads are open to interrelationships of what is before them …. (Clarke and Parsons 2013:39). The water point is reached only to be left behind; every point is a relay and exists only as a relay. A path is always between two points, but the in-between has taken on all the consistency and enjoys both an autonomy and a direction of its own. The life of the nomad is the intermezzo'. (Deleuze and Guattari 1987:380, cited in Clarke and Parsons 2013:39)

The overall intention of my analysis was to determine how and when nurses engage with curiosity, through exploring the ways in which events, realities, experiences and meanings, as set within a range of discourses and the broader social and political context of nursing practice, operate on and impact upon such engagement. The resultant interpretation arising from the nurses' stories has been derived from the content of their narratives, through a thematic analysis of the data.

But I feel that is too simple a statement.

It gives one the impression that I sat with the complete data set of all six nurses, segmented it, derived themes from the segments and hoped that the data contained in the nurses' stories would answer my question. Whilst to some degree this is true, it is not the whole story. The process of analysis I undertook was intense and mentally exhausting, but intellectually very rewarding.

My analysis took place on four levels and followed the principles of thematic analysis as set out by Riessman (2008) and Ryan and Bernard (2000), whilst also drawing on the post-structuralist thematic analysis conducted by Tamboukou (2013).

Level 1

Reflections post interview (2a hbc- gi- lat 14.00) - 20/5/13

Something interesting is happening I feel. I am hearing recurrent themes. The first participant I interviewed talked of adopting resistance tactics with her curiosity…. The same has happened in today's interview… the second one so far. They have both used words like 'stealth', 'covert' and 'under the radar'. One thing which has crossed my mind is whether it might be useful to have 'nodal' conversations across all respondents – i.e. taking points raised or insights from previous participants to the next participants - rather like an extended conversation across all 6 respondents.

Would such a move compromise the voice of the one who is speaking with the one who has spoken? Is that an intrusion of voices on voice? an imposition on individual agency? Would it corrupt a story in the telling or a story told? Or does it enable a collective voice to come through individual voices as a means of virtual participation? A virtual dialogue?

I am in a place of ethical and methodological surprise.

Following a discussion with my supervisors, I made the decision to undertake a 'virtual, participative conversation' across subsequent interviews. To mitigate ethical and methodological concerns, I firstly drew on the Deleuzian principle of immanent ethics, whereby one is cognisant of the value of experimenting with new ways of encountering and actualising ideas, to open thought and move beyond boundaries (Kaufman 2011). Secondly, I drew on the practices which underlie 'empathic curiosity'. For example, if subsequent participants made fleeting reference to concepts which their colleagues had spoken of, I would ask them to expand. I did not 'leap' into these concepts and break the flow of their story, but found a place in the interview which had a natural break and I would ask: 'It is interesting that you mentioned something about xxx earlier, some other people I have spoken to have also mentioned something similar, could you

tell me more about xxxx?' or, I would wait until the 'natural' end of their storytelling and say: 'Some of the other people I have spoken to have mentioned xxx, do you have any thoughts on that?'

This process is what I term to be a nodal dialogue and formed an initial level of analysis. By nodal, I mean being aware in course of the dialogue where lines of thought intersect and connect – from node to node. I took a rhizomatic approach to the interviews, in that I journeyed to intersections and looked for lines of convergence and flight from one participant to the next. According to Holloway and Freshwater (2007a), some level of analysis and insight always takes place during interviews. The question for me is, what do you then do with that analysis and insight? Do you ignore those insights and 'park' them somewhere for when you come to 'do' a 'final' analysis once data collection is complete? I personally see 'interview' as the wrong word. An interview suggests an unequal balance of power in terms of thought exchange and participation. A dialogue on the other hand suggests mutual exchange, albeit in this case, virtual. I take the view of Lather (1993:680), in that rhizomatic practice; *'works against the constraints of authority, regularity and common-sense, and opens up thought to creative constructions …. to break down present practices in favour of future ones.'* In undertaking this 'virtual dialogue' approach to the interviews, I followed a line of flight by being attentive to my analytical thought which was '*the unknown knocking at the door'* (Deleuze 1992:165, cited in Tamboukou 2003a:29). Supported through a process of reflexivity, which asked 'what could this look like, if…..? what benefit could this bring? I paid primacy to ' *the thought from the outside ….. to the moments of invention'* (Foucault 1987:37:, cited in Rajchman 1991:160)

One might question the ethics of conducting 'virtual' conversations as the content of one participants' thought is shared with others, without explicit permission. However, the ethical principles which underlie the protection of anonymity have been assured. The participants were not aware of who had taken part in the research and thus I do not feel I have breached confidentiality.

I was also attentive during the interviews to support the participants' narration and facilitate gestalt. That is, to allow participants to move through levels of configuration of their story (Riessman 2008). My initial broad question was one aspect of helping nurses to shape their story. Throughout the interviews I applied empathic curiosity, clarifying points and asking questions such as; 'what happened next?' or 'that's really interesting, tell me more about that?' so that they could elaborate, move between the parts, the wholes and bring in experiences and events.

I worked closely with my supervisors during the interview process, sending them copies of each transcript as a means to ensure that whilst I followed lines of convergence, I did not close off the participants' voice on other matters of importance and significance to them. In other words, I did not enter into 'inferential leaping' (Holloway and Wheeler 2010) and either close off lines of the participants thoughts and experiences or infer premature conclusions from the emerging data. My purpose was not to try to corrupt the telling of their experience or 'add' anything to it, but to open another space and see if they had experiences of others experiences and what that meaning held for them. I was following lines of flight through a nodal, rhizomatic process (Riessman 2008, Hurren 2000).

Level 2

My second level of analysis took place during transcription of the interviews. I transcribed the interviews verbatim. Transcripts were coded with a numerical identifier for the participant, date, time and location. Each transcript was paginated and numbered line by line. Transcription of interview data was done immediately post-interview. Whilst undertaking transcription I noted several 'fuzzy themes' emerging from the data (Ryan & Bernard 2000:780). These were constructs or phrases that kept appearing, but to which I ascribed no meaning at that point. On each individual transcription, I highlighted the constructs and phrases in yellow. As an example, the type of constructs which appeared were; stealth, fragmentation, seduction, anxiety,

compliance, subversion, person-centeredness. I repeated this process across all six transcripts. On completion of transcribing, I took all the highlighted constructs, listed them and put them to one side. This process gave me an initial, but superficial 'sense' of what the data might be presenting in terms of its content. It allowed me to work on the surface and think about the processes/constructs which may surround events (Riessman 2008).

Level 3

I re-printed all transcripts to provide a fresh set with no markings and to provide a clear space within which to immerse myself in the data with minimal distraction. This level of analysis follows a 'thin' level of analysis (Holloway and Freshwater 2007a). I read and re-read the individual transcriptions and looked for events and situations which participants had used to centre their experiences of curiosity within. I segmented these sections of talk to identify them as set within a temporal, discursive and contextual frame. For example, I identified the events nurses described, the experiences of curiosity as set within them, the discourses that surrounded them, the context they emerged from and the order of appearance they appeared in the text. I looked at the order of appearance to gain a sense of temporality.

The next step I took in this process was to link the constructs I had identified to events and experiences. For example, I identified where constructs such as 'fragmentation' or 'stealth' were embedded within a specific event, series of events and discourse (s) and looked for the meaning, responses and feelings that nurses ascribed to it. I was now getting more of a sense of how nurses' experiences of curiosity were being constructed within contextual complexity and conflicting discourses and how and when they engaged with their curiosity.

From this process, I was also beginning to gain an understanding of the genesis of their curiosity as it was represented in the text i.e. what was driving it, the problems nurses faced in engaging with their curiosity and the actions they took to ameliorate

these. I repeated this process across each transcript. Woolly themes and the beginnings of a plot were beginning to emerge from this process. For example; containing anxiety, person-centered care, fragmented practice, professional identity and subversive tactics were identified at this point. Although the process I undertook here seems linear, it was nothing of the sort. I went backwards and forwards across individual transcripts, often taking circuitous routes, until I felt I had exhausted the data for clues as to how it might fit with the themes.

Level 4

Although I had become aware of emerging themes I needed to check across the whole data set to see if these themes reflected the essence of what the participants were saying, whether I had captured contradictions, incomplete sketches or meanings hidden in the text. At an intuitive level, I felt I had to 'listen' to the whole of the data, rather than its parts – to let it speak. I wanted to capture and encapsulate specificity and depth of meaning to the way the themes themselves were formulated. They had to have power and meaning to re-present power and meaning. I also needed to think about the coherence of the narrative thread, what the 'plot' was and what the narrative itself was in terms of its trope.

Holloway and Freshwater (2007a:81) describe this element of the data analysis process as; *'….one of incubation …. …whilst the researcher is in a relaxed and restful state of being and doing 'nothing'.'* I would suggest that whilst I see this as a process of 'percolation', it did hijack every waking moment, including those of sleep for over four months. My reflections at that time paint a picture of fragmented thinking, which although disjointed, were borne from looking through the lens of curiosity and helped me to refine the themes, determine the plot and went some way to helping me decide what the 'narrative' was. Here is an edited extract from my reflections at the time (the original runs to 20 pages):

I have spent hours reading the data.. delving into the experiences, actions and emotions of my participants' curiosity….. reading and re-reading…trying to refine the themes … they do not yet reflect the depth nor the essence of the collective story.

I have gone through each transcript, delving into detail, shredding it into minute parts… fracturing it, fragmenting it….thence piecing back the shreds to form into shards….. and thence from shards into themes …. thence the whole (what does that look like?)… then leaving it all alone for a while…….

Step back……

I will find an answer soon and hold high the Holy Narrative Analysis Grail.

But something still niggles….. …….Flitting …….Floating fragments.

……And yet somewhere there is something…..

……No lazy thinking – (Bohm again) …….. think

'Let the data speak'….

More cigarettes…….

Put the pizza in the oven

Is there a meta-narrative hiding amongst their narrative?

Think….Exhausting.

Pizza cremated. Dippy eggs then.

'Let the data speak'….

There is a madness to my curiosity.

Go into the secret space…….

As nurses we strive to keep holism/ therapeutic practice together – curiosity by stealth – realising power and agency – integrating knowledge, albeit in a covert way -a resistance to the fragmentation?

……..and within that, does resistance raise our anxieties

And then….

Do we contain our anxiety by 'pulling down the shutters' or by taking our curiosity 'outside' ('carrots in drainpipes, social media, mediocre practice') – so trying to contain and resist the fragmentation of knowledge generated within each curiosity encounter?

Are we afraid of the power our curiosity has to generate and integrate knowledge and then expose it – subservient still to perceived stronger masters?? Wearing the professional and organisational irons? compromised and confused agency?

Or do we try and mend the fragmentation – isolate it, bind it, comfort it? Fragmentation thus contained…….. finding the alchemic space

And …

As a parallel process do we not also have power and feel liberated when we choose to retreat – or when we choose to make 'post-its' and then never get back to investigating the curiosities they raise' –to taking curiosity to integration and application - to feel powerful about how and when we engage with curiosity ? feeling liberated to perhaps say – 'now my curiosity must 'stop'

Is curiosity replenishing and productive? A contradictory force which provides the power to fragment and expose nursing's conceptual and theoretical foundations and bring us in a rather fragmentary way to an understanding of the present?

Does curiosity in nursing practice - fracture and disrupt the rhetorical system of which it is a part, which then prevents it from becoming systematised, thereby de-stabilising the framework which (wants to) hold nursing in its place- as many of the participants attest?

Nursing practice hewn from a mighty rock …. Shards carefully and quietly gathered, patiently and curiously crafted. w-holistically architectured?

Research hewn from a mighty rock …… Shards carefully and quietly gathered, patiently and curiously crafted …… but the sand still shifts……..

The themes which emerged from this process were:

- Perceived truth(s)
- Moments of incongruence
- Alchemic space
- Defying the Panoptican

'…… *once a story is told, it cannot be called back. Once told, it is loose in the world.'* (Thomas King 2003:10 – The Truth about Stories).

I have taken the individual stories of the participants and combined them into one 'big' story in the belief that collective stories have transformative properties (Richardson 1990, cited in Holloway and Freshwater 2007a), and that their narrative acts as a '*fundamental scheme for linking* (their) *individual human actions and events into interrelated aspects of an understandable composite.'* (Polkinghorne 1998:3).

This is their curious story[16]……..

[16] In the following chapter all names have been changed to preserve the anonymity of participants.

Chapter 5

Curiously Wrought Practice

To see to our preservation, we cling to our rocks like limpets.
Ocean may bluster,
Over and under and round us; we open our shells to imbibe our
Nourishment, close them again, and are safe, fulfilling the purpose
Nature intended,--a wise one, of course, and a noble one, we doubt not.

Is it the calling of man to surrender his knowledge and insight,
For the mere venture of what may, perhaps, be the virtuous action?
Must we, walking our earth, discerning a little, and hoping
Some plain visible task shall yet for our hands be assigned us,--
Must we abandon the future for fear of omitting the present

It is most curious to see what power a few words –
a well chosen proclamation – appear to possess on the people.
Order is perfect, and peace; the city is utterly tranquil,
Under a rule that enforces to flattery;
a nice and natural people.

One cannot conceive then, that this easy and nonchalant crowd that
Flows like a quiet stream
Could in a moment, resist and be changed to a flood; boiling as of molten lava.

Edited extract from Amors de Voyage Canto II
Arthur Hugh Clough (1819-1861)

Where sections of talk might directly identify the participants' role or place of work these are noted by ***

A short dotted line ….. denotes a short break in speech
A long dotted line ……. denotes a longer break in speech

At first glance, the nurses in this study provided an impression that the tapestry of nursing practice seems to be a perfect weave. Beautiful in its craftsmanship. Woven from the finest materials to stand the test of time. Its creators work diligently, honing their exceptional skills and knowledge to fashion an emerging portrait. From various positions and with an array of tools, the nurses who weave the tapestry engage with their curiosity in an attempt to explore sources of knowledge and integrate them, towards the creation of a whole. Whilst a pre-determined template of the portrait does not exist, the nurses possess an abstracted sense of what it will look like when complete. Their text is built upon things unsaid, but is understood. A discourse of wholeness provides the spectacles through which they view the world. Pervading their text, they see each part of the tapestry as related and inter-connected. An intrinsic satisfaction to their craft arises from the myriad of knowledge activities undertaken during the construction of the whole. Within this constructive process, imperfections which may compromise, conflict or contradict the essence of wholeness are identified and rectified. Curiosity is the means they employ to move between the warp and weft. It acts as a cognitive map to identify anomalies and conceptual conflicts, and bring forth knowledge assets designed to improve their craft and actualise a collective ambition towards restoration of the whole.

Perceived Truth (s)

Central to their portrait and to which nurses concentrate their curious effort is their client, patient, service user, whichever descriptor they choose to adopt (hereafter referred to as patients). The nurses view their patients as holistic beings, whole persons. Their nursing practice built upon a philosophy of person-centered care. According to Morgan and Yoder (2012) person centered care now pervades nursing practice. In their recent concept analysis (Morgan and Yoder 2012), person-centered practice consists of attributes such as holism, individualism, empowerment and respect. All of these attributes are considered to be the essence of nursing practice, which form the core of nursing's professional value system and sense of identity

(Horton et al 2007). Woven together in a cognitive, relational, moral and ethical web, a professional world-view emerges which guides nursing practice towards the realisation of person-centeredness (Morgan and Yoder 2012).

Perhaps becoming a regime of truth and more recently described as nursing's '*virtue script'* (Nelson 2012:204), person-centered caring has been built upon an archaeology of nursing knowledge, derived from an historical culmination of a series of aggregated theoretical and empirical attributes (Paley 2001). As an investment in their perceived professional power and identity, nurses have purportedly adopted these attributes as forms of nursing knowledge, so differentiating nursing knowledge from that of their medical colleagues and other healthcare disciplines (Gastaldo and Holmes 1999). Foucault (1988), cited in Veyne 2010: 108) might describe such an investment as a means to develop strategies of power, within which certain truth games or practices of power are constituted. According to Zeeman and Simons (2011) a high value is placed on nursing knowledge by nurses, bringing forth a perceived uniqueness and power to their professional practice, authority and credibility.

Knowing, manoeuvring towards knowing, being in a position to know, taking action to know and being able to apply knowing in practice seemed of high importance. Motivated by their curiosity, the knowledge journeys which the nurses took were often created in the immediacy of the nurse patient interaction, arose from events and issues arising in practice or were centered around their ambitions for practice. The desire to know what, to know how, to know why and 'knowing that' permeated their text and followed the taxonomy of knowledge integration put forth by Rolfe (1998) and Christensen (2009:87). Wanting to be in a position of knowledge, the nurses' who took part in this study undertook multiple efforts to construct and apply their knowledge, taking various routes, approached with mutable degrees of intensity. In their study, James et al (2010:1514), recognise these dynamic efforts of knowledge seeking and integration in nursing practice as a desire for nurses to stay 'knowledge wise'. Rolfe

and Gardner (2005) would add that such a dynamic, takes place in local, particular contexts to evoke a journey towards practice wisdom.

Linking in partnership with colleagues or through innovative means, knowledge was sought and perceived as powerful to nurses and meaningful to direct patient care. As Crigger and Godfrey (2011) note, nursing practice, informed through a reflexive, partnership dynamic inculcates a sense of potential transformation of both person and situation. Similarly, James et al (2010:1513), suggest that the knowledge journey of nurses takes a hermeneutic dialectic turn, consisting of '*constant movements and excursions',* suggesting a progression towards understanding something that is there, almost there and not yet there. The goal is perhaps for profession, personhood and practice to 'become' something other than currently exists through reflexive correspondence.

Bohm (1980:70) describes such a reflexive process of becoming as a 'dance of the mind'. Within this dance, thoughts, ideas and insights, both fresh from critical and creative cognitive acts and from memory, mingle together in a consistent process of integration (Bohm 1980). Such a process, termed as 'the becoming of knowledge', has no 'definable aspect that is absolutely fixed' and is lived within full awareness (Bohm 1980:81). The 'dance of the mind' serves to mitigate fragmentary knowing and static thinking and dispose us toward harmonious action to inculcate a sense of truth and reality, which is perceived to be whole (Bohm 1980:70).

Sam

If nursing is about holistic practice – which it is, then it's about being curious. I'm curious about how patients feel and curious as to finding out exactly what has happened to them…connecting the parts. That's where my curiosity leads me to. My framework that I put in is person centred, looking at the whole person. I'm quite analytical about it all. Pulling it all together. That's what my curiosity does. It's to actually be really thinking – all thinking- all kinda trying to determine what's the best way, what's been helpful, what's not been helpful to the patient and their treatment. I think that's just an on-going

process… all the time. And I like to be curious .. to think…… I think about things in a dynamic analytical way. It empowers me. It's the person centered thing. That's what nurses do. That's who we are. It's a philosophy underpinning the way we work and it's what I believe in. I won't settle for anything less.

My curiosity is about knowledge acquisition. That kind of seeking it out. My curiosity leads to learning which leads you to more learning. It leads you to substantiate and question what you are doing. It facilitates learning. Keeps you alive as a nurse… so to speak…….keeps nursing alive…I can say it has facilitated my learning. I can say that with confidence. My development as a nurse is an example. I could have left nursing, but it's where I like being. We just have so much knowledge as nurses. Sorts us out from the doctors and the bio-medical model!! (laughs). We're not flamin' handmaidens anymore! (laughs). Yeah…….the avenues I have explored and learning in different areas and from all different sources appeals to saving and keeping my professional self.

Like, take recently….. my curiosity was aroused and I'd though of a research project which could try to determine the actual quality of the interaction between practitioner and patient. Some of that is looking at the actual nursing interactions with patients. The other research has been patients' response to nursing interactions. But there's something around how you capture the essence of interaction, the communication, the relationship which the nurse does. How can we determine the thing, the essence that helps something work as done by the nurse…… from the nursing perspective?

So, there's my curiosity kicking in and the beginnings of an idea. An idea of how the interaction…. I can't think of another way to describe it really…….. something that can capture the essence of how that person has experienced their relationship with their nurse and how the nurse has not only experienced it herself or himself, but what they have actually done to set it all going. And it's almost as though in my mind I've kinda thought that ….

Actually we need an analytical framework to think about it. We all bring to our relationships how we have experienced relationships before that. So there would be an aspect of thinking how we might have used those skills in a positive way and really use that to help. Or, they might bring negative aspects and their interaction would then be to work with that negativity to think; 'O.K., how do we tame this, how do we help this nurse moderate their negativity so that we get the best out of the situation?' That might be what influences everything they see and experience. So, that kind of… thing……..my curiosity has been really kind of aroused in that way… thinking also… how do you measure some things?. All those tools out

there… there's got to be something out there that is more accurate to measure the essence of things…. Or it might be that we might need to look at making our own tool.

Also, I realised that to work with people in ***** like I do, that we needed counselling aspects bringing in and I thought that I would be able to use those counselling skills. So I went off and did a course on it so I could continue working here in a more…. erm.. a more knowledgeable, more helpful way for my patients. It kept me interested. Kind of keeps me engaged…. I look after myself ……..by actually fulfilling my curiosity. I think you have a professional duty to be curious.. it elevates nursing…. Puts it up front. Yes.

But I also think the reason why I kind of learnt about the counselling is because, perhaps because in the nursing role, just day to day nursing, there was a resistance in me that would do it in just a kind of drone way. I get bored by that. I didn't want to be like that. So it brings more to my nursing role, so when I'm speaking to other members of the MDT I suppose it kind of elevates me in their eyes….. it might even……. it shows, that I'm really knowledgeable.

Also, one of the best books we might all read about nursing in nursing is the Peplau book. That… when I read that… I certainly got it. That's it! That's what nursing's like. That's what nursing is. It's a model we can use well. That's what I also like to bring to my nursing ….. the theories are good to use. (Page 11 lines 12-19,, Page 12 Lines 13-29, Page 21 lines 20-25, Page 21 lines 29-36, Page 22 lines 5-9)

Georgi

Curiosity helps me to ask questions … looking at the whole person……What about this? What about that? What is good for THIS person? You know, … the one in front of me now. Curiosity is coming in to play on a constant basis. You need to be curious about the person in front of you – individualised care…….. erm….. so I think a good nurse is basically curious. Being curious is very important to me. It's part of what nursing is all about….. it's about professional practice.

Being 'professional' for me… … I'm always on a quest to know more. I am like this all the time… for giving individualised care. I use my curiosity to do that. I am a curious being. I have a picture in my head about what nursing professionalism is about…….. . Being curious, pulling it all together…. that's where my curiosity goes and I ask, 'where does my knowledge and learning fit within that?' The professional way is the curious way. It's all about the how and the why's…. to fit it all

together for the benefit of our patients. We have a different perspective on things than doctors or physios do…… Nursing is different… we need to differentiate ourselves… set us out from the crowd…be better.

We need to put ourselves forward and be seen. Not too long ago, I got interested in internet blogging … curiosity started me because I thought there must be something about this social media thing. Twitter was one particular platform I was curious about and I like that. So I had a look…… and social media was becoming a platform for micro blogging.. I was hearing more and more about it and how nurses could learn stuff from one another. So then I started following nurses and that's where I was kind of encouraged as other nurses came back to me….. and it helped me to understand the new things that were happening in nursing. I was asked if I wanted to connect with a nurse in *** and then I was asked if I could do some of the 'chats' and lead one of the learning forums. That was a great feeling. Made me feel good….. like I was really contributing something to the future of nursing.

…..Thinking about the curiosity, it teaches you that things don't always stay the same, so your curiosity helps you to reflect on the present situation and imagine the future situation. So, I'm thinking now of future e-nursing and learning …how that would look.

What happened last week was the Twitter storm over a big issue, you know…… Well, yours truly got on twitter about that and joined in the conversation about it. My curiosity allowed me to go on social media and that was one of the good things about getting connected with others…. Twitter went berserk about it.. they call it 'viral' !!! (laughs). I was quite pleased that that took off. The stuff on the social media, I see is part of my professional role.

I like to get action around my curiosity and create discussions around 'why?' and 'how?' …. ……So, I like to create those discussions around patient care and take things forward. You know, why is that patient behaving in that way? What else can we do?…. 'how can we do things differently?' you know, nothing is ever straightforward. So not just…. So I ask both the team and the patients and families and I involve the students. I like involving them…. Anybody really.. anybody who is willing to engage. So I drop things in like: 'Did you hear the other night that conversation about what was going on there?'.. or conversations like 'Did you hear what she (refers to patient) was saying to so and so?' and things like 'What did you make of that?' So I get people to really think about that. I would say; 'What do you think?' I will do things like that. I think nurses should be curious. That's my thinking. So having those conversations… I like to have those conversations.

(Page 2 lines 1-8, , Page 6 lines 6-13, Page 7 lines 1-8, Page 7 lines 10-12, Page 8 lines 1-3, Page 8 Lines 14- 17, Page 11 lines 29-32, Page 12 lines 1-2).

Ian

The point around my curiosity is to build a body of knowledge around the whole person. As nurses you have to be 'present', use your knowledge in the moment. The patient is central, the one in front of you NOW. That's what you have to do. To know. To understand. To kind of see what lies behind something. That's our motivation and purpose as professional nurses. To get to the core. To get to the centre of things. Using your curiosity, drawing it out …… It's about me knowing and the patient getting the best outcome which meets their holistic, individual needs. Connecting the pieces together is important to knowing things as a whole. When you are with patients in the immediacy of that encounter, your curiosity kicks in to get the connections, being able to understand what might be a key trigger in a very informal piece of dialogue, which you then put together with other things, snippets of information, which create a picture and then that's set against the evidence. You then arrive at something that is not just an intuitive or perjorative judgement, but to actually understand it in an integrated context – put the parts into the whole…… As nurses, it is our reason for being.

So I am constantly curious to learn things. I was curious about using a piece of research they did in ** University about how people procure medication. It was a collaborative study and they found that people use Google and traded information across social networking sites. You know, they shared information: 'Where did you go?… Oh! I went to this site and bought such and such for this price'… You know. So you get this sort of way of 'knowing'. I might also go to google scholar, the general internet, or to pub med or to CINAHL or psychinfo to see what the latest research is.

But what I would also do is look at the stuff that's also not reported in the journals, like the attitudes, the thoughts, the trends. That kind of stuff. I also consult Professor Google! (laughs). I'd see what was said in terms of what is validated, but also what's speculative – see if there is a theme there, see if it takes me in a direction. Then I'd try and test it out in practice to see whether it's valid or not. So I might be a bit more refined about it and think well: 'What does it mean in terms of clinical knowledge? Where does it fit?' So I might then go and look at the stuff on the evidence base more readily. I'd also pick up the phone and speak to a colleague and say; 'I've just heard this today, have you come across anything?' It benefits me in my world and it's easy to pick the phone up to a colleague and ask the question: ' Have you come across this? Is there a base? Has it been reported? Do you know anything formal about it?' So that's where I would go. If it gets

to the point where I can't set it against the literature and it seems reasonable, I will go with it in practice and I will go 'off piste' with it.

By that, I mean that a lot of the time, we don't have the research base to defend our practice – particularly in nursing. It is knowing things do work, but not knowing how they work. So sometimes you might come up with non-conventional ways of helping people, you might use an organically emerging intervention. As an example, I was working with a patient who had a real issue about ***** and that was impacting on his well-being and translated into his whole life. I needed to find a way of helping this guy. So I became curious as to how I might help him. So, say he was thinking: 'That hand must be dirty, therefore I put myself at risk and I am going to fade away on the spot'. And I say: 'Look. You know I'm quite happy to touch my hands. I'm quite happy to lick my hands. If I do, will you?' So, I could sit and lick my hands. And eventually, perhaps when he feels safe enough to do so, he could join me in licking his hands too.

Where that came from I could defend, if my 'internal' supervisor is stood on my shoulder, checking my opinion. It was not considered received opinion. So, my 'internal' supervisor was saying: 'If somebody pressed the pause button now, could you defend this intervention? And if I looked hard enough I could find the evidence to support that intervention in terms of an ***** experiment…. from the evidence on ***. In practice, you know how you have got to grasp the second and you have got to do it in the immediacy of the context, with your 'internal' supervisor on your shoulder, being clear about the nature of what you are doing and why you are doing it. You know, if you had to defend it, could you defend it? Sometimes it is a completely 'spare of the moment', kind of.. …almost spontaneous moment, from somewhere back here (gestures to back of head). So, I think it's about being curious and creative, being very organic, but doing it within wise parameters and knowing that it is a considered intervention.

I work on the principle that being curious and asking questions is good. Asking key questions with patients. I remember the days, back in the dark ages, where people said you can't ask some questions because it will upset patients or evoke undesirable responses, conflict or disruption. Well that's just wrong. So I'm not convinced that well chosen, considered questioning is detrimental.

We are also lucky to have a nursing team where we have very healthy challenge and we believe in helpful challenge. We are a good professional group of nurses. We've got a great camaraderie…. all understand where one another is coming from. As a team we are quite powerful. Our collective knowledge is quite impressive. At least I think so! (laughs). So I can say to

my colleagues: 'How are you getting on with such and such a case ?' and we'll have a conversation about how it is going and I'll say, ' Well, have you thought about…..'.. or, someone will say to me: 'Why are you doing that? Have you thought about such and such?…'. You know… it's very, very healthy, it's very transparent. I think none of us have an ego. You know we will say: 'What the fuck am I to do with this patient… haven't got the foggiest idea what to do today, so any inspiration will be greatly received please.. (Page 2 lines 18-22, Page 3 Lines 19 -32, Page 4 lines 4-9, , Page 9 lines 1-5, Page 9 lines 8-12, Page 9 lines 16-22)

Mary

I am curious to deepen my knowledge into things and try and continue to further my knowledge of things. I can help my patients better when I know more about different things. Give better, more rounded care.

There has been times, especially when you've been on the ward.. and you are curious because you have come across something and you think .. I need to find out about that and you write it down- make a note. Try and look for stuff.. I'll have these bits of paper and post-its that I have stuff written on which I haven't found out about – so sometimes if I don't do it instantly, then it might take me a while to do it – or not do it at all – but with certain things I do try and do it straight away. I get frustrated if I can't…… it's always at the back of my mind – feel guilty…. sort of thinking I should be doing that …I should be doing that. I should be finding out. I should be learning all the time. People expect that from a professional nurse. I should be seen to be giving holistic care from a wide knowledge base. I think it's just how nurses should be.

At the moment we have a patient who is from ***** and there are probably ***** issues. I am certainly curious 'cos, there are concerns about how she is being treated and I'd like to know more about why they moved from ****** and come to *****. Her relatives won't let us speak to her on her own, so I am just trying to investigate, um.. find out why, if there is a **** issue with them or if its something else.

So why I'm curious and why I am investigating ……to check …… I could be going totally down the wrong direction and it could be nothing ……but I am quite concerned there is an issue and that I need to deal with it to maintain ***** ……It makes me even more determined to investigate what's going on, really – especially with ****** – if there is blocking of things then that makes me a bit more suspicious. So you have that in your head, you have got this picture in your head – and it's just bits and pieces…. So I need to put it all together …. so there is a determination to find out…….

I think you have professional boundaries though, don't want to step on toes…..– so I have involved others– and its not just myself – I mean, this patient had other services involved, when she came into hospital – and I have involved other services….. and maybe what I would have to do is think, well, I've done all I can to highlight the issue, but I'd still want to sort of look further really. I feel satisfied when I have learnt something. I don't like just asking questions and being told the answer. I think it's a much better way is to take your curiosity and investigate things yourself……I've always enjoyed that part. I'll still want to look and find out what are the issues, but then, the other professionals have guidelines and boundaries that they stick to…. erm – and they are sorting it out in their own way. Nurses get excluded sometimes….. you often feel like you are the poor relation….it doesn't feel good if you don't have the whole picture ….. you don't feel you are respected or doing a professional job…… On saying that though, I will find out … nurses have their ways of doing that….. we don't like not to know.

We need to know and have the knowledge. Being professional is all about finding out….. to give patient centered care– that's our 'niche' as nurses and we need to preserve it……..I don't think that ever stops really. I'll be relentless. There are ways nurses have of keeping ourselves in the picture, in the forefront for patient care. But you can get a bit saturated with it. Your curiosity can be tiring…. Exhausting even! (Page 1 lines 1-26, Page 2 lines 26-29, age 3 lines 1-10).

Shirley

It's the professional values ……. that's what guides you. They're part of you as a nurse. My curiosity is about me learning …. just being really enthusiastic and thinking I can learn. Thinking I can make things better for my patients if I know more….. improve their lot ……. That's what it's all about really. otherwise it's not person centered care is it? It's not a professional way to work. So, it's the knowledge bit and doing a good job for my patients that fires me up……. curiosity really fires me….. It's the holistic bit. That's what nursing practice is about. That's what I'm about as a professional nurse.

Most times I learn from my colleagues. Like the other day, I saw a patient who tells me that she started injecting her own medication. Also she…….. sometimes…. In the past she has said things that haven't been true…. But she's also been in situations that have been very risky and she's downplayed the situation. It's really difficult to find the truth with her. And when she was talking about doing her own injecting, it doesn't seem right for this person. It's really, really out of character for her. And I came back from the …. I asked her about which injection sites she used, if she was being

hygienic…using clean stuff… needles…. But there was something in the back of my mind asking if she was really doing it herself, there was something in her account that wasn't quite convincing. And I was discussing it with a colleague and erm……. My colleague said she had actually assessed her the week before and it really interesting about how my colleague had said she had asked the questions and I thought she used curiosity in quite a good way, that she had said to her..' Well, *how* do you inject?'… and you know, she talked her through the process of, you know, of whether she had used this or that, swabs, you know, which needles she used ….. where she injected…….you know, it was how she kind of walked her through it. There was a lot more richness to the detail and she came away with a lot more knowledge, I thought…… so I think just from asking my colleague I gained knowledge that way…….

…..you know…. nurses have to have some sort of curiosity to learn and acquire additional skills. Like this morning where my teams' got really good knowledge about *** and ****. So, say if one of then is talking about something or he is seeing a patient, then I can ask if he can tell me about what he knows… you know.. having that sort of curiosity… but then also about maybe like peer learning, whether that's kind of formal teaching sessions.

Or just the kind of more informal things…. Like the *** team. Some of them have done **** work, so maybe we could go out and do things with them and learn new techniques. Things like using new ideas like that or *** scales or things like that. You would kind of pick things up and you could incorporate new things and improve your practice and incorporate it into how you ask questions and you can become more therapeutic, more holistic in your practice. It would feel more like mindful practice ……. I think that's what separates us out from other professions – mindful, therapeutic practice …..

It's like knowledge diffusion through the team, rather than coming back from a course and keeping it all kind of to yourself. It's the opportunity to work alongside people who have acquired new skills and knowledge. Keep it all maintained…….

Like one of my colleagues… he was very keen on kind of narrative type work. He did work around **** with one of our ****** in the Trust and they would work with people with their experiences and work with them in producing this narrative in the first person. They would type it up and give it to the patient so they had more of an understanding of their condition and progress. We need to do more stuff like this in nursing …. I aim to be inspiring like that. That's my ultimate goal really. For me as a professional nurse to engage with practice like that, 'cos that's what you want for people. Be curious….It's so simple. Very satisfying. Very empowering.

(Page 1 lines 14-27, Page 6 lines 21-25, Page 9 lines 15-27, Page 10 lines 9-12, Page 10 lines 32-34).

Janet

I just feel as nurses we need to curious. We need to be curious to know about what's under that wound, what the diet and fluids are, how are they feeling? What are their preferences? All joined up.. …. You know the whole person thing……. person centered… holistic…. Not to just give a fleeting glance …… You know, look at what's under that dressing?…. You've got to have that curiosity, you've got to find out about the patient ……look at the state of the mouth… you have to know… You can't just say you've 'looked the patient over'… that's just cursory and not very respectful of the patients real needs……you don't ***really know*** about the 'whole' then, do you? You've got to be curious, look under things, around them… not just on the surface. Look at the whole picture of the person. …… It's a joined up process. It's sort of like – assess, plan, implement, evaluate. You know, that's how nursing works if you carry it through properly.

Also, I like to find things out… know more. The main source would be like the staff, especially around *****, 'cos that's a new area for me and some of them know far more than I do on the subject. I'll also go to my peers or the Matrons or resources like the intranet. Like this morning, medical physics. I've just fired an e-mail off to them around you know, what other things can this piece of equipment do. I'm gonna put in a request for a course on that – or get one of them there experts up here 'n teach me.

So, you know, using all the resources you have got available. And it's like I'm just doing the off-duty now, so I've gone on the intranet to look at care of the ****, to see what the courses are and what the dates are – get on to one of those. I printed those off erm… so you know, you've got loads of mediums where you can get knowledge and information from. As nurses we do have to show that we are worth the money! (laughs).

If I've got an idea to help the patient with something new I've learnt, I'll probably discuss with the patient, find their perceptions and their reality and see if they marry up. That sounds patronising. No, not patronising, but sometimes perceptions can be different. Ermm and then I'll probably discuss it with a speciality nurse or somebody who is a specialist or experienced in that field… and sort of use my own experience as well. If needs be, I'll probably end up looking at the NICE guidance – only a summary though – on the intranet or NPSA. You've got a wealth of information through the internet and through the hospital intranet and your colleagues. I'll probably use a mix of those. (Page 22 lines 1-9,Page 23 lines 1-14).

BBC News

Source: http://www.bbc.co.uk/news/health-28581878

- NHS efficiency drive 'necessary'

  13 May 2010 rising demands from the ageing population. The **NHS** had been working on the assumption that it should make £20bn of **efficiency** savings by 2014.

- 2011 'could be toughest year' ever for NHS

  29 December 2010 ….but now we risk the **NHS** going backwards." But Health Minister Simon Burns said: "Reform is a necessity, not an option." **2011** will be really tough…

- NHS : Poor Care-Relatives consider legal action

  11 November 2011 evidence was being gathered from 17 families, for cases ranging from 2002 to **2011**. The Care Quality Commission (CQC) found the hospital had failed to meet legal standards for giving elderly patients enough food and drink and treating them in a dignified way.

- Health trust staff 'among most stressed'

  21 March 2012 Hospital staff are stressed and pressured, a staff survey has revealed. The **NHS** survey for **2011** showed…

- Jeremy Hunt denies 'culture of targets at any cost' in NHS

  8 March 2013 Health Secretary Jeremy Hunt warns that complacency over standards of care in hospitals in England could be putting lives at risk.

- Quarter of hospitals 'at raised risk of poor care'

  24 October 2013 25% of hospital care 'requires improvement' or 'is inadequate' as part of a shake-up in the system ordered after the **Stafford Hospital**…

- 'Painful' reforms of NHS 'necessary' says Hunt

  27 April 2014 Health Secretary Jeremy Hunt says "painful and difficult **reforms**" of the **NHS** are necessary because of increasing demand on the service…

- How many nurses short is the NHS?

  15 July 2014 … working on hospital wards compared to in 2010. **Nursing** workforce in numbers. Just over 175,000 **nurses** employed by hospitals - up 6,200 since 2010…

- The NHS privatisation debate

  31st July 2014. It has been one of the talking points of the week and one of the most hotly debated subjects on social media - is the NHS in England being privatised by the back door?

'Discourses are not once and for all subservient to power or raised up against it… We must make allowances for the complex and unstable process whereby a discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart' (Foucault 1998: 100-1).

Moments of Incongruence

One could say that the knowledge activities which nurses undertake, coupled with a commonly shared view of person-centered practice may give rise to what Foucault (1987) terms as an apparatus of knowledge-power, where whatever is thought to be true provokes obedience to that truth. However, the work of Bauman (2000) suggests that we live in a world of liquidity, where familiar codes, patterns and orientation points to which one is familiar and guided are now diminishing. Interruptions to our known truths now invoke shapelessness to once stable forms (Bauman 2000). Uncertainties begin to creep forth, petitioning stasis points and invoking a sense of incoherence and an awareness of displacement from our known reality (Baumann 2000). The practices conceived by nurses as practices of truth, may appear as 'lines of fragility in the present' (Foucault 1998: 36), and may be subject to reform. The nurses attested to sensing and experiencing the emergence of this fragility as they began to witness a de-construction of their known world.

Shirley

It was only a couple of months ago that I came back to where I am now. I was working in a team that were involved in opening a new service. It was one of the first of its kind. It's a new concept around ****. So we got chance to take innovative ideas forward. You could use your curiosity to the max. If we were interested in anything or had an idea, our manager was good at encouraging us to go off to different places, like the voluntary sector and make relationships and learn from what they did and bring it back. And if there was anything we were interested in learning we could go off and

learn from experts ….or we could…they were good at sending us on courses. Even at that time money was tight, but the project was thought through… we all had to do that…. and demonstrate how we were helping utilise resources better…. You know.. by patients not having to go through several expensive services instead of one. It helped us all take the lead on things.

It was great.. a great experience. It was nice… we had time as a team to discuss and debate and talk about which areas we were interested in… developing groups, taking the lead for things, doing research on little bits… finding out what the evidence was on this and that… it was interesting and we were all excited about our practice and being a part of taking that forward…. There was an air of optimism. There was a lot of time on the ward for development. There was an hour everyday where we could reflect or develop clinical group work. We could encourage the patients to also get involved in developing new things. We had an hour a week where if we had any issues we could discuss things as an MDT. There was a team approach to everything… care planning….. discussing a patient in depth or an area of practice in depth. Everyone including the healthcare assistants were involved. Everyone felt valued. It was a really positive empowering experience. We worked with some very challenging people and the work was challenging, but there was an air of optimism and inclusion.

But it was a terrible shame. The senior managers from somewhere up high shut the project down. Said it was all due to re-configuration and the reforms in the Trust. I mean, we had done research to measure outcomes… the results were really good. The patients were getting really good improvements. So why shut something down that is delivering excellent results? It was like giving us all lollipops and then taking them away. It was awful. They said they wanted people who were dynamic and would improve things for the patients.. be creative…… but I think we were sold a lie. Yes…. definitely sold a lie. We were led down the garden path to nowhere. Our curiosity wasn't needed any more it seemed. (Page 5 lines 3-27)

Janet

Just a year ago, my senior managers asked me to do some project work and that's what completely ignited my curiosity , beyond my wildest imagination…… because I had to look around patient deterioration and learnt about audit and it just seemed to fuel my curiosity… fuel me really and to strive to sort of change things. I was learning so much. I want to make a difference. And even if it's just a small difference……you know.

The project was around patient deterioration ermmm ….looked at observation charts and I became quite innovative around the observation chart. I invented a graded response chart that's all colours and you know, I audited the original one……. ' an it was sort of like looking at practice and how you can change it – and as I say, it fuelled me. I probably became a bit of a workaholic doing it because I got quite obsessed.

Not obsessed, but I was so enthralled with it and the difference I thought it could make that – you know- I became erm, I became quite outward and robust – yeah - I could get up and give presentations on Trust development days in front of 70 people. WOW! You know- it really sort of empowered me, having that autonomy to actually look into something and get my teeth into something, just sort of fuelled my curiosity on and on.

And from there…… ..I'd finished the work on the observation chart and I ended up looking at developing staff courses on audit and such like.. all stuff related to what I'd done. So, it's not just looking into something, it was having a look at all the other things that could support what we were wanting to achieve, like courses, education, empowering the staff.

With this project, I actually found something I enjoyed, where I could be innovative and I can be quite arty as well. It's like I did the whole of the 'obs' chart on Microsoft word – that was a real learning curve… but I did it! ……an' I sort of got into the computer and it was something that could sort of … eer, where I could use my experience, my nursing experience, but I could also incorporate other things that I enjoyed. Sort of like creating things, as I'm always creating things, making shelves at home…., you know, do allsorts of things and eerm…. . for me, it's a combination. I think the main thing was that I was given something where I had control over it. I had free rein and I was allowed to run with it really. I wasn't directed … I had very loose direction… had hardly any direction. It's around the NICE guidance – that's the only direction I had. I didn't know how they wanted it or what they wanted and then … they just said they were really happy with what I was doing to improve patient care.

Then then it became frustrating because they pulled me off the project. Said it wasn't necessary anymore. They just said the Trust had different priorities now….. had to make sure they were being efficient and meeting targets…. They said it was more important that their staff concentrate on doing stuff to save money. They were so dismissive. I felt it could have gone on – there was so much more to do with educating all the Trust staff…. How are they supposed to implement new things when they don't have the knowledge and understanding? I felt I had wasted my time. I felt the managers had wasted my time. I was so disappointed in their attitude. There was a need for more work around the education er… er… about

rolling out the 'whole programme'. They've given it to the service improvement team now. But I think I was upset because, as I say, it just incorporated all those things that were just 'curious me' really. I really felt cheated. It was as if my knowledge and experience wasn't needed anymore. I felt awful..... (Page 2 lines 1-34)

Mary

They asked me to come back to a ward level to try and improve patient care and give a better service to patients on the ***** ward. They said this ward was not meeting its targets on things. I suppose I was flattered into it! (laughs).

Originally, when I came, I just thought I'd just sit back and watch what was going on, how the staff were working. But I had to interact straightaway. For instance... It's like they wouldn't question what's under a wound. And I had an instant – we had an instance where we had a gentleman and he had a wound and this nurse had not actually looked under the bandage for a week. Nobody had. The care plan was there, but it didn't have review dates and nobody thought to actually look and see what this wound was like. And then I sort of got a hold of it; realised when I did a walk-round that nobody had looked at it. So I took it down -- and it ooh! it stank. So I cleaned it and dressed it all and did a proper care plan.

The problem is that nothing is joined up these days... separate plans for this, separate plans for that, protocol for this, protocol for that. So all the staff end up doing is ticking the boxes on all the separate documents... they don't think... not curious about the actual patient... but you can't blame them... it's the Trust who have done all this stuff to measure things, meet targets and financial outcomes.

What has happened to their curiosity? You know, to me, they should have been curious. There were a lot of qualified and experienced nurses that had looked after this gentleman. Has everybody suddenly become mindless? Lost their brains? Stopped asking questions? They've all been spoken to. Nobody thought to actually create their own review date on the care plan or think 'oh! It's not been reviewed'. You know they had washed him, they had hoisted him out of the bath and he had this bandage on his wound and nobody had thought to look under this bandage. As I say, it went on for a week and it was quite stinky. Fortunately, it was ok, but as I say, nobody's curiosity had ignited to look. Nobody engaged their brain and thought to check it. It's this whole tick box mentality... it's very worrying.

I couldn't let this kind of practice continue. I put loads of systems and checks in place, tried so hard to get them to think to be patient centered. I think with coming from **** to *****, they didn't respect me in a way as a *** nurse, because

they thought I didn't understand the patients needs. . But basic nursing care is basic nursing care, wherever you are. So there were a lot of issues. They weren't engaging in trying to improve anything. Then it came to a head when we were measured against the dashboard. That's a ten point quality indicator where you look at hospital acquired infection, pressure ulcers, falls, documentation, staff satisfaction, patient satisfaction, complaints,. Cleaning,. can't remember the tenth. It'll come and bite me in the backside (laughs) …. And em… we were quite low on the scores to start off with – you know – out of ten we were about 4 as rank rated …. I was on holiday when they did the ranking and I came back to absolute awful. The managers were really angry that we hadn't met the targets.

I had been trying to turn things around. Spent all the hours God sends coaching the staff, mentoring them, putting systems in place, running teaching sessions. I did all this in 3 months! And do you know what the managers did? They blamed me for not reaching their targets and quality indicators….. I'm not a bloody miracle worker! I worked so hard to turn things around for them. They had invited me to do this remember! Anyway, they ended up giving me objectives around my performance. Then they questioned my leadership and I think they were more concerned around targets as opposed to ensuring the basics. I disagreed with that, because the main thing that needed attention was the basic stuff. And er.. you know I think nurses have to have that curiosity. I think if you worked in a production line and there was no variance, then you could get away with not having that curiosity. But I think with nursing you've got to have it. You know.. to give the full care because, as I say, everybody is an individual, they've all got little idiosyncrasies and it's just, well……

Anyway…….the managers weren't too happy ….. They felt that I should not be doing the basics. I didn't agree. Look at what's happened in Stafford….. Well, thinking about it, I'm not surprised really….. There for the 'Grace of God' and all that…. know what I mean….. hmmmmm. If it's all tick-box and targets, you only just need to be a check-out chick in Tesco's, not a professional nurse . You know……. to just give basic care…….. You've got to have that curiosity, you can't nurse by numbers and you can't have checklists. So, they ended up performance managing me, sent me off on a fucking course. It was so insulting. That was the last straw… like a slap in the face. So demoralising. They had flattered me into it all and pulled the rug out from under me. Never again. (Page 5 lines 30-37, page 6 lines 1-29)

Sam

I was asked to apply for a job in *****. I was told I would be able to change things. I was led to believe that my way of thinking, my passion for person hood and holistic nursing was supported. I allowed my self to be seduced. Seduced into

feeling I was brilliant. Into thinking that what I had was what they wanted. I got into the job …. and the staff…. I just couldn't communicate with them in a way that I was used to. I just saw staff stressed, working really hard, trying to contain difficult situations. It was all risk management. Risk. Risk. Risk. Working with patients who were *****, needing medications, DNA'ing on appointments, staff and patients not going to ***** meetings. It felt really kind of; Oh God!' It felt that the whole environment was going to hell. It was fragmented, was mad. I ended up feeling mad myself. It was really stressful.

It burnt me out. I was trying so hard to see what we could improve, keep things person centered. There was no room for curiosity. None. No thinking. No time to think. You could barely keep on top of it all. Really kind of keeping up with ticking boxes, making sure that discharges were ready on time, checking risk management plans, audits, care plans - making sure they were all done. It was all task based. You had not time to actually communicate with anybody… staff or patients…couldn't communicate. It was a real challenge. Everyday communications – saying good morning, small talk, connecting with staff or patients was not meaningful. The patients' wife, husband, brothers, sisters… they were the ones that needed care… the environment stressed them too. You couldn't even give them any time to talk to them (sic). Not even at the weekend. Just to try and give relatives a picture and information of what was happening with their loved ones was almost impossible….. so soul destroying for everybody….. Not good. I just felt like a drone… a machine……you know.

It was all during the re-configuration of the service in ****. Closing down of some places and people were so stressed. The buildings seemed to be the priorities for 18 months, not the people… there were some very sick people….Decorating! Decorators all over the place, can you believe that? fucking stupid……..That for me was the worst time… the worst.

I learnt a lot though. In retrospect my experience of it was that it was a really good learning curve. Really challenging. Made me feel as though I was not in a position to effect change. My curiosity wasn't needed. Wasn't leading me anywhere. It was just making me feel more and more despondent. I couldn't change anything. I realised I didn't have a niche. (Page 18 lines 1-23)

Giorgi

I was asked to come into this job… they phoned me and asked me to apply. A colleague said to me: 'It's really good… we've got you coming into the team.. you've got new ideas, you want to do new things.' I think there's almost like a… that's what

a lot of practice relies on these days… the fresh blood coming in. I felt the job was going to be really good. When they interviewed me, they said they wanted people with new ideas, fresh thinking. So I was really enthusiastic.

When I started ……. at first there were quite a few of us on shift. We had a protected hour each week and all of the MDT would come in and we would all sit around a big table and discuss a case. It would be about someone we all knew and just all contribute to the discussion about what was happening to this person. You know, draw out themes, compare to other patients that we knew and try and think about how we could work better. It was just space to think about care planning and to think about what was happening. The culture supported support curiosity. It was about asking questions. I've always been interested in people. Why they think the way they do, why they act like they do… I think it's about when you find a situation or a person and it's something where you are interested and having the time to go away and think and do something useful with it. I think curiosity has the potential to help patients, but also yourself. You know… give you a sense of satisfaction from work and benefit colleagues and practice in general. Curiosity is helpful to let you know when something has been done well. In a general sense curiosity is about taking things to a level of improving practice and improving care and that's what we were all about.

I do want to be curious and I think learning with others is good, but there's ….. well, it's not so good…… having time to reflect …. things have changed dramatically …. Time to be curious and think differently is really lacking in my role at the moment. It's not so much a bed of roses…… it just doesn't feel like that at the moment. No time. It feels like we kind of react to stuff a lot more in our jobs now… and that's not good for patient care or for developing practice….. .. but you are bled dry …..and then you just get set in your ways like everyone else. And I almost feel like that's where I am… no ideas because no time to think and I feel quite stifled because there's no room to develop. Haven't got time to think mindfully. I feel I'm at real risk of stagnating. What's going to happen to my practice, to patient centered care? to my curiosity about things? You know, it's not just local to our team it's throughout the Trust, throughout the NHS…. I bet if you interviewed all the nurses in the NHS on their curiosity, they would all say the same thing. It all seems to be short term thinking. It's really frustrating. You are led to believe you will have the opportunity to use your curiosity and then it's all snatched away.

There's even practical limits in terms of.. …I used to really like reading journal articles erm.. you know… just even reading essential NICE guidelines… but just in the office where I am at the moment.. and it sounds ridiculous in this century, but we haven't got a consistent internet connection . We can't always get access, so we will be seeing patients and I'll think: 'what's current best practice for early onset *** or what shall I be recommending for someone with a history of ****.'

You know… can't look it up, so then you are having scrabble around. It is quite stifling……. but that's just how it is. It's… you know… you try and raise it with managers, we've been saying for months that there are problems accessing new information and evidence, but you can only do that for so long before you give up and think: ' Well why should I bother? What can I do?'…. you know… you become reticent.

When I try and talk to the managers they just say: 'Oh it will get better' or 'we are making changes' …. You know… but.. really! My managers are nice people and I find… that definitely, my senior manager I can be really open with her, which is really helpful, especially when it's a stressful job…. Erm… I can speak really freely with her, but her response is: 'Things are going to change' and 'things will get better'… but that's been the standard response for the last 18 months now. It's like: 'what's going to get better?' and 'when's it going to get better?'.. you know.. there's no specifics. It's all bollocks really. I just….. at first I just … I was really frustrated and then I realised it was contributing to my stress and now I just kinda think…….I was looking for another job, but I think I've just got to just kind of manage. But thinking about that, it's not beneficial to my patients…… Just managing is not good enough for them……. It is really difficult. I don't know what I can change. I suppose I would like to have time to use my curiosity to provide the best care from having the time and resources to look for stuff and digest it… and think of ways to integrate it all in my practice. It's so difficult to find that time……

It's terrible actually…. this team I work in at the moment has been running since about **** and we sometimes work around *** ermm.. and we are expected to see people within 3 hours and so it is very time pressured .. erm.. and we don't have…… there's only 3 of us on shift at a time and there's no time to get together and talk about cases. We've completely dumped reflective practice….. no time……

There's always somebody at the office door saying: 'You need to come and see this person right now. Why haven't you seen this person? This person will 'go off' if you don't see them now.' 'They have been here over the time.' It will be your fault if we breach our times.' You know……. Everybody is just so obsessed with targets. Targets, targets, bloody targets…… just obsessed. It's just chaotic…. The phone's always going, the bleep is always going off…

So….. you know…… it's … you just don't have time to sit and consider… consider mindfully…. We see all these people who are very poorly, they need to be seen now and straightaway, and we're sort of responding to that… and the clinicians are putting us under pressure. You know, it's all NOW! NOW! NOW! and we are sort of going along to the beat of their drum

and maybe that's not a good thing. If we could just stop the fire-fighting … All of this has an impact on my curiosity. It stifles it. Stops it. ……..It's a feeling of us being distressed and in crisis. It's a really stressful environment. It's just so stressful. We are all really, really stressed….

… sort of like now, in my job… I'll meet someone that I'll be very interested and curious about their situation and ask them questions. But really, I'm asking questions in a certain way, a way that is already formatted and set and I have to document them a certain way….. in a way that's formatted. I just have to rush through it. I have one hour to ask all the set questions. Then I have to document it. Then I go on to the next person. That's the way we have to do things. I don't have time to think about it. Whereas actually, if I had time to really think about that person in front of me and the situation they are in, I could help them better and have better outcomes for their care or somebody else's care.. 'cos there might be similarities in their story which might help me help somebody else better.

If I spend the next twenty years seeing patient after patient with the same old assessment and prescribed ways of working like we have now, that's not what I want to do. I won't be here if that's the case. I may as well work in a factory. Working in the NHS is like working on a conveyor belt. It doesn't really feel like engaging with your curiosity. It's mechanical and robotic. There should be a sign in every Trust: ' Curiosity and thinking not needed here.' It's all about risk…. compliance…. fragmentation…. It's not about people as whole beings and what really makes them tick.

But you just think: 'I've just got to get through it'. You just think: 'I've got to go and ask the set questions, type it up and move on to the next one'. And that's quite sad. Makes me really sad. You can have some really poorly people in front of you and you risk not making a connection with them and their story… you can miss something really significant. You are listening to them but you have to stay disconnected, because the assessment is disconnected. You can't… that's a weakness of mine really… maybe I spend too much time with people… and other staff say to me: 'No, you can't do that. You just have to do the bare minimum, stick to the set questions and move on to the next person.' So, there is a set way of doing things. There are all these scores, pro-formas and targets that need to be completed which takes time away from the real needs of patients. Our assessment documentation expects us to cover certain areas. It's all a bit tick boxy and yes/no answers… you know, asking patients inane questions as if they were all the same. That's our knowledge base in nursing now. It's all prepared for you. You know… you almost worry that one day they could put it all into a computer programme and replace you with a computer or robot.

So where's the need for curiosity in practice? All these generic set assessments… all prescribed……It removes your curiosity. Removes the need to think. You feel like you have to cover the set things.. the set questions. You are expected to cover those…. I suppose a lot of my colleagues now….well…. … don't particularly question any of this or anything about practice. They don't speak up. I don't really know anyone who questions things or even has an inclination to challenge the system or improve things…… and can you blame them?

God! That is really bad. That's really bad. It makes you wonder how we ever will move forward in nursing if no one is doing anything. Nursing practice is just going to stagnate. It makes me wonder if we have moved forward at all. The NHS is only interested in targets and money… set ways of working……it's all so fragmented…..how can we provide improvements to care or person-centered care in this climate? ….. Certainly not from where I am sitting anyway. It's all a bit crap really. It's all been made into tick box, production line nursing. Doesn't bode well for the future of nursing…… (Page 14 lines 7-21, page 15 lines 1-37, page 16 lines 1-37, page 17 lines 1-2)

Ian

The thing is if you try and do things differently….., if you are seen to be engaging with your curiosity, it is seen as challenge. And in today's NHS, challenge suggests that somebody has kind of dropped the ball. It suggests that it's punitive. It suggests that it's critical. And certainly in our setting we have a clutch of hospital managers who absolutely will not permit challenge. It's handed down higher wisdom, which I'm not convinced it is wisdom at all. The more we are curious, the more we are seen to challenge, then it becomes hierarchical. You know..:(referring to managers talk) 'I've got these measurement tools, these protocols, these indicators- the compliance list is endless by-the-way - from the Board and I'm just handing it down to you. Just deal with it. Just do it'.

So, I think we have two levels of challenge. The first level is that happens clinically around case work and it's done in a good spirit and with camaraderie. It's not to do with failure. Then translate that to a management context and it's absolutely filled with testosterone and peer failure and criticism and clinical mis-management. It goes down like a cup of cold sick. So, I think from my point of view with the team I work in there's a lot of transparency. I don't think there's transparency and understanding when it comes from the management system. People are watching their backs all the time, there's a lot of defensive behaviour going on. I think there's a lot of: 'I've not heard it, so it's not happening; don't tell me about it because I'll have to do something about it'.

Curiosity is inhibited in this environment. And it's getting worse and worse.

Managers are fighting for their positions, fighting for their budgets. I think people are concerned about being challenged, because it's perceived as personal failing and weakness. I think there's a real sort of chest thumping attitude in hospital management. I don't think that's anything new, but I do think it is more pronounced now. It's not new… always been there. I just think people believe they are doing the best they can in the resources they've got and don't like to hear about, maybe that it needs to be different, because that means doing something. And doing something means kind of stretching your resources or thinking more creatively – being curious.

My experience of being openly curious is like trying to speak with no voice. You are silenced in effect. Nothing happens. There is very, very little possibility of a clinician influencing change for the good or for the bad, because the Trust is interested in its risk assessment, its financial position. It's interested in not breaching targets. It's to do with punitive and measurement investigation. Every time I hear our manager talk it's always to do with: 'I'm just conducting a disciplinary or a fact find on this complaint or untoward incident'. It's very scrutinising. There's a sense that the Trust is trying to keep its stability, to be seen to be functioning and providing against its contract. Nothing more, nothing less. Compliant rather than curious. No room for innovation.

Not innovative at all. When I came to **** we had the potential for a really innovative service. We have had no investment at all. The Trust is interested in numbers through the system, as opposed to quality. It talks about outcome measures, but outcome measures only when it proves when the service has been satisfactory. They are not interested in the patient at all. Individualised patient care is not in their dictionary. It wants numbers through and payments in. That's what they want. Because of the under investment, we are a mediocre service. What could have been innovative and superb is mediocre.

If I said to you I've got * years and * months before I retire…… and I'm thinking: 'Just let me get there'.

My concern is I don't want to turn into a person who coasts for the last * years and * months in clinical practice! and that's how it makes you feel, because what you can bring to bolster clinical practice is not valued. It is not part of targets and projections of the numbers game.

Clinical innovation and improvement …. Pah! It's rhetoric. It's a buzz word. It's meaningless. In fact, our Trust is now coming away from a ****** structure and talking about '******'. So if you heard that language, that dialogue, it feels

that it is to do with the patient and the experience and the journey and to do with … how do I put it…. It's to do with improvement. But it's not. It's to do with the latest language that disguises the fact that nothing is happening. It's a different language to describe the same inertia. Fundamentally it is to do with the Trusts finances, risk position. It's to do with winning and fulfilling contracts. And no matter how you change the language, it continues to be the same. It doesn't translate from the boardroom into clinical services. There is an element of fear and survival. It feels like every man for himself. People are looking after their own interests to be best placed.

Most clinical people are doing the best they can with what they have got. You put your head in your hands on most days in despair and frustration. There is little traction. But, the imaginary world of clinical improvement is just that… imaginary. It doesn't exist. I don't get involved in practice improvement or innovation because it is seriously inhibited. So, I don't … at the practice level we are told that improvements are not the role of clinical teams. That any decision or improve or to change things is managerial not clinical. How does that work then?!! Curiosity? Clinically led innovation? Oh! Please!!

BUT….my personal position is that I'm absolutely fastidious about what I do with my patients who I see on a day to day basis. I do what I need to do with the person who sits with me to get the best for them….my patients deserve better. So I don't sit there and think I can't be bothered. But it feels that the more you do, the less you do, if you see what I mean. Somehow it doesn't get through that the service works because the people are committed to their patients and actually make the service work. So, I think our service, and many services they're good….. not because they are managed, but despite the way they are managed.

I'll give you an example. I've used **** for a number of years about 7 or 8 years.. we then started to see patients coming in talking about another approach to care that they had heard of. So we investigated it. Looked at the evidence base. Three of us went to the training which was tremendous. And the reason why we did that is because patients came into *** saying; 'I went on to the internet and I followed the video which shows you how to get better. I followed the video on Youtube and it works'. And we thought to ourselves as a team: 'Is there anything in this? Is this something we need to explore?' This was a lot of patients coming to us saying the same thing. Not just a few, this was many… from different social groups, backgrounds, ethnic groups. So we looked at the Youtube video that people had seen. We started to ask; 'What is this? What benefit does it have? Why do they get better? Do they get better?' So, as a team we started to look into it and the evidence base surrounding it. It transpired that there was some research to support it as an intervention for ******. We thought it would be a great idea to work with the university and do a small trial on it. Similarly there was

another intervention to help with **** and we wanted to do the same thing. BUT……..Could we get the Trust to agree?... No. Their response was that we already have **** as the so called gold standard intervention and that's what we are commissioned to provide. These other things we had seen have a robust research base – they are better approaches than we currently have - but the Trust also said that the outcomes they were looking for were the ones set against their service agreement, which is what they are commissioned and paid for.

Don't have a problem with that, but if we can use additional, complimentary interventions which are equally or more robust, and we are willing to run our own trials to look at outcomes, improve quality, innovation… all that. Then what's the problem? It frustrates you to hell. Why did they pay to send us on the training? What was the point? Can I get them to be involved in the smallest of trials? We even wrote a lengthy business case for research on it… all costed out, university were agreeable to collaborate and provide expert research help. But no, they wouldn't bite. The discourse on improvement and innovation is rhetoric.

So, I feel my curiosity is being eroded, suppressed, dismissed……

But the here's the thing. The curiosity that **is** encouraged is that which fulfils the Trust agenda. ……

So, the Trust say to us: 'This is the framework, the treatment protocol…intervention, this is the data we need, these are the questions you ask patients'.

It's all set…. prescribed. Meaningless. It's destroying nursing practice.

Curiosity in the main is related to the Trust agenda… from a risk assessment perspective. It enables them to say; 'Our nurses/clinicians inquire about frequency of ****.' And they can tick the commissioner's box. Meet the terms of the service level agreement. But it doesn't allow **us** as nurses to be able to provide interventions which are meaningful.

All of these set ways of working ….it makes the NMC code of practice sterile. It makes it one dimensional. It takes us back a thousand years. It inhibits inquiry. It inhibits any desire to undertake research. It inhibits innovation. It inhibits any kind of anything new or improvements to clinical practice. Because….. if we all don't tow the prescribed line, the protocol line, then it will result in punitive action. If you follow the protocols, you are safe. If you depart from the protocols, you are told you are not insured and therefore it is your case to answer.

So, clinical knowledge is becoming redundant. I suppose it's a point which raises the issue of dominant discourse from a systems perspective…… but it's all done out of fear….because the….. what happens 'up there' is to try and control, to stop any kind of randomisation - to make it manageable, understandable, quantifiable, risk free and regular. Don't get me wrong. There has been a need to improve patient safety ….. but it's all gone too far…..the pendulum has swung too far in one direction and it's got stuck.

Curiosity makes things messy. It causes disruption … disruption which diverts from the corporate line…. It's about mediocrity……Erm……. I can't deal with just mediocrity. I makes me mad…..

But…. what that says to me is that it is better to have a well behaved corporate clinician who is…. Safe isn't the word…. But it's someone who is not a threat to the Trust …. rather than have somebody who has excellence as a driver and actually moves practice forward. I think we have done a lot in nursing…. Our evidence base is much stronger……nurses understand more than they did…nurse education has changed for the better. Nurses now know where to go to find the evidence. Our practice is more informed and we have been encouraged to be more curious about practice. The difficulty we have is in the dominant language spoken across the NHS which is about compliance …. We have become automatons. Puppets. You know, just pull on all our strings, make us dance to their tune and then they chuck you in a corner where all your strings get tangled.

If we use those skills and that knowledge we have as nurses by engaging with our curiosity, it comes at a cost. A great personal cost. Personal cost is personal risk …..it is being seen and labelled as a maverick. The personal cost is the exhaustion of having to use a circuitous route to get to the end product our patients really need, rather than take a shorter route which is far more sensible. That's the labour of it….. because you are constantly being curious…..thinking: ' Where can I get this resource? How can I get the help this patient needs? How do I get round that barrier? How do I do it an ethical way?

Curiosity…… it takes it out of you…. you just feel you are constantly banging your head against a brick wall. It is absolutely exhausting and it's constant. It never lets up. It's living with those tensions…. which get tighter everyday. It has a great cost. People put their heads down… keep it below the firing line…….they do things like say: 'I've only got * years and * months left'. I don't say that with any pride. Actually, I feel a great sadness.

You just get so battle weary. You feel isolated. (Page 9 lines 8-39, page 10 lines 1-37, page 11 lines 1-37, page 12 lines 1-10)

'As the connections have been broken by the fragmentation and isolation of work, they can be restored by restoring the wholeness of work. There is work that is isolating, harsh, destructive, specialized or trivialized into meaninglessness. And there is work that is restorative, convivial, dignified and dignifying, and pleasing. Good work is not just the maintenance of connections – but the enactment of connections.'

(The Body and the Earth: 133)
Extract – *The Art of the Commonplace: The Agrarian Essays* Wendell Berry

Alchemic Spaces

What we may begin witnessing is a series of tensions arising between professional discourse and institutional discourse and the knowledge-power relationships between the two. In her research, Canam (2008) noted that whilst nurses approach their practice from a dominant holistic discourse, drawing on the perceived power of nursing knowledge, they are also constrained and influenced by a corporate surveillance model, designed to monitor effectiveness, contain costs and protect corporate interests. Scott (2010: 227) elaborates on this paradox, suggesting the emergence of 'performative regulation', whereby practitioners are shaped by seductive discourses which involve a mixture of coercion and voluntarism.

In Scott's (2010:227) view, seductive discourses allow for 'performative autonomy'. Here, practitioners readily engage in acts of voluntarism, perhaps taking up appealing institutional offers which promise degrees of control, empowerment, knowledge acquisition and autonomy (Scott 2010). However, performative regulation plays together as a reflexive mechanism with performative autonomy, with practitioners subject to constraints through the 'deployment of institutional rhetoric' (Scott 2010: 227). Individuals may thus become suspended between discourses and knowledge-power relations and their expectant tensions, enforcing a state of liminality.

According to Turner (1974), liminality represents a state of being betwixt and between different constructs of the world which groups of individuals inhabit. This state of

liminality inculcates a growing sense of fragmentation, leading to feelings of stuckness, incoherence or bafflement in the individual, who then seeks to make sense of differentiation and find comprehensibility and a return to the whole (Turner 1974). As Bohm (1980:24) suggests, ' ….*we will look at the whole …… and be attentive and alert to learn about it, and thus to discover what is really an appropriate sort of action, relevant to this whole, for bringing the turbulent structure of (fragmentary)vortices to an end'.* Philips (2002) attests to such a process having no well defined path. However, as 'virtual fractures' appear in perceived realities, they open up spaces to consider freedom, which arise from fragmentation and dissention (Phillips 2002:336). Similarly, and drawing on the work of Foucault, Maria Tamboukou (2008) argues that fragmented textual selves seek spaces within which they may hide, disengage or undertake forms of retreat and renewal; spaces where they are free to become multiple dispersed subjects (Best and Kellner 1991).

Janet

I have to put a lid on my curiosity at work, otherwise I couldn't cope. It's like certain things which you like think are a good idea and you take them through and you can't get the staff engaged…an' you just think, 'But its such a valid idea, why can't you see it?' and then you think that maybe it's just not the right time… and I'll think, 'Oh.. I'll come back to it'. Then unfortunately it might get put on the back burner and it'll never rise again because something takes over or another priority. And you think, 'Ohhh.. I wish we'd done that, 'cos that would've improved **** care and been quite good'.

But to be honest, most of the time, I think you have to put things on a back burner and that's an avoidance, but sometimes you just can't face going down that route really… especially if you work in a world of chaos. Erm.. and as I say, you'll put it on the back burner and it's like… I've got a pile of papers there (indicates to desk) and they've been on the back burner for twelve months now.. and that's information for the patients, but I've just put the lid on it all. I've got the ring binders and everything to put them all together. Sometimes, ….. in a way….., it's just like opening Pandora's box. You know, 'do I or don't I?'

You know.. 'What's it going to reveal? What am I going to have to do about it?.... and if you haven't got the space sometimes you have to 'triage' your curiosity. But it's like, with curiosity.. you know.. it gets put on the back burner and I hate to say I leave it alone.... say, 'Bugger it!' .....God... I'm fickle aren't I?

But erm.. so, yes.. sometimes you avoid it because you think, 'I don't have thinking time to do this'. Unless.. obviously it's something you can't avoid .. But err... patient wise, I don't think I avoid curiosity, but innovative practice and systems I might avoid, because I think that's too big now and I'll think, 'I'll just have to leave it on the back burner'. Like all that stuff there (points to corner), hopefully it might all spontaneously combust! (laughs). It's like I've got a bag of stuff there from a road show I went to and got some fantastic ideas from there.... And that's just stayed there.. 'cos it's been triaged.

I have to find ways to be curious outside work. I have to muffle it in work. You haven't got that luxury in work.... yeah... muffled. Because you can't ... you haven't ... in a way time's ... time is a luxury. Erm and sometimes you have to erm.... And I think this happens with the staff sometimes... you have to just do the basics and you can't. You would like to go that extra bit, but you can't because you just haven't got the things to do it. You haven't got the staff, you haven't got the time. You've got all the demands. They come first and even if you might be intrinsically doing curiosity, being curious about stuff, you can't actually act on it. It's like I've got a lot of frustration. I'd love to have a week where ... it sounds awful... where I didn't work on the ward. I could sort out the storage. I could improve all things round there like the stores cupboard. I could look at stores and supplies, instead of trying to squeeze it in and end up always running around looking for stuff. But you know, instead of trying to squeeze it in in half an hour here and half an hour there, you know. I feel like I'm spinning loads of plates at once. Erm... and all of a sudden they'll come together or they'll fall...

I do a lot of innovative stuff at home, especially when the football's on... thank God it's finished! (laughs) ..... ermm.. so, you know, I make cards. So I just sort of like tap away at home... get lost in my own world.... as I say.. you can't really have a harmony around your curiosity at work.

Like with my allotment, I'm always curious... looking for different ways.... You know, to ... it's like my carrots. I know it sounds daft, but I found some drain pipes and thought: 'I am gonna mix some sand, peat and soil and see how they do this year' (laughs). And everybody is looking at me like: "What are you doing!?"

It's so I can keep the carrots above the carrot fly and it's so they have room to grow long roots. I put my Grandad's old plumbers' crow bar down it and made sure they they've got an easier route to take and so hopefully they will be p-e-r-f-e-

c-t. (laughs). So you know, I get my curiosity space that way. Oh! And there's the library…. there's one in ****. I go there in work time ….because.. usually on a Wednesday, cos I get peace there. It's funny cos this is my curiosity again, cos they've got small books and I just happened to look and it was a history of **** from 1920. Yeah….. and the pictures are fabulous.

The peace and quiet is good there…..As I say, the quiet…. mmm. I can use the internet there. My curiosity takes me off at a tangent. A classic example is ---- this is quite amusing--- but this is a classic example is the internet…. Erm… I was going on the *** Building society website to get a statement and when I Googled it I got, Nova Scotia. So, I went off to Nova Scotia and found all these links. I ended up on the Titanic – then to the passenger list and then went to Crosby at Bruce Ismay's house and then on to the 1911 census! (laughs). It was great!

It's the peace and quiet in the library. But I have to be honest, I don't look at the text books or nursing journals or research or anything like that. I'm a rare one going to the library, because I never see any of my colleagues in there. I see medical people, but I never see any nurses. Very rare. Very rarely see nurses in there. It's my escape. (Page 16 lines 12-16, page 17 lines 8-21, page 19 lines 22-31, page 21 lines 3-22).

Sam

Being curious….it's really interesting, because I work **** and I find myself leaving from… leaving from work.. and finding myself pulling up in the traffic lights and I turn and look and think, 'That driver, he's pulled up again.. or she's pulled up again'. … it's a bit like groundhog day. For the first hour of getting to work is the same. The same cyclist coming down the road…. I can anticipate he's gonna weave around the cars … all that kinda thing. It all feels very routine. That consistency … clocking on…. finishing at five o'clock ….and the predictability of it. I don't like it. I don't like it. And I know anyone would say; 'Oh! I'd love to have such routine'. But I don't like it. It's the predictability of it. Obviously things change, but there's something about.. I don't like to see the predictability in people I'm working with. And I know that each person that I work with, I know that … even though… this intervention says that this person with *****will find really helpful, I think; 'No….. no…. it's not that predictable. Patient's are not predictable. It's not that black and white'. So I have to be curious. That's the curiosity, the kind of curiosity that keeps me alive. Does that make sense?

In many ways…….. I begin to tolerate all the rubbish at work.. everything's in bits and pieces …. Nothing works that joins up for the patients. I just have to tolerate it. There are some things that you can change and there's something's that

you can't and it feels a little bit.. I'm not being defeatist … its just sometimes ….. actually… sometimes I just think, 'I'm going to get as far away from nursing as I can…. As far away as possible.'…… but then I might never do that……ermmm. So its almost as though, that what you've got to do is mediate… mediate in your head……. tolerate…. and to find a space where you can begin or continue to express that curiosity …in a helpful way that doesn't…. that just helps me feel satisfied about my curiosity…… that my curiosity is being attended to by myself… …… What I have of my own kind of sense, my own part of being a nurse is that I know I have worked really well within the meaningless situations we are put in….. trying to make sense of it all.

But sometimes I do want to escape… just escape…….

We are not nursing……. not allowed to be nurses with all this .. all this prescribed pathway stuff……

Stupid really.

I just got so down and frustrated…… so I began to think of a way that nurses could get together outside work and find space to talk about things. So I came up with my own group! I call it the thoughts and feelings group (laughs). It's not formal… everyone understands that. It's more about having a dialogue. The thoughts and feelings group is very much about facilitating conversation, communication and interaction with others and trying to make sense within the group. We are all nurses. ……It's about thinking about things, checking things out. Its about not making assumptions because somebody is angry. It's about us having a space to be curious about why we are angry and let's be curious about the sadness we feel too. It's funny, some people talk about they have a great sense of loss…. 'lost nursing' someone called it the other day. You know.

We do things in an inclusive, respectful way, so we can also respect the silences too. People come out of the group saying: 'I found it really helpful.' It's about providing space to explore and make sense of things. It's about getting a sense of the 'whole' back. (Page 15 lines 21-32, page 16 lines 16-28).

Ian

It's all very wearing…. my curiosity can definitely wear me out at work… you know.. the old emotional labour of nursing kind of argument from some time ago. Of course it can, because you're working with real issues and real issues in real lives…. with real people. It's a journey. After 21 hours of **** practice a week…. So for 21 hours a week I have someone to

see… constantly……it's perpetual curiosity…….that's not considering time needed on top of that to do with ridiculous documentation, form filling and admin. That's 21 hours solid clinical work… no breaks. After a while, I don't quite know my own name! (laughs). I go home and face a rather large gin and tonic… and that's because I'm all thought out …. My curiosity cells are dead. There's nothing left. It's exhausting. You are not spending your day talking about the price of bread. You are dealing in people, with people, for people. At the same time of doing that, because you work in such a crap environment, you are also trying to keep sane.

When I go home, I pull down the shutters. But it is draining… because the people you see are really sick. It is exhausting…. There has to be some way to re-coup the energy to face another day so you can keep finding your way around the corporate crap.

I also do work for ***** outside of work. That is so rewarding and refreshing. I feel free to do and say things, come up with new ideas and take them forward… I am not constrained. I can engage freely with my curiosity there. It's a really creative space……. (Page 7 lines 14-28)

Shirley

I keep asking for reflective practice, but the managers won't release the time…. say it's not a priority… can you believe that?! You need something to help you make sense of everything. Improve things… reflect on your knowledge… see where the gaps are.

You just get so lost sometimes… trying to make sense of what is going on… trying to resolve what patients need and what the organisation is demanding. You always feel caught between the two. Like that llama in the film Doctor Dolittle that has two heads…. What's it called now?……'Push me-pull you!' that's what they call it… it's just like that, being pushed and pulled in one direction then another …. Then getting lost somewhere in between….. then trying to find your way out or back again. It wears you out. You just get so caught between all the needs.

So, I go home, light my candles and get in the bath.

Then I put on my fluffy dressing gown and slippers. Then I sit by the fire. Then I get lost in a book. Then I feel warm again. Then I start to feel more like me again. (Page 19 lines 7-16)

Giorgi

The reflection needed to be curious around practice can't be done at work. You can't be reflective at work and so you can't be curious. So, I feel suppressed. There's the medications, patients need to talk to me, I need to sit with them and talk, spending an hour sitting talking to them .. ...an hour yesterday spent having a conversation between a service user and a ******.The patient wanted me there and nobody else. So those immediate needs for these people need to be met and there isn't room in nursing practice for curiosity to develop or improve. Clinical supervision is not there. I'm not learning anything new for nursing care – not at work anyway.

But.... I do want to explore and understand. I have a fantastic mentor now. I had to go to unbelievable lengths to find her. She's very good. She is very competent at the reflective side and I get a lot out of that. I have to seek out mentors like **** to develop that side of me that wants to be visionary and innovative, to ask questions around the future of services and what things could be like. Erm... so that... needing that... that's outside of my clinical role and work and I have done that because I can't deal with being in confusion all the time ... I haven't got a space at work..... I haven't..... I can't..... It's actually out of the question... there's too many competing commitments. You can only manage the immediacy of things and that causes stress .....there's some stuff you can't do and it gets so frustrating, but it has to find an escape somewhere. So I get together with my mentor and she helps me think things through, gives me an opportunity to work it all out. She lets me express all my big hairy ideas for nursing... I feel safe being curious with her. I might be in cloud cuckoo land, but at least somebody listens and takes me a bit seriously! You know... she's one of these people that makes you feel you can fly.... take off into a different direction... it's very liberating..... (Page 3 lines 14-18).

Mary

You know, when the tools you have been given don't fit the job, how do you let somebody know that it doesn't fit the job? ..... Well, you can only feedback to somebody who is in a position to change it. A good example would be, where there's the admission assessment forms... it's such an old admission form and it's not capturing things at all..... it led me down the wrong way of questioning .... I mean for the patient... the questions I have to ask on the form don't suit their actual needs.....and I said to my manager that I didn't think the form worked any more. And she said; 'Don't worry about it.... Just fill it in'. So the sense of frustration and confusion is sometimes overwhelming. I know that conversations have been going on about changing the form and I have ideas in my head as to how it could change for the better and what it should look

like. But I know I won't be part of that conversation… I won't be invited to talk about re-hashing it. So, I have this sense …. a feeling ……it's a feeling of 'unfinishedness' and 'incompleteness', which is quite stressful.

I have to make reminders to myself if there's something I'm curious about and I can't get any joy at work. I send e-mails to myself at my home address which says 'think about' this or that… and so.. a good example is that I don't get the chance to explore my career development and what I want from work or what my strengths are. I never get the chance to ask, ' What kind of nurse am I?' so I'm curious to know how other people see me.. I'm curious to know what kind of person I am… like the Johari window stuff, you can never know … you can feel a bit odd….. a bit of an oddity. I said to my husband last night that I felt a bit odd sometimes. The problem with being a bit odd… …… when I have a work life balance… I'm only in work for 37 ½ hours…….. And the other part of my life .. it's how I cope .. I manage the tension outside work…… age helps you manage because you get perspective on the tensions created at work. I need to fulfil all the dimensions of my life, not just in nursing. For example I'll listen to radio 4 and I'm curious about life in general and so are the people around me, so work is only one part of my curiosity. So, to find space I do a lot of things and that fulfils a need, because it's unrestricted. There's an empowering side to these things.

Sometimes you just have to stop thinking, stop trying to make sense of it all…. it is too tiring. I have a good life outside of work. So I am a bit odd in that I go to really abstract plays, read books that other people do not read… I know I do…. I'm reading all sorts of different stuff that other people I know would not read… it's always delightful to find somebody that does!!! (laughs)…….. the Secret Life of Socrates at the moment! (laughs)…….. so my escapes leads me to read in huge amounts.

…… curiosity is of itself a good thing and I think it's just in my DNA. I can't be any other way. It would be interesting to see how the NHS would use curious people and do something positive with them…… being with like minded people.. curious people.. it's very empowering, refreshing.. you feel inspired from curiosity.. it gives you resilience to face what happens on a daily basis…. I know I have the other part of me outside work where I can be curious and that validates who I am…….

And it's not a power thing… it's not about if you are curious that you are on a power trip…. Some people do think that.. they feel intimidated by it sometimes….as being too powerful to cope with… because curiosity should lead to learning and doing things differently.. ….that's why it has power but people are afraid of that power….. But curiosity can be a powerful tool for everybody…… it is for me, but only if it is enabled and you can do something with it….and I can't do that in work.. it's

that space thing again.. a curiosity space….and sometimes, even when you do want to change things, people don't know where to start or what to do… and most often the staff don't want to engage….that's why I often can't do things, I don't know what to do next…. So you have this idea and have gone out to find out more and then you can't do anything with the knowledge ……. so people feel powerless and frustrated….. and that's power in a disabling, oppressive way…. That's when you feel incomplete……..and so you have to find a space to see if you can make yourself complete.

(Page 6 lines 27-35, page 13 lines 1-11, page 15 lines 23-29, page 16 lines 1-3, lines 26-32)

'Those who exhibit curiosity are upstarts…. who challenge the nature and order of things….representing a rebellious impulse that could endanger the state and the individual …… (Benedict 2001:22)

Defying the Panoptican

Beswick (2000) suggests that curiosity is not just a cognitively critical motive which stimulates us to explore, learn and integrate knowledge, it is also a construct imbued with a strong intrinsic desire to craft something with care. In his de-construction of the critical elements embedded within the construct of curiosity, Beswick (2000) explores its etymological root, noting the meaning in its origins. In Beswick's (2000:2) analysis, the meaning underpinning the word 'curiosity' is 'to cure'. The phrase 'to cure', survives in the now rarely used phrase, 'the cure of souls', which Beswick (2000:2) translates in a more modern sense, to mean 'the care of people'.

Whilst curiosity may be a fundamental ingredient to the care of people, Kashdan (2009) notes the need for curiously crafted work to contain a sense of intrinsic reward. This sense of intrinsic reward, stimulated by curiosity, arises through a process of creating, maintaining and resolving conceptual conflicts (Beswick 2013). According to Kashdan (2009) conceptual conflicts arise from a perceived gap or a lack of fit between an incoming signal and one's world-view, resulting in a sense of incongruence. If not attended to, this sense of incongruence leads to feelings of fragmentation and a

perception that our world view is in jeopardy of being thrown into chaos (Kashdan 2009).

According to Stacey (1992:81) chaos 'breaks symmetries' of systems of thought and moves one into a state of the unknowable. However, Beswick (2013:2) contends that curiosity has reflexive properties, whereby individuals seek out spaces in which they may identify disturbances, acknowledge and make sense of contradictions and begin to emerge into a field of openness to alternative strategies, where the 'care of people' might be curiously crafted once more. In Beswick's (2000:4) view, curiosity lies at the borderlands of chaos and cosmos and has the potential to purposefully guide individuals on their journey towards a perceived construct of wholeness (which he calls cosmos), within the confines of contextual restrictions.

One might suggest that the reflexive movement which curiosity stimulates may reflect that described by Freshwater and Rolfe (2001). In their opinion, Freshwater and Rolfe (2001:533) suggest that whilst reflexivity prompts a journey towards an understanding of how the self is situated in the social world, as achieved through an 'inward gaze', it also moves beyond introspection to presume an ethically and politically engaged commitment to resist power and constraint. Additionally, Freshwater and Rolfe (2001) note the post-modern nature of reflexivity which bears parallels to practice and knowledge which is situationally contingent. In other words, reflexivity is situated within a localised sense-making space, which draws upon localised knowledge, from which politically engaged acts of resistance may take place (Phillips 2002).

Investigating the managerial and State imposed constraints on nursing autonomy and decision making, research conducted by Traynor et al (2010) suggests that nurses rely on localised practice and systems knowledge to work around limitations. Where nurses sense or directly experience constraints or external resistance to their professional world-view, knowledge and preferred ways of working, they seek indirect ways to have influence the clinical setting and take action to craft patient care within a framework of

moral action (Traynor et al 2010). Similarly, Freshwater et al (2013) note the emergence of non-conformist behaviours and positioning undertaken by some nurses to resist forms of surveillance. As Phillips (2002) contends, dissension and aspirations of freedom of thought and action are antecedents to forms of resistance. They are the inventive spaces in which resistance is developed. In Phillip's (2002:339) view, dissension is 'not a new discourse', but is the process of subjecting present discourses to a reflexive, 'inventional' pause, before one moves into an inventional moment - a point of alternative possibility.

Mary

It's just about trying to care for people, to meet their needs. We had a patient - a young patient who had ***** and she had..... erm ... we thought she had maybe ****** and both myself and my colleague got quite involved with her. She had been with us for about 10 days ...and I suppose.... well she couldn't ..... eerm.... So we were both curious about why she was ..... of why she is not feeling good ... 'cos this thing she was having was not really anything to do with what she came in with..... her family were only involved a bit. ... well, they weren't around much at all and it was a very, very, quite a heavy time for both of us - emotionally hard work because we were so much trying to find out what the issue was with her. I felt for her .. she was relying on us.

So me and my colleague got together and were discussing it all and we felt we didn't have the expertise to help her .. we thought she needed some ***** input. We talked to the doctors and managers about it, but they said that it wasn't part of her care pathway. But the thing is, they weren't with her all the time like we were and didn't really see what was happening to her. So.... errmmm.... .. well... I have a friend who is a ****, so I spoke to him and asked him if her would come in and see her. I had to keep it quiet.... I changed my shift and my colleague's so we were in one Sunday, when it was quiet and none of the **** were around... I timed him coming in so that I knew nobody would be around.... He had a chat with her and said she needed **** especially for when she went home....

We both learnt so much from him about ****, so that's knowledge I can take with me the next time... but you can't really share it with anyone, cos they might make the connections... you know.....So, before she did go home I made a few calls to people I know and got something sorted for her.... They all understand what it's like at the moment... there are ways of

doing things……you know, if it's not on the care pathway that they are put on, then patients don't really get what they need. If you ask me what I spend most of my time being curious about, it's about how to ethically get round the rules and systems…..(Page 5 lines 13-32).

Giorgi

I won't always take no for an answer…. well, not no…. I won't take the first answer as absolutely the right thing for the patients. It is kind of imbued with me to be curious about all the different aspects of things… I need to know more …… the more I know, the more I can help the patients……..Mistakes… yeah…. Well maybe not mistakes….I may go down the wrong avenue and realise at one point down the line that it's maybe not in my remit… curiosity has got me into minor skirmishes… I think maybe eyebrows are raised frequently. You know… 'There she goes again!' (laughs) …… But curiosity has to be maintained within everybody to get results. But, I have to find a corner for it.. bring it in carefully….. secretly… well, not secretly… quietly…… by the back door so to speak….

We can change things if we use learning, to manage things better for the patients …why be blind to that?. So, with my curiosity, I see or read things and ask: 'Oh! That's interesting, who will that benefit? how can we benefit from this?'… and little lights go on in my head!!' (laughs). Curiosity has to lead somewhere. It's more than questioning. It's got to lead to a change in practice. I can see a reason as to how and why we could do something. In the team… err.. I might say: 'This is good.. these are the things that are out there.. new things with ****.

One thing curiosity has helped me to do is when a big report comes in from 'on high'.. So a good example would be the Francis report… it's a curiosity study in a way… its asking about why these things happened and that can be quite empowering ….. and there has had to be some kind of discussion about why these things happened. I began to think after that report… is any of that happening on our ward? Have we any of those behaviours? I did think I recognised some of the things in it in my team. For example, skills, stresses within the team, poor relationships within the team… power games in the team, lack of professional values. Time pressures, tensions, how do we care? how do we raise concerns?, do we make sure they all have water and food? …. so all of those things….. so Francis was a good example for me to look at and do

some thinking. I wanted to set up a discussion within the team about it all… have an open conversation….I did discuss it with my manager, but she said absolutely not…. Said we couldn't … she went ballistic….. said it wasn't my job to do that. So I suggested we get the Director of Nursing down and we could have a discussion with her! I though she (manager) was going to blow a gasket…. She said under no circumstances should we let anybody think we might be doing things that are in Francis….

But we did have a talk in the team about it…. I waited until all the 'high ups' were on holiday and did it anyway. So we have had conversations and we have looked at the basics… making sure we do those little things that matter. I just think that .. gosh… well we have… we could have better practice. Francis can help with that. It comes with authority. There's an empowering side to these things. There's an empowering side to that…. there's something about learning … there is something about curiosity being empowering. When a report like Francis comes out and it's either damning or ….. there can be something in there if you recognise that, because you have a duty to challenge. How can you be professional if you haven't been curious about what is in front of you or behind you and working within your team? How can you be accountable if you've not been curious about practice, when you've not asked questions, because questions are going to be asked of you in any case.. aren't they?.. so why haven't you asked those questions? Why aren't we curious? Why don't we take the action? Why don't we learn? Why ***aren't*** we learning?….you see…..

But there is a silence with the Trust… yes, there is…… on a simple level it makes life easier. Curiosity is not something that's particularly welcomed.

But then why should I be complicit? why wouldn't I challenge things?

……There is a mis-fit though. Curiosity is not nurtured in the NHS……

(Page 8 lines 35-37, page 9 lines 1-34)

Shirley

I can be a bit of a maverick with my curiosity. If it means helping my patients to get better or get a better service, then I'll think of ways to do it.

A few weeks ago we had a patient came in. He'd come in two or three days earlier and had had a full assessment with two of my colleagues. My colleagues had asked him all the right questions, did a very thorough assessment. But this patient had been saying he needed ****** and he was really unhappy about the outcome of the assessment and he left saying: 'Well, I'm gonna complain then.' He was really angry, making a lot of threats and stormed off. He then came back when I was on shift. I read the assessment and thought: 'Oh God! I've got to go and see this man. It's going to be a nightmare. He's just going to get really angry like last time. He's gonna get really angry and shout at me'. And me and my colleague went to see him and.. we basically said:' 'Look, we are not going to do the same assessment as before and ask you all the same questions you have been asked before…… tell us what's going on?' and we ended up talking to him about … he ended up telling us that he'd been into **** and … and it turned out that was the trigger for his condition and that had not come out in any of the previous assessments… and there had been lots of them. He'd had a difficult time. We got him talking about all sorts of things. It was so interesting. He was so funny. He had us in stitches.. nearly crying with laughing. But at the end of it he said: 'I feel so much better'. And that was great…… We walked away feeling we had a really good interaction with him. We spent a good hour with him, the same amount of time we would if we had done the same bloody set assessment with him ……..and we were still able to write it up according to the 'required format' and fill in the boxes…. But we saw this other side to him and he got to talk about things which were important to him. It was nice to listen to him and see the other side to him. It was really nice.

You know you have this assessment… it's so prescribed…. has all these set questions on it. We have to manipulate it to get the outcomes the patients need. It's all done under the radar. I suppose you look at that assessment and know it's not useful to the individual sat with you… we all sat and had a good chat with this guy and had a cup of tea…. That's what I tend to do…. If anyone asks, I tell them I used 'such and such an intervention,' which is also 'Trust approved', so I can get away with having a meaningful chat over a cup of tea.

The set assessment we are told to use asks about problems, but if you start off with problems, you get problems. The other way of doing it …. the person-centered way…..you get more of a person as a whole. If you ask about problems you

get all the negatives. Whereas if you can sit and talk to patients about ..... Well... I'm from ****.. so if I get a patient from around ****, I will say: 'oh! I'm from **** ... whereabouts are you from there?' and you're not supposed to spend time chatting cos you've got the set questions and the time targets built into it and all that... but I will say: 'I'm from *****... do you know such and such a place? Did you go here? ' you know. You're trying to link in with them... it gives you more of an idea as to what they are like as a person. There's something more satisfying.. you see more of the person, not the problem. You don't want to just sit for an hour and fill in a meaningless form and ask bloody stupid, irrelevant questions... you need to get them to talk about the stuff that's important to them, whilst still getting at the difficult stuff and still assess them. It can be a really awful process otherwise. It's a bit brutal otherwise.

A lot of my work is with *******. They're people who are really sick and you think: 'This person is really in a bad way, they are in a lot of pain.. you know... they are so unwell... in a terrible state in multiple ways. And you are expected to ask all these questions like: 'Have you done any exercise today? How is your appetite today? ' ... and then tick the box to say you've asked it....you know.. how stupid can that be?... It's bloody obvious they're in a shit state..... you know, if they have just jumped off a fucking bridge and their leg is hanging off, you don't ask them if they've got a good appetite, do you?!.. for God's sake!.. It's just ridiculous.

I've got another colleague who subverts the assessment in funny ways... he's brilliant. There's one part of the assessment that looks at diet and appetite and he'll say: 'Have you been eating and drinking ok recently? And do you cook?' then he asks:... 'So what's your signature dish then?' and then he'll go on to talk to them about what he likes cooking and little things like that that are more caring and humanistic, asking about pets and telling people about his cats.... things that we all know are important to people. He SO subverts the assessment. But he gets better results. It softens the relationship and the whole approach. I think you can learn better by being curious about how other people do things and take some risks.... risks that are about being curious about the ways we do things and doing them differently.

God! I go home terrified sometimes. I have to take risks and do some off the wall things, otherwise the Trust would come to a halt... we don't have an endless supply of beds ... or so we keep getting told.....and we can't admit everyone to hospital so we have to discharge people home. I discharge people home regularly that at the end of the assessment, they say: ' I'm gonna ***** if you don't admit me' and I just have to say: 'I'm sorry you feel that way.. but....'. That happens at least twice a day. You go home and your heart is in your mouth. Sometimes you make real leaps.. even if you take a risk.. especially if

you take a risk ……..you have that sense of intuition, with the evidence and experience and your curiosity sort of well….. it brings it together and you make a leap… and try it and see how it works.. I'll still go home and worry though….

I see on the news all the time about old people being left in beds and on trolleys, not being fed and things like that and I think it's really bad, but there is another side to that story. I know it's because we don't have enough nurses to do the job well and there's all these targets and protocols and set assessments. Nurses are not callous people who don't care. You know.. and that's almost what those reports imply… … you know.. you do a job under really harsh circumstances and feel so criticized. If we had more time to develop practice, to be curious and change things and improve them.. if we felt inspired and felt empowered it would be really amazing.. really interesting. But actually.. the reality is we feel like we have to answer to this great big machine….. we've got boxes to tick, we've got set assessments and protocols to use which don't fit what we do……

So we invent stuff as we go along…. practice moves forward under the radar, like I said. . ……. I would like to develop practice properly… but there's also knowing what to do. Sometimes I wouldn't know where to start. Even if I went and sat in the Trust library, I would think: 'I don't know what I'm doing… what do I do? where do I start?' Although, thinking about it……..I suppose I might think about my practice and read journal articles about **** and look at current best practice.

I have an idea that keeps being batted about in my mind…….. so I might look at that and see if it's worth doing or if it's a waste of time…….. but really, I wouldn't know what to do with it…… I wouldn't know what to do with the idea or how to develop it or take it forward, who I would go to for taking it forward? Taking practice forward is not encouraged. There aren't many people in practice who stand up and say: 'I'm doing this, do you want to get involved?'…. You know.. ' There are these projects going on .. do you want to become involved'. There are no role models… no role models in the Trust… no nurses or anybody I know that are engaged in anything like that. It's just not part of practice. It's not encouraged by anyone.

Ultimately I would like get involved in research…. looking at things which are really relevant to improving practice and patient care. But I have absolutely no idea where to start or how to do that……I don't know who does it in the Trust…. There's no one I know who does anything like that. I've mentioned it to my manager but I just get placated…..

So I think that's what's missing is encouragement and becoming involved… some kind of engagement process for learning and innovation and improvement……There isn't that culture… at least not one that's promoted… I know we do have an R & D department, but I don't know what they actually do.

Things are stagnant and don't move forward with collective practice… but individually, I can make changes to my practice… sometimes…. But I have to be careful because of the set assessments and protocols and such like. There's a limit to what even I can do as an individual. The reality is everyone keeps their heads down. The knowledge that's generated on an individual basis is not being shared with anyone so we all miss out. We are not capturing any of that. We're missing out on developing an evidence base from our practice…… what does that say about our profession? I do wonder if it was any different 10 years ago…. Probably not…. And if it will be different in 10 years time …… probably not…… and you do use that as an excuse not to do things 'cos you think nothing's going to change anyway. I don't feel that at the moment I would benefit. If I was going to do something, I would have to do it in a structure that supports it and encourages it. Otherwise, I'll just have to keep doing it all under the radar. (Page 10 lines 32-28, page 11 lines 1-34, page 12 lines 1-36, page 14 lines 5-21, page 15 lines 1-15, page 16 lines 31-34, page 17 lines 2-5).

Janet

There was this work I was doing to develop teaching sessions for the staff on ****** and the managers asked me to stop doing it and go up to ***** to help them out for a while. Anyway, as I was based up on ***** , away from prying eyes, --- I was still near ***** ….you know . So, I still got involved in the teaching. I was teaching the **** as well. So I was still sort of getting learning across ….. and I was still embedding the ***** and ******* and so I still sneakily do it (laughs). You know - It's like the ***** I'm sort of semi-involved in that too – you know, sort of sneakily again….. erm, with the ****** who I get on with exceptionally well and she sorts of helps me facilitate carrying on. In a way my curiosity has opened up loads more avenues really, particularly when it comes to teaching on the wards and beyond. I'm involved in the *******. Designing that course for ******. So I'm doing it anyway, you know---- it's my plan b! (laughs). I've just been on the internet and now I'll see how I can incorporate it all the teaching materials into my ward. If they find out, I'll probably get shot… but there you go. Thing is, we can all learn so much, I don't understand why can't we do it all openly? Why does it all have to be hidden? …. I despair of the NHS at the moment. (Page 9 lines 8 -17)

Sam

We work with some really critically ill patients …. they are very ill. So some of the patients that I'm working with…. there are only a small cluster … and at any given time. But they have been functioning. We know that your body adjusts to not being well… it compensates and has less expectations of itself. So these clusters of patients can look after themselves in a very kind of sophisticated way. They know how to keep themselves going. They can pay attention to when they are feeling ill. My kind of approach with them is ensuring that are ok. According to our unit, the treatments are there, but you know …..it can sometimes do more harm than good, err,….by actually imposing them on people. You have to work with the patients, work with what you have got.

So now we've got, we've got a situation with one of my patients, where .. with me facilitating her to being quite empowering of her care and directing it.. trying to let her know what's available to her … because she is just not happy with us and what we are doing…. I'm kind of seeing her and speaking with her as an individual and respectfully trying to help her think about what she really wants to do. The situation is that, instead of us as a team… which was where my curiosity has recently led me into a bit of conflict…..where instead of us as a team kind of rolling out the expectations of what she can do to remain engaged with our team, ermmm, instead of them doing that, they've kind of said, ' No. This is what we have to do. It doesn't matter what she wants or says, just stick to the care pathway'.

But the pathway was not suited to her, it changed the goal- post on her progress. She's not happy…… and as a result of that, she is now in the process of trying to discharge herself from our service.

So… but, she is not going to get better anyway. The fact is that she is going to die. She is going to die anyway…. not today hopefully, not next year- hopefully…. But the fact is that .. my kind of sense is that actually, we are asking too much of this lady. Why can't we just continue working with her – doing things on an individualised basis. We've got our risk assessment, we've got a relationship with her. More often than not, if we remain engaged with her and we're able to look out for her, without actually saying to her, 'If you don't do this according to the pathway, they we will do this to you'. You know, .. a particular kind of treatment that would be prescribed to her at her next visit would include *****. She wouldn't want that. That was the worst thing that could happen to her. So recently, my curiosity led me into a lot of conflict with my managers…

I was trying to find a different way to approach the needs of this lass. You know, we are clinical experts, collectively a highly skilled, expert team. Why can't we accept the fact that it would be in this person's best interest to do things differently. It would be detrimental to her to just blindly follow a set pathway. Why can't we just accept that she has some say in her care? And then we kind of support her thereafter…. Why can't we just work *with* her.

Somewhere … and this is the cynical part… somewhere in the service, higher up the ladder, they will be thinking 'risk', 'clinical governance', 'We can't allow deviance from the pathway.' …… and I think that's the detrimental wider influence that's happening with nurses in general now …. Why didn't nurses think that patients were dehydrated? And go and attend to them? It's out there …. Every newspaper you pick up, they are asking the same questions. You know… two nurses have just been struck off and you kinda think to yourself, 'Well, actually…….. my team, my curiosity… mmmmm - …..',

I just come up against 'risk'…. and that's regardless of the fact that they haven't actually looked at the needs of the patient. So she just gets so distressed; and what she has done now is get so distressed with the way she is being treated with this pathway, that she can't tolerate it and she is threatening to write a letter to the Trust and to her MP. But regardless of that, it is really important that she might have found her voice at last. Otherwise, for this lady it's just same old same old…. Patients become liberated by that… basically what she is, is liberated … they are liberated by that. The thing is, what is the hold that we have over patients? …. We haven't got a 'hold' over anybody and yet we blindly follow care plans, pathways and procedures which are useless.

All in her care plan this patient has had a really difficult time…. erm.. like going shopping for instance and I thought it would be really helpful if we could take her to the supermarket ….that's when my curiosity got me into trouble this time!! (laughs).

I arranged to go shopping with her and people found out and my manager said: 'Where have you been with her?' I said I'd been down to ASDA.. that we went shopping. And it was, 'Well, you should not have done that.' and I said that I didn't really understand the reason why…. because in my judgement, this is what we do….. she needed to be able to go shopping and do it and be confident and I just thought, ' I really can't respond to patient's needs as and when they arise'. You know… kind of treat them like that… you know we need to treat them on an individual basis. Yes, of course, if she wasn't capable, that's different… but it does come into promoting somebody's personhood….using professional judgement – shared decision making – there's another new mantra! But it's about personhood … that way of working, that's what's been really

ingrained in me and it just felt really important and I didn't agree with the manager. I just kinda thought, 'Right ok…let's go to bloody ASDA'…. And we did. As far as I was concerned the managers attitude it was all a load of bollocks. At that point… it was bollocks.

Fortunately, it all went over the patient's head… she didn't know the hoo ha of what was going on in the background……It worked for her. I am seen as somebody who does not tow the party line… somebody who was always questioning, looking to do things right for the patients. You kind of accept it… this is how it is. I'm not over concerned that when I go to work that my line manager would look at me and think I'm a trouble maker.. I'm just kind of thinking: 'Ah well as far as I'm concerned, I said what I needed to say, did what I needed to do' and I feel a little bit like … fine about it because it was doing it out of promoting patient care – individualised patient care. It wasn't because I needed to make a point……. you just use your curiosity to use the intelligence and knowledge you have and then find your way around things… you just have to test the water sometimes ……. I couldn't give a monkeys' if the managers don't like it…… and I'll keep on doing it……

Ian

I come out fighting to get what I need for my patients….. let me just say.. you can get where castor oil can't……. So for example, if I needed somebody to go have a particular treatment and I can't get them in to see anyone in my Trust because she doesn't fit the protocol…. … oh! and so bizarrely, she is actually disadvantaged because she is classed as being well, … that is, as far as the protocol is concerned. She needs to be 'medically' ill to have this other service. So, I've been around long enough to know that I can find a way into the *** service by using a particular language. And I say to the patient: 'When you get my letter, you may not recognise yourself in it because I might be gilding the lily to get you this treatment… do we have an 'understanding?!' … So when I write the letter to the GP, I will talk about all the problems she has an the fact that so many working days could be lost for this patient with impact on income etc. etc.. you get the picture….it's all true… there are no lies in the letter, but the letter does become emotively manipulative with an emphasis on certain areas, depending on which language is being spoken at the time and with which target audience. So any GP can relate to the priority language and say to the commissioners that this patient fulfils certain criteria which you make sure fit with what is strategically important at any given time.

Castor oil principle… Use the system to your advantage.. yes. I'll never be dishonest or misleading, but there are ways to get what you need for your patients, even if you do have to go all around the houses.

There are those times when I sit there and think; 'Should I?, should I? should I have a go and do it anyway?' But I tell you what I do though……. I say to the patient: 'There is this treatment called ***, which we can't do with you here. But if I were able to do ***** with you, it would look like this. Let's use something from what you just told me about ****** . And I would go through the whole routine and suggest they go to the internet and try it out. I still provide them with the treatment that's on the protocol… so I'm still complying… but defying!

You know, patients are more responsive and honest to a more meaningful way of doing things. You see….. so I can ask the same question from the Trust agenda but get a better response, a more meaningful response to aid me to help them….. But, it takes longer… it is more respectful. It enables the shaggy dog story to emerge. I'm wise enough to know that if I contextualise the question, it is useful to me to put it all together with the rest of the story and what is presented to me. What I can then do is ask more questions which provides me with yet more of a bigger or detailed picture. It's far more meaningful. It's mindful practice.

Curiosity in the main is related to the Trust agenda… from a risk assessment perspective. Like I said before, it enables them to say; 'Our clinicians inquire about frequency of ****.' And they can tick the commissioner's box. Meet the terms of the service level agreement. But that's different the way that it happens in clinical practice to use the information for the benefit of patients……. and more so, for us to be able to provide care which is meaningful.

Curiosity de-stabilises. Because I might appear to play the party line …. do I really believe that corporate line thing? No.

Would I write a well worded letter to get somebody treatment? Yes.

Would I make a direct referral to a service rather than having to go through the GP to make it faster? Yes.

Would I tell the patient how to access another area of treatment, so they are empowered. Yes.

Curiosity is done by stealth. It destabilises the systems and generates sub-systems and that's exactly what the NHS is trying to inhibit ….. any kind or irregularity… something that is nor protocol, proforma, plan or pathway …..

But in actual fact it creates sub-systems … hidden sub-systems….because people buck against the algorithm. Find ways around the system. The NHS is not influenced by reality. People are constantly trying to weave ways around the corporate compliance line.

I'm not convinced of that even in the busiest of settings there is the opportunity to look at practice and share the knowledge we get from practice…… or to think we are valued or there is a culture to value thinking and questioning. If something is not valued why would you waste your time in doing it? You know, when Fleming looked at a piece of mould in a cup which had been sat on his windowsill for a week… and he thought: 'what the hell is that?' and he started thinking 'why has that grown? Under what humidity? Conditions?'… etc… then he was able to describe and think about what he could do with it and then experimented…. I can understand how that works, but that depends on the person having the ability and the… erm… the encouragement and the climate to then develop his idea. If you are sat in **** as a ***** nurse and you start to think about a wound and what is happening with it… and you are that busy and you don't feel particularly valued… are you actually going to think about seeing if a different dressing or technique of bandaging might work…… no… I don't think so. Where there is value and where there is opportunity and a climate which supports curiosity and innovation.. then it might happen. The climate is important for it. I consider myself to be assertive.. I'm not timid, but even when I've come up with ideas I can't get engagement or support… I can't get that support. People keep their heads down… keep it below the firing line. Sure, if things were supportive, it would enable me to satisfy my curiosity to see if my ideas did work and I would be able to test things out…. I would feel much more empowered. I would feel as if I had greater scope and tools to help my patients better. I'd feel I had ability. I'd feel I had a voice. I'd feel I had influence in practice and I could contribute to healthcare. I'd feel as if my observations, thoughts, impressions and knowledge derived from practice were useful in a tangible and open sort of way. As opposed to just being the ramblings of a mad poet. So, I'd feel as if good could come of it. It would be so motivating, so empowering…. curiosity, learning, asking those sorts of questions: 'Is this any use? Will it improve patient care? Shall we try it out?……. but as a nurse, I'm not seen as an innovator …. I'm seen as somebody who just nurses patients…. that's all…. and it's tragic…

So, we have to rely on the castor oil principle….. gets round every nook and cranny ….. quietly – even when they are watching…. But they don't see.

Curiosity……..it's all done by stealth… and nurses are masters at it……..

(Page 19 lines 16-37, page 20 lines 1-20, page 21 lines 1-20).

Parting shot from Mary

'Interesting isn't it? – I think we go round and round with our curiosity……mmm……'

Beside a sparkling rivulet he stretched
His languid limbs. A vision on his sleep
There came, a dream of hopes that never yet
Had sought his mind. He dreamed a veilèd maid
Sate near him, talking in low solemn tones.
Her voice was like the voice of his own soul
Heard in the calm of thought; its music long,
Like woven sounds of streams and breezes, held
His inmost sense suspended in its web
Of many-colored woof and shifting hues.
Knowledge and truth and virtue were her theme,
And lofty hopes of divine liberty……

Edited extract from:
The Spirit of Solitude
Percy Bysse Shelley 1792-1822

Chapter 6

Liberating Curiosity

Having had the opportunity to hear and interpret the participants' stories on curiosity and express my own, I am now led to reflect upon what that emergent narrative might be telling us about curiosity in nursing practice and how the knowledge derived from it might contribute to new knowledge on the subject. Reflecting on the participants' and my own stories of curiosity, Mary's parting words echo in my mind. For me, there is something poignant, familiar and novel about her notion of 'going round and round' with curiosity. I use it as a starting point to lay out my understanding and knowledge of curiosity in nursing practice and reflect upon my experiences of conducting this study. Throughout this thesis and particularly in coming to write this last chapter, I have learnt much about my own curiosity and that of the participants. I have often felt myself going round and round with my curiosity – on a journey with existing knowledge and towards the novel of knowledge hitherto untapped. Sometimes, it has felt like an endless journey – a journey where I have often felt I would never reach that liberating moment where I could be confident that I have done justice to the purpose of it. I think the reason for this, is that I have constantly looked through my curious lens to reflect upon the questions I posed for this study, to pay care to the narrative of the nurses who took part in it and to look at the implications their curiosity narrative has for nursing practice.

The question I asked was; 'In an environment of competing discourse and constant change, how and when do nurses engage with their curiosity?' By asking this question my intent was to better understand the lived reality of nurses' experiences of curiosity, understand the factors which may indicate how curiosity is enabled or inhibited as a mechanism to promote knowledge integration and application; and gain some insights as to how nurses might ameliorate processes and practices which impact upon their engagement in curiosity. One of the things I have observed is that, the nurses who took part in this study presented an integrated frame for their narrative as they see it lived in the context of the NHS. The rays of their attention refracted the 'how and 'when' as

part of a narrative whole which is inextricably bound together. The strategies (the 'how') which the nurses used to engage with their curiosity are bound within a temporal (when) frame, with both being in contextual relationship. They move around, through and between these frames of reference. From my own experience of curiosity, I can understand reference to perpetual circuitousness.

Quite frankly, my curiosity during this particular constructive process has led me to many places in the cognitive and emotional realms. I have gone through constant refractive movements with my reflections and ideas not only with this chapter, but during the writing of this thesis, in search of a shape, form and intensity which will do it justice as a credible contribution to knowledge. The myriad of discourses on nursing, knowledge, curiosity, truth, authenticity, representation, justification and a whole host of others have played through my mind; and that is not to mention my situatedness in the texts of the participants, my self, my work and my home life. All of these texts or discourses, however we want to label them, have been seductive drivers which have refracted themselves as prisms of light, each of which I feel I have had to grasp and pay attention to. I have found myself in and between inter-textual spaces which reveal my situatedness, as Pryce (2002) suggests, as multiple and often conflicting realities.

One of the things I have recognised whilst undertaking this PhD is the nature of permanence my curiosity has. It is always there, lurking in the background and travels with me in the realities I find myself in at any one given time. When I look at the overall purpose of this study which was to lift the veil of their perceptions to reveal the lived reality of nurses' engagement in curiosity, I have discovered that it is not a singular reality the nurses encounter with their curiosity, but like myself, they encounter and live multiple realities, which all mix together in the muddy sands of nursing practice and all that it entails. The nurses also try to grasp the refractions of light which emanate from the prism and engage with their curiosity to make sense of those realities. When we lift the veil, we find they are situated in a world of patient need, a world of nursing, an institutional world, a health and social care policy world and their own individual sense

of person-hood. All of these worlds have unique discourses which compete for their attentions and influence their engagement with curiosity.

However, I am not convinced that curiosity, as circularity, adequately portrays the complexity, breadth and depth of the knowledge journeys the nurses actually took with their curiosity. I am not intending to dismiss, silence or contradict Mary's voice here. Rather, my intention is to pull on her impression and that of all the nurses of their lived reality of curiosity. By doing so, I hope to recognise and illustrate the complex sophistication and contradictions, which I think are inherent in the collective nurses' narrative. I also think it provides an entry point for the reflections I have on the curiosity narrative of all of the nurses who took part in this study, along with my own experiences of conducting it.

Indeed, the parting shot from Mary attests to her engaging in an endless knowledge journey which holds curiosity in permanence with it. Her expression of '*going round and round with our curiosity*', suggests it is embraced and perceived as a powerful partnership in her search for knowledge, with a purpose to care. Engaging with curiosity in this way could also be said to be true of all the nurses who took part in this study, by virtue of their constant reflexive excursions and returns in their pursuit of knowledge to provide individualised patient centered care. They were all quite clear that when they engaged with their curiosity it prompted an awareness of the status and state of their knowledge, in the immediacy of the nurse-patient interaction. Their curiosity was not only engaged in the one to one nurse-patient encounter, but was also engaged to address the how of their engagement as they moved into places, practices and with people who could provide them with the knowledge to fill the gaps they perceived to have. By means of curiosity, the intent was to expand their knowledge repertoire to reflect their conception of the professional values and beliefs which they not only deem important to the provision of holistic, individualised person centered

care, they are also values which they feel differentiate themselves from other healthcare professionals to reinforce their sense of identity.

Since Nightingale, nursing has vested considerable effort into establishing its place and worth as a distinct professional body. Within attempts to raise itself from a place of philanthropic patronage and deferential servitude and establish legitimate professional habitus, nursing has followed an oftentimes tortuous path of scholarly development, educational and practice reform (Tosh 2007). Often shaped by debates on the fundamental character of nursing/caring and the nature of such knowledge, dichotomous discourse has prevailed amongst many of its scholars and educationalists, with arguments extolling it primarily as a transcendental, vocational discipline on the one hand, or alternatively as a rational-scientific, professionalist discipline on the other (Traynor 2007). Within such discourse, nursing has undergone a philosophical and epistemic struggle to build a distinctive body of knowledge (Beck & Young 2005). Nursing scholars have vested much energy in articulating nursing's uniqueness and in staying true to epistemological loyalties (Benner 1984, Savage 1995), to find ways of creating and applying a knowledge base which reflects an agreed meta-paradigm, is pedagogically relevant and practically engaged (Tosh 2007, O'Connor 2007). What nurses are left with, according to Risjord (2010) and Clarke (2011) is a patchwork of nursing knowledge. Nursing practice thus becomes a bricolage activity as it draws concurrently on the range of epistemic and paradigmatic traditions and influences which are now inherent in nursing practice (Gobbi 2005).

Whilst such knowledge work has evidently contributed to nursing knowledge, the historical impact on the nursing profession has been profound in that nurses are clearly influenced by these discourses, with caring, person centered values, life-long learning and the use of evidence-based practice and their attendant knowledge now central to their practice (Mantzoukas and Jasper 2008). What has become important to nurses in practice is that all knowledge, no matter its typology, form or source, is utilised

pragmatically at the patient-practice interface (Fulbrook 2003). The 'bottom line' for nurses in general, and for the participants in this study, is that their knowledge informs and shapes outcomes, fuelled by a caring ethos and based on the individual needs of patients (Fulbrook 2003, Liss 1993). Without exception, all of the nurses in this study attested to their curiosity being bound in relationship with knowledge and perceived this relationship to be important in their day to day provision of holistic person centered practice. They were as Schmitt & Lahroodi (2008) suggest, motivated to and drawn towards inquiry into specific and related knowledge, which were instrumental to and determinative of their conception of professional knowledge and caring practices. One could say that the importance that the participants placed on their curiosity and its interaction with professional nursing knowledge is a shared vocabulary that gives power to their conception of professional values and legitimacy. According to Berger and Luckmann (1966) such shared vocabularies serve as designated modes of operating, being and behaving within professional communities and constitute a socially constructed reality. The social reality thus constituted, provides a 'plausibility structure' – a social base of significance which serves the community with a matrix of conditions for knowledge and its transformation (Berger and Luckmann 1966:177). We could then perhaps conceive that the participants in this study inhabit their plausibility structure, which sustains their collective conception of their reality and within which curiosity is situated and integral to the matrix of their epistemic condition.

If we are then to believe, as the nurses in this study illustrate, that curiosity is central to their knowledge correspondence and its construction and serves as a socially constructed reality, we are perhaps taken into the realm of new knowledge, which raises implications for nursing epistemologies and reflexive forms of learning. Within the narrative that the participants attested to, it could be said that knowledge in their world, stimulated by curiosity, is subject to constant construction through constant comparative processes, followed by informed action. Whilst this type of reflexive action for the purpose of knowledge exploration and integration has been reported elsewhere

in the nursing literature (Rolfe 1997, Rolfe 1998, Johns and Freshwater 2009, Freshwater 2002b, Freshwater and Rolfe 2001, Estabrooks et al 2005, Rolfe and Gardner 2005, Freshwater and Avis 2004, Avis and Freshwater 2006, Kinnsella 2009, James et al 2010, Christensen 2009, Christensen 2011) and is nothing new, the presence and function of curiosity in reflexive knowledge activity has not.

The most common forms of reflexive activities reported in the nursing literature concern, in the main, reflective practice and praxis. Both have come about as a means to reflect, upon knowledge which may arise from any source and explore the tensions that these may bring about for and to practice, so nurses may negotiate and determine how they 'ought' to practice (Avis and Freshwater 2006:217). Whilst there is much reference in the reflective practice literature on its epistemological value to nursing practice (Kinsella 2009), there is little or no mention as to the role curiosity might play as a cognitively critical motive to take 'want to know' action (my quote marks). If we take the view of the nurses in this study, they were interested to want to look at their practices in a different light, because they wanted to know more and create better ways of working and practising. This is a view supported by Sandberg and Tsoukas (2011), who attest to the importance that organisational practitioners place on knowledge work, refining their practice through a variety of knowledge seeking and integration activities. Specifically in nursing, the role of praxis, a term used frequently by noted educationalists such as Freire (1973) and Eraut (1985), serves as a knowledge construction and integration function and is defined by Penney and Warelow (1999:260) as '….informed action, which when reflected upon, changes the knowledge base which informs it'. In Freire's (1973) view, praxis acts as a decoding mechanism which evokes challenges to existing knowledge and stimulates the emergence of new knowledge, which is tested in practice through reflexive action. Praxis in this sense is seen as a marriage between knowledge and practice, through the presence of an 'epistemically curious mind' (Freire 1973:101).

However, Freire (1973:101) does not expand on what he means by an 'epistemically curious mind' or how curiosity might function as an enabler of praxis. Likewise, the influential work of nurse theorist Patricia Benner (1984) describes the ways in which knowledge for nursing practice is gained, elaborated, integrated and refined over time. Benner (1984:5) attests to the importance of the role of 'perceptual awareness' to stimulate this knowledge construction process as nurses become aware of their knowledge gaps and seek to fill them in order to develop skills and competencies and move from novice practitioner to expert practitioner. However, Benner (1984:5) fails to explicate the meaning of 'perceptual awareness' in any detail. We are therefore left with little idea from Benner (1984) as to the nature of the cognitive function which may prompt the progression of clinical knowledge.

Kashdan (2009) provides insights into the relationship which curiosity may hold with reflection and perceptual awareness and bring new understandings to nursing theory and pedagogy, which have not been previously addressed. According to Kashdan (2009:4) curiosity is enacted in 'a razor thin moment when we are truly free'. It is a space of liberation which rests at the intersection of interest and meaning, which motivates us to reflect and ask ourselves challenging questions about our knowledge which has 'become'; to discern gaps and to take definitive action, to explore and to know what has now become uncertain or unknown, so we may know again. Kashdan (2009) views this 'razor thin' moment to be one when we are mindful and alert to what is happening – we are *aware* of our present and *perceptive* to what is happening (Kashdan 2009). This moment of perceptual awareness allows us to enter into a state of astuteness and discernment to highlight that which counts as anomaly or ambiguity in our current repertoire of understanding (Kashdan 2009). In such moments, we *perceive* incongruence, a gap or gaps in our knowledge and become *aware* that our current knowledge does not fit what is already known or believed to be true (Kashdan 2009). We find ourselves in a place of divergence (Kashdan 2009). Kashdan (2009) goes on to explain that in this moment of divergence, we are also in a position of the

new or novel – we find ourselves in a finite zone of evanescent freedom – in a space between what is known and what is not known. It is a space that I am personally familiar with and a space that the participants sought out and embraced. We find ourselves at liberty to take action and exploit the moment, proceed to reflect on our knowing, undertake exploratory activities to refine existing knowledge and seek out new knowledge and integrate new or refined knowledge into practice action - a process Schmitt & Lahroodi (2008) term as epistemic curiosity. According to Freire (1993) whoever takes ownership of the process of what he suggests is curiously stimulated knowledge activity, constructs for themselves their theory of liberating action. Knowledge work in this sense is a liberty related act, through which we interrupt the known momentarily, to push at its limits (Stocker 2014).

If we re-enter the participants' knowledge journey here with the connections made above, they take us to an illustration of nursing practice which in their world, is set within a powerful discursive trilogy. A trilogy in which curiosity's virtue is entwined with that of liberation, both of which rest in relationship with the discourse of nursing's evolving epistemological script. Whilst this notion of a tripartite relationship may contribute a new understanding of the archaeology of nurses' episteme and which serves to lift another veil in their lived reality of curiosity, the assumption is that they are free – at liberty to engage with curiosity. Their voice at this point in their narrative suggests that their theory of liberating action, as perhaps illustrated in their 'curiosity to knowledge excursion', is unencumbered. If we take the classical Socratic view of liberty put forth by Mill (1991), which sees liberty as a commitment to truth as an intellectual ideal (Stocker 2014), coupled with Berlin's (1969) normalising view that liberty should be sanctified by non-interference, we are perhaps left with a perfect view of the world of curiosity in nursing practice and its attendant position on knowledge construction.

However, the nurses in this study also led us to places where they began to feel disturbed and concerned. They related their disappointment, frustration and sadness at

being unable to progress with valued knowledge activities, perhaps realising that whilst such liberating discourse may constitute a known and preferred reality, such reality is subject to contention. In Pryce's (2002) view, realities are open to question by the presence of multiple realities, which co-exist through their discourses, as parallel power houses claiming legitimacy. In this sense, realities are fragile and subject to fragmentation and fracture (Pryce 2002), truth becomes tenuous, power becomes elusive (Ceci 2003). The participants all provided examples of the transitory nature of the freedom, power and legitimacy their curiosity could bring, as they realised they were situated in rational systems of compliance, predicated by imposed formulaic practice. Where they once experienced situations which fuelled their curiosity and supported a wellspring of learning, knowledge integration and liberating action, they were subject to dominant discourses of fiscally rationalised determinism. Fractures began to appear in their known reality. Their wish to return to the construction of a 'whole' was to them, thwarted.

As their ground began to shift they became aware of the limitations their curiosity was now subject to and experienced significant, system generated inhibitors to their engagement with it. They felt their curiosity was no longer liberated, but was constrained to such a degree that their professional knowledge frame and its attendance on holistic patient-centered care was invalidated. Perceived to be under constant restriction, attempts at negotiation with managers to refine, release or identify resources which, in the view of the nurses might repair the fractures, proved fruitless. Instead, the constancy of a cascaded and reinforcing message of regulated and pre-conceived thinking was profoundly felt to be informed by hegemony and fragmentary to their conception of holistic care and the knowledge that requires. Their sense of frustration and isolation arising from their perception of a dominant mechanistic world was palpable in their text.

The nurses thus found themselves embedded in a political reality – a reality they perceived to be dictated by their respective organisations and influenced by an economically informed, formulaic NHS policy discourse, which strove to remain supreme and in that process, supplanted their epistemic values and contained their curiosity. Such an implication suggests that our curiosity, and the knowledge we derive from its liberating action, is neither innocent nor untouched by the power of dominant discourse. So, on reflection, whilst we may have a desire to engage freely with our curiosity, Ceci (2004:1888) reminds us that, '….. our capacities are conditioned by non-epistemic factors not just some of the time, but all of the time'. When we find our selves in a place where dominance subverts our capacity to be free, we find ourselves situated in an objective world constructed by those discourses, where our actions and practices are subject to alternative notions of truth (Ceci 2004), where knowledge and quite possibly, curiosity and liberty, are contingent, partial and located.

And yet, curiosity is there, it is 'hard-wired in the brain …….. it is the engine of our evolving self' (Kashden 2009:6). We cannot escape it. Even when dominant discourses prevail upon our desire for knowledge which curiosity seeks to set free, we can undertake activities, as the nurses in this study did, to ameliorate the sense of restriction and go into spaces and places where they could either engage freely with their curiosity or withdraw to find coping strategies. They sought out their own space where they were at liberty to engage with their curiosity. When they returned to an environment where they perceived their professional text to be in dialectical tension to rationalised prescriptive discourse, they undertook resistance strategies to liberate their curiosity again. They did not want to accept the perceived position on offer – that of (in their words) an automaton or 'check-out- chick' at Tesco's, nor did they want to buy into the fragmentation of care which was being sold. In Foucauldian vein, they refused to acquiesce to dominant relations of knowledge and power and the discourses which supported these, but sought a range of alternative possibilities in which to exercise their curiosity and stay true to their learnt professional script – their notion of truth, their

known reality and their expression of liberty. However, this movement of resistance to return to their truth and essence of liberty took its toll. Enacted through stealth and secrecy, the actions the participants took to engage with their curiosity were full of risk and entailed constant questioning on the morality, rigour and validity of their curiously crafted actions.

Reflecting on the nurses curiosity narratives in this study, I think they are heavily influenced by the historical legacy of nursing's inherent struggle to be regarded as a distinct professional body and all that entails, in terms of the acquisition and application of a unique body of knowledge. They are, by virtue of being in the profession, caught up in a perpetual search for knowledge and the perceived liberty that brings to their practice. Yet, they are also in constant flux, pushed and pulled between organisational realities and the reality afforded by their immersion in professional nursing texts. It is not surprising that they 'go round and round' with their curiosity'. The nurses in this study clearly recognised and rejected the fragmentation and prescription brought about by an NHS focus on quantification and economic stringency measures. When they noted the limiting impact of the fragmentation and prescribed ways of working these enforced measures bring to their knowledge and professional practice, I feel they engaged with their curiosity as a means to return their daily practice interactions to a conception of an integrated whole. In terms of how they went about this, they engaged their curiosity and sought out the knowledge they needed to return to the whole, albeit by stealth. Only then, when they had 'gone round and round' with their curiosity to find the whole relative to patient need, were they satisfied that the care they were providing was at the standard they felt at liberty to give. Engaging with their curiosity in this way, I feel they sought to discover ways in which they could mend the fragmentation and pull it back into their conception of a whole to provide an optimum level of individualised care, in spite of the restrictions placed upon them by organisational discourses.

However, as we have seen, the nurses in this study felt exhausted by this underground process which their curiosity had stimulated. This is not surprising considering the intensity of the emotional labour required for nurses to ameliorate the professional and emotional tensions afforded by contradictory and competing discourses (Walsh 2009). The energy expended in their emotional labours impacted upon their engagement with curiosity to such an extent that many of them had little energy left for curiously led, creative thinking out-with the immediacy of the nurse–patient interaction. Within the perception that a discourse for curiosity is lacking in the NHS, the inclination for nurses to engage in improvement and innovation initiatives is open to question and synonymous with the views of the participants, raises issues for the progression of nursing practice at the level of the individual and that of the clinical team.

With the above in mind, I am beginning to understand why the nurses I was involved with prior to my PhD in practice development work were reluctant to engage with their curiosity. If we consider the nature of improvement and innovation initiatives, such as practice development (PD), which as a discipline embeds reflective practice, the uptake of evidence based practice, engagement in clinically led research activities and considers the role of knowledge arising from practice as central to its purpose; improvement or nursing development work of this kind involves the notions of reflexivity and praxis (McCormack et al 2013). If we are to believe, as I suggested earlier, that reflexivity and praxis are perhaps bound within a discursive trilogy whereby curiosity, knowledge and liberation work together as enablers of knowledge correspondence and construction; yet the context within which improvement work such as PD is not conducive or supportive of its discursive elements, wherein practitioners are exhausted by circumventive activities, then our efforts at improvement and innovation are at significant risk of being compromised. Additionally, if we revisit the work of Benner (1984) at this point, who attests to contextual importance when it comes to the progression in nursing skill and competency development, we need to consider the epistemological structure within which our nurses are situated. According to Cash

(1995) the prevalence of competing realities, discourses and epistemologies do not serve to raise the status or progression of nursing knowledge and practice. Many years on from Cash's (1995) paper, we seem to be in a similar place where distorted realities, discourses and epistemologies currently being experienced and prescribed, do not seem to serve the facilitation of nursing's progression through the knowledge work it wants and needs to do to care and keep moving forward. This lack of progression is a perceived reality, which the nurses who took part in this study clearly outlined. In one way or another, they all expressed concern for the future of nursing and for their individual development. As such, we need to consider the prospect and implications of a curiously bereft and therefore, an intellectually impotent nursing workforce and the impact this would have on our future professional progression and standing.

Whilst it would be an understatement to say I feel gravely concerned about the future prospects for curiously led nursing practice, I can relate to the dichotomies which pull on the energies which curiosity demands. Exhaustion for example, is a sentiment I can quite easily relate to. My own experience of curiously crafting knowledge for this thesis has at times been intellectually and physically exhausting, as I too am subject to competing discourses which pull on my attention. Some of these discourses are generated as Walsh (2009) suggests, through my professional self-talk and the expectations I perceive others and institutions to have of me. As I strive to ensure the validity and rigour of the knowledge I have generated, by means of a post-structural, reflexive process I have chosen to adopt, I have often found myself in novel places where I am bound to engage with my curiosity, so that I can seek ways to justify my decisions and claims, so that the knowledge I generate is both credible and trustworthy. This reflexive and (being post-structural), creative process has taken its toll. There have been some days where I sit down to write, but am so intellectually drained that I have become paralysed. I have had days where I just simply sit and do nothing. As desperately as I try and engage my curiosity to come up with something

reasonably intelligent and intelligible, I have been at a loss to know what to put on the page. I have gone into my secret space in a state of quiet crisis.

Whilst exhaustion and paralysis may be a by product of curiously led knowledge work, I have, by virtue of being in a university environment which values my curiosity and the knowledge generated from it, been able to be open, vocal and transparent with my process. I have been able to ask for time from my managers and help from my supervisors. Unlike the participants, the resources I have needed to enable my curiosity and enhance my potential have been at my disposal. The discourse that currently surrounds my curiosity in terms of its contribution to on going learning and scholarship is, in the main, liberating and enabling, albeit exhausting. However, prior to my current role, I had worked in an environment which I perceived valued fiscal drivers over curiously crafted knowledge, which left me feeling silenced and powerless. Being in that space for many years, which interestingly was within a university, inhibited my curiosity and foiled attempts at research, scholarship and learning. It is one of the main reasons I have come to a PhD so late in my career.

Even so, if I am honest, there have been at points during my PhD where I have wanted to break free and put a hold on my curiosity. Like the participants, I have felt that its power has oftentimes breached the boundaries of my energy and intellectual tolerance to such a degree that I have often found myself de-centered and in a state of struggle. My energy and intellect has had to be shared between the day to day expectations of academic work, my thesis and my home life. The inherent pull on the energy which my curiosity demands have often left me bound within competing tensions. There are times when I have not felt liberated by my curiosity, but constrained by it. I have felt weary and often in a state of flux by curiosity's seductive call to liberty. It seems to me that liberty may also be socially constructed and subject to contention. According to Stocker (2014:47) 'liberty related acts include struggles'. Without contention to its form

liberty cannot exist, as liberty is never in a finished state, but is contingent and set within a web of power relations with the self and with others (Coole 1993).

Despite my struggles, I think the key difference between the participants and myself is that I have not found that I have needed to generate knowledge and engage in a learning journey by means of secrecy or stealth. When the participants reverted to means of stealth and secrecy to be at liberty to engage their curiosity, they were clear in their view that their curiosity and its attendant epistemic benefit for their individual on-going learning and professional development was silenced. They felt it was not needed, appreciated nor legitimised by the dominant, politically informed discourse which was felt to be taking centre stage. Silencing my curiosity or having it silenced by external forces is not an attractive option for me. However, when I reflect back on the time that I did feel silenced, and knowing what I now know about curiosity and its potential force for knowledge and liberation, I think that part of my frustration was not having a language for curiosity.

Whilst we know that curiosity exists, I don't think that we have really understood its text to be able to enunciate its importance in our professional acts, in nursing practice or in the nursing academy. We have not been able to express its form and function – its power of signification. We are in silence in the absence of an articulated curiosity text. As Coole (1993) suggests, we may not conceive ourselves as being in the ranks of the free, when we cannot offer an account of what constitutes our freedom code. Perhaps in not having a language to articulate and engage with curiosity and its liberating force, leads us to feel constrained and impotent to the point where we re-engage with our quest for liberty and resist, to either undertake activities which remain below the radar or break free from curiosity's intensity and move into our secret space – perhaps to remain in a quiet crisis.

Whilst curiosity may have a seductive nature and is seemingly caught between the socially constructed realities of NHS organisational compliance discourse and the

freedoms afforded by nursing's discourse on episteme, I do not think that gives us licence to sit in binary thinking and ignore the potential that curiosity may hold for the progression of nursing knowledge and practice, or the potential it could bring to clinically led improvement and innovation. When nursing in the UK is at a crucial time in its history due to increasingly intensified moral surveillance and public scrutiny on its caring practices, as we have seen from the Francis Report (2013), the value that engagement in curiosity brings to professional nursing practice and its contribution to curiously crafted caring and knowledge work, cannot be understated.

Whilst I do not see curiosity as a panacea for all the ills we are currently faced with in nursing, I do think that until now, we have not had either knowledge of or a language for curiosity and thus, we have lacked the capacity for a discourse on curiosity. From the new knowledge generated in this study, which connects curiosity, nursing knowledge and liberty in a powerful tripartite relationship, for the benefit and potential transformation of nursing practice, albeit mediated by socially constructed realities, we cannot, as the nurses attest to in this study, hide the knowledge we generate from our curiosity. As Ceci and McIntyre (2001) suggest, as nurses, we can choose to remain in a place where nursing knowledge is subjugated by prevailing dominant discourses; that is, our knowledge can continue to be supressed, disallowed and deemed inadequate, or we can enter from the margins; not to suggest that dominant discourses are wrong, but to illustrate the that the discourses prevalent in the system are incomplete and insufficient. The intent would be to 'imagine worlds of possibilities otherwise forbidden' and enter into hitherto unknown spaces – spaces which may at first be full of fear and ambiguity, but which may benefit from the power of discursive practices- from dialogue (Calas and Smirchich 1991:598).

My own recent experience of entering into this unknown space to begin such a dialogue and support a discourse on curiosity was interesting and informing. I had accepted an invitation by the Executive Director of Improvement and Quality at an NHS

Trust to present this research at a one day conference on clinically led improvement challenges. I had spoken to him on the phone to provide him with an overview of my presentation and was clear that its content may be seen as contentious to existing NHS improvement discourse. I was clear that the content of the talk would enter from the margin. I was reassured by him that this was perfectly fine. In his view, the purpose of the day was to stimulate alternative ways of thinking so they might engage a critical mass of Trust staff in their improvement agenda. The audience included a cross section of staff which included the Trust executive team, the research and development team and a mix of designations of nurses, doctors and therapy staff. Following my presentation and an invite by the conference chair to open up questions and discussion, participants became very vocal. Many of them, including the Chair (a consultant micro-biologist), voiced opinions from their own professional perspective which resonated strongly with the experience of the nurses in this study. They provided personal examples of the limitations and impact current NHS discourse was having on their curiosity and their ability to deliver curiously discerned care. In pulling the opinions of all concerned together, the Chair suggested that the Trust as a whole should engage with its own curiosity and come together to begin a dialogue on the subject. Although the participants had reached their own conclusions to begin a dialogue, I felt that I had successfully delivered upon my intent.

At this point, my invitee, the Executive Director of Improvement and Quality, came rapidly from his seat in the audience and abruptly closed down the Chair's suggestion, saying that to avoid any ambiguity, dialogue on the subject would firstly have to be discussed, mandated and shaped by the Executive Team and the Trust Board. The energy to move toward the unknown had been stripped of its power and muteness prevailed. I now felt I had failed in my attempt to stimulate the beginnings of a dialogue on curiosity. I too had gone into silence.

I am reminded here of Freire (1985) who, suggests that the invocation of silence is a form of abuse, by means of its capacity to render an alternate view of the world mute. Fromm (2011, first published 1964) might add that such action possesses a rigidity of thought, where the future is seen as repetition of the familiar and where leadership, afraid to begin a dialogue on the alternative, stifles creative thought and prefers to remain in a prescribed bureaucratic frame. Whilst this might sound like I am wagging the finger of blame for muteness at bureaucratic leadership, I am reminded that perhaps those who sit within the bureaucracy are themselves embedded within a socially constructed reality, which is tasked with wielding the power of the omnipotent NHS machine to reinforce compliance and is also under scrutiny and surveillance. As such, we can see that the bureaucrats may also be actors on a stage, where they direct the production of a distant machine driven truth, with their lines learnt from a powerful, pre-prepared policy script (Ceci 2004).

Whilst I came away from the event with the impression that my act of dissemination, as political as it might have been, had failed, I was later to learn that this was far from the truth. It transpires that my presentation had been e-mailed across the Trust (by stealth – I believe), by participants who were vocal on the day (they had all received a copy courtesy of my invitee prior to the event). The proverbial cat was out of the bag it seemed and there followed a groundswell of discussion on the topic of curiosity. The executive team eventually acknowledged that a dialogue on the limitations of current formulaic practices would be useful.

My learning from this experience was graphic in that leadership, whatever its form, is a powerful tool to either inhibit or enable a dialogue on curiosity. One could say that the very act of resistance undertaken by the conference participants was also an act of leadership, in that they had a language for curiosity and a vision of how different their practice could become as a result of engaging with that language. Likewise, the senior

team in the Trust were also aware of the language of curiosity and took steps into the unknown to begin a dialogue.

Although the construct of leadership is known to be ambiguous in and of itself, contemporary approaches to the subject suggest that leadership is demonstrated through acts that people accomplish together, through discursive means including knowledge exchange, conducted within a spirit of inquiry and critique (Raelin 2011:198). Collaborative approaches to leadership such as Raelin (2011) puts forth, may therefore be useful in creating a dialogue on curiosity and help a stronger discourse emerge on its power for reflexive knowledge activities, learning and engagement in improvement and innovation.

In promoting a collaborative, dialogical and therefore transparent approach to leadership as Raelin (2011) suggests, there would not be the need for nurses to engage in curiosity by stealth and the attendant anxieties, personal risk and exhaustion this brings. As the nurses in this study said quite clearly, if they could engage freely with their curiosity they would willingly contribute openly and transparently to the creation of new knowledge to improve practice and promote practice innovation. In fact, on those occasions they were involved in practice improvement and innovation activities and could engage freely with their curiosity, they did attest to the benefits such work brought to nursing knowledge, practice, patient care and to themselves as individuals.

Whilst there is an NHS discourse on improvement and innovation, its language still reflects that of measurement and control (and perhaps reinforces the inherent knowledge prescriptions and fragmentation that brings), as can be seen from the recent extract overleaf. This means that the voice of leadership will need to be loud and strong to effect the step change required to communicate and include a language that supports curiosity. Perhaps a collaborative approach to leadership also comes with a new language for some key leaders in the NHS, although the newly released

NHS Leadership Framework (NHS Leadership Academy 2014), upon which NHS leadership development activities are based, does espouse qualities of collaborative leadership. Phrases such as 'working together', 'deciding together', 'inclusiveness', pepper the text (source: NHS leadership Academy – Leadership Qualities Framework 2014).

NHS England NHS QUALITY – IMPROVING PATIENT CARE CONFERENCE – MANCHESTER CONFERENCE CENTRE 26TH NOVEMBER 2014

You may be aware that the NHS is facing the biggest financial challenge since its inception and, at the same time, is tasked with continually raising the standards of care. Following the Mid Staffordshire scandal and the damning reviews of Berwick and Francis the quality of care is under heightened scrutiny. Increased transparency, regulation, productivity and performance measurement initiatives are aiming to drive up improvements in care.

Personal communication - e-mail received on 15th November 2014

Whilst leadership might be a useful tool to promote a discourse on curiosity, the developmental activities which support nurse engagement in curiosity will need to be resourced and sustained. The nurses in this study did attest to the lack of knowledge and access to practice improvement methods and approaches and raised concerns as to 'knowledge lost' due to a perceived lack of supporting structures. Apekey et al (2011) would agree, suggesting that whilst leadership is a key attribute of improvement, many clinical staff at the ground level lack the knowledge, skills and models needed to bring about improvements to their practice, are unaware of the tools and approaches which support the process. Some of the facilitative resources that come to mind for this purpose are the practice development frameworks which currently exist. The role of skilled facilitators who work alongside nurses to enable their improvement and innovation efforts, has been recognised as a useful resource and approach to practice based and informed knowledge activities, which includes the use of reflexive androgogies (McSherry and Warr 2006 and 2008). Many facilitators are usually set within the organisation as members of internal practice development teams and as

such often understand complex organisational structures, are networked into these and can therefore broker help and negotiate acquisition of resources (Dogherty et al 2013). The role of the facilitator is to first of all to assess the contextual factors which might inhibit or enable successful practice improvement initiatives and help practitioners to reflect upon and address these (Kitson et al 2008). Actions for improvement are then planned according to priorities identified by clinical teams in conjunction with service users and multi-disciplinary colleagues, with facilitators utilising various adult learning processes such as action research (Walsgrove and Fulbrook 2005), action learning and appreciative inquiry to promote learning (Graham et al 2007, Trajovski et al 2013). Collaborative working and leadership development at all levels is core to the facilitation process, with an emphasis on knowledge evaluation, generation and integration (Dogherty et al 2013).

Notwithstanding the benefit of internal facilitators to knowledge work, one might also consider the advantages that academic-practice–service collaborations may also bring to promoting and sustaining a discourse on curiosity, knowledge work and practice improvement. A recent paper by Rolfe (2012), suggests that whilst many nursing academics and scholars are highly adept at knowledge generation, much of their knowledge expertise and output rests within the confines of the nursing academy and remains invisible and inaccessible to clinicians. In Rolfe's (2012) view, knowledge generated by the academy fails to transfer to practice and contribute to practice improvement. In recognising this issue, Walsh et al (2012) suggest that practice-service-academic partnerships would be a useful contribution to both knowledge generation and its transfer in practice, so bringing benefit to clinical improvement outcomes and academic impact outcomes. The knowledge generation expertise of academics works together with the knowledge meaningful to the service partner and its clinicians, with an overall goal of building internal capacity, within a whole systems, integrated approach practice improvement (Walsh et al 2012, Chin and Hamer 2006).

Important to this process is the presence of leadership, facilitation and a move towards the development of clinical/ academic careers (Walsh et al 2012).

Within the academy itself, I would suggest that practice improvement, leadership and learning methodologies could be integrated into the under-graduate nursing curriculum. Whilst this is the case in my own teaching context, a recent discussion I facilitated with under-graduate students on the subject of curiosity and its epistemic value for practice brought forth an idea from one of my students. His suggestion was that the university and the service should come together to design and deliver an extension to their three year course. This course, he suggested should be of 12 months duration and be part of their degree and clinical preceptorship programme to prepare them to lead, learn, teach and undertake practice improvement. I must admit, that was one of those occasions as an educator when your heart sings at the presence of highly intelligent, creative and committed students, who, if given the tools and resources, will not only make great future nurses and take the profession forward, but will also sustain a discourse on curiosity.

Whichever approach or combination of approaches we take, a discourse on curiosity must surely begin. With the words of one of the participants ringing in my ears, whose opinion is that the pendulum has swung too far in the direction of prescribed, algorithmic ways of practising, we are at risk of an intellectually impotent nursing workforce and a move into an epistemically curious desert. However, there is the another possibility that we need to consider and that is the question of whether nursing has become stuck in its own epistemic discourse, with dismissal of an NHS corporate reality which is driven by economic rationalisation and a need for prescriptions and formulaics to promote patient safety and productivity. There may then be a need for nursing to engage with curiosity to examine its own discourse and question whether it is stuck within a true belief of what nursing is and is not; of what it will tolerate and what it will not. If we hang on to an unquestioned liberty frame which curiosity purportedly

brings about, we may be in danger of replacing one form of rhetoric for another. As Kashdan (2009) warns, we may choose to ignore the challenge our curiosity can raise and stay within our epistemic frames of reference of what we believe to be true and thus remain in a state of certainty (Kashdan 2009). Whilst there are arguments in the epistemological literature as to what constitutes true belief (Whitcombe 2010), Avis and Freshwater (2006) address the issue of justified true belief in the context of nursing practice and suggest that in nursing practice, a range of beliefs may be present which are considered by practitioners to be true. Nurses hold a network of beliefs which have been socially constructed through contextual interaction, and until such time as these beliefs are critically examined, such beliefs are subject to question and scrutiny as to their claims to truth Avis and Freshwater (2006). Similarly, Whitcombe (2010) leads us to examine the notion that when such beliefs are thought to be truths or unchallenged justifications, they end inquiry prematurely and thus negate curiosity as a driver for alternative considerations. When curiosity is not engaged, knowledge and beliefs remains static and unverified leading to familiar and routinized ways of thinking, behaving and working (Eraut 2004).

One might conclude then, that the razor's edge of time, within which curiosity, liberty and knowledge await their freedom, could once again be lost. We might therefore remember that curiosity is an ambition to go beyond that which is (Benedict 2001).

Going Beyond

This study presents a snapshot - a glimpse into the contemporary world of curiosity in nursing practice. It is the contextualised story of six registered nurses, in a world of over 400,000 (statistical source NMC 2014) and so it could be considered as a partial representation of a nursing narrative on curiosity. With such a small sample size, one could suggest that the study has its limitations in terms of the generalizability of its findings to the wider nursing population. On saying that, I have presented the findings from my study at a variety of nursing conferences locally, nationally and internationally, where conference participants have demonstrated an overwhelming resonance with the study findings in their own contexts of nursing, and in some cases within other healthcare disciplines and practices. These conferences have included:

- ****** Hospitals NHS Foundation Trust, Research and Development Conference, September 25th 2014. 'Whither Curiosity in Practice Improvement?'[17]

- Sigma Theta Tau European Nursing Conference, Sweden, June 16-18, 2014. 'Exploring Curiosity in Nursing Practice'

- University of Hull, Faculty of Healthcare Sciences, Annual Research Conference, April 28th 2014. 'Researching Curiosity in Nursing Practice'.

- RCN International Research Conference, Glasgow, April 2-4 2014. 'Exploring Epistemic Curiosity in Nursing Practice'.

- University of Central England, Birmingham, Faculty of Healthcare, October 18th 2012, Conference on 'Developing the Nursing Workforce' – Leading Practice Innovation and Improvement'.

- RCN International Research Conference, Harrogate, May 16-18 2011. Symposium – 'Caring- Rhetoric or Reality?'

With the sense gained from such resonance, the issue of population generalizability becomes one of resonance with 'processual generalizability', whereby the experience

[17] The location of this Trust has been removed due to ethical and anonymity reasons, as my experience from it is discussed in the body of this thesis. A definitive location can be given to examiners upon request.

and lived realities of one group, reflect shared truths to others in their situations and settings (Holloway and Freshwater 2007a:114).

I have found that the value of undertaking a narrative approach to inquiry has provided an opportunity to gain in-depth, rich insights into the complex world of my participants' curiosity and I note my thanks to them for their honesty, time and their courage to share their experiences with a complete stranger. To do their stories justice, I have as Holloway and Freshwater (2007) suggest, focused upon the meaning and intentions of the participants and represented this through thick description, which a narrative methodology encourages. I have also represented their narrative as a composite whole, with integrity to the data as it was presented (Polkinghorne 1995). The way in which the data presented itself was important in terms of the focus I took on knowledge and liberty. In my mind, this is what their narrative was telling me, albeit through my own interpretative lens.

Although I did attest to aspects of self-care as an important part of engaging with curiosity, I could have entered into the psychological aspects of curiosity and discussed issues of anxiety and well being in more depth. Whilst attending to the psychological aspects of curiosity may have provided some insight into answering my question on the enablers and inhibitors to the nurses' engagement with curiosity, the methodological premise upon which I based my enquiry was of social constructionism and this is the major line I followed. I also identified in the body of my thesis that there is a gap on the socially constructed aspects of curiosity in the existing body of research on curiosity. This study therefore brings new knowledge to the area on the socially constructed aspects of curiosity to the curiosity research field. I have also addressed curiosity in the context of nursing and from the perspective of nurses. These are also areas which have not yet been addressed in either the body of research on curiosity or within nursing research. With reference to the latter, curiosity has not been addressed in the body of nursing research which explores nursing's epistemological theories, pedagogy

and practice improvement and these are areas to which this study also contributes new knowledge.

A further limitation of the study could be considered, due to the fact that I did not return to the participants as a means to member check my interpretation of the data, or have participants validate the themes which I identified from the data analysis. Whilst this may have been useful as a means to provide a sense of trustworthiness to the data analysis and add to the study's overall rigour and believability, I was conscious of the fact that narrative inquiry concerns itself with human experience as set within a temporal frame, where the narratives which are set therein are subject to change and transformation (Clandinin and Connelly 2000). As such, narratives that once were, have shifting tendencies to become something other, as time progresses (Carlson 2010). Stories which the individual re-counts at one space in time, may have a different meaning to them further down the line as their understandings and their realities might be interpreted differently (Carlson 2010). Therefore, the possibility of being in an endless cycle of interpretation, analysis, interpretation, could, as Traynor (1997) suggests, become an unending exercise which does not serve the purpose of verification well. Having adopted a reflexive approach throughout my thesis, I am confident that I have created a robust audit trail, which demonstrates a critical approach to my own biases, interpretations and assumptions and provides justification for the decisions I have taken along the way.

Undertaking a reflexive methodology, within a post-structuralist frame has appealed to my curious mind and to my penchant to deviate from the norm. I do blame my Father's tendency towards panoptic resistance and eccentricity for influencing me thus. However, I will take ownership for my own actions, in the belief that I have my own power, albeit socially constructed, dependent upon which reality I find myself in at any one given time and knowing that my power and reality is subject to contention and revision. It is this sense of shifting realities and being surrounded by competing discourses and the power they are perceived to bring, that has perhaps been my one

key lesson from conducting this research. In many ways, the opportunity to undertake this research has been both catalytic and cathartic.

In catalytic terms, I am now much more aware of the impact that discourses can have on my engagement and that of others with curiosity and I understand why we undertake resistance strategies in order to feel powerful and liberated. But, I have also learnt that once liberated, I am again trapped within my own curiosity cycle in a search for something other than is. My truth can be lost just as quickly as it has been gained. I have begun to understand myself that much better. Whilst as we have seen with the nurses in this study (and myself), our circular journeys with curiosity can be a tiring process, the beauty of engaging reflexively for me, has enabled my curiosity to take me to creative processes during the research and try out new approaches. I speak mainly of the rhizomatic approach I took to data collection.

Whilst rhizomatic approaches to research have been reported in the narrative research literature, the approach is a very recent development (Loots et al 2013) and focuses upon analysis of data, not upon data collection. As far as I am aware, attempts at adopting rhizomatic techniques in data collection have not been reported in the narrative research literature. Therefore, I have contributed to an alternative or new approach to data collection. Once my thesis has been examined, I will publish a methodological paper which sets out this approach, so that it may be more widely peer reviewed and critically commented upon.

In cathartic terms, I feel I have found a voice. This thesis is a capture of my life's work as a nurse and as an educator and to have the opportunity to express this is a great privilege. I had not realised the breadth and depth my curiosity could take me, nor had I realised its importance quite so profoundly to nursing practice. Whilst I have a voice here, the voices of the participants and the voices of the nurses I spoke to prior to my PhD are also present. We each take a seat and I find their company and their presence reassuring. It is reassuring because I am a nurse and I have a sense of belonging to

their community, thus there is an element of familiarity. I have represented their truth as I saw it, although I know it cannot be a perfect representation, as there is no such thing. There is always an alternative – as Foucault would have us believe.

I ask myself who needs to know about this research. If I believe anything I have learnt from my participant stories, it is that there is a danger of curiosity being lost in the machine that is the NHS. Whilst I understand that the NHS is politically influenced and has always been used, in my opinion, as a political football, the prospect for nursing's curiosity and all that that entails for patient care is worrying. With that in mind, dissemination of my research needs to include the executive level of nursing. There is a 'C' missing from the six currently out there. Alongside publications in the nursing practice and research journals, a short report to the Chief Nurse would be timely. A joint paper arising from a conference symposium entitled; 'Caring – Rhetoric and Reality', is currently with my primary supervisor and apparently under consideration by journal editors. I have been invited to publish a book based on my PhD and will endeavour to get this underway, once I have recovered my curious energies ……

…….. Recovery - A sentiment which rings loud as my current call to liberty, and to which I now pay heed.

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Appendix i

Literature Search Strategy

The purpose of the initial search was to identify any studies which had been conducted in relation to curiosity in nursing. Resources including Embase, OvidSp, Ovid Medline, PyschARTICLES, PsychINFO, CINAHL, Google Scholar and Leeds University Library's Journal@Ovid full text were advanced searched and limited to peer reviewed journal articles written in the English language, published at any time and included those with abstracts. Search terms included:

- Curiosity in nursing – yielded 3 results, two of which were opinion papers and one contained only a fleeting reference to curiosity
- Curiosity in nursing practice – yielded zero results
- Curiosity in developing nursing practice – yielded zero results
- Curiosity and nursing practice – yielded 101 results, all of which following abstract reading contained only fleeting reference to curiosity and were discarded
- Curiosity in healthcare – yielded zero results

A further search was conducted from the same resources and with the following search terms and included:

- Integrating knowledge sources in nursing practice – yielded zero results
- Integrating knowledge in nursing – yielded zero results
- Integrating knowledge through curiosity – yielded zero results

A further search was conducted in COPAC with the following search terms: Curiosity in nursing; Curiosity in nursing practice; Curiosity in developing nursing practice; Curiosity and nursing practice; Curiosity in healthcare; which revealed 34 returns, all of which following abstract reading contained only fleeting reference to curiosity and were discarded.

A search utilising resources including Embase, OvidSp, Ovid Medline, PyschARTICLES, PsychINFO, CINAHL, Google Scholar and Leeds University Library's Journal@Ovid full text were searched and limited to peer reviewed journal articles, with abstracts, written in the English language, published at any time and was also conducted using the generic term 'curiosity'. A total of 4135 papers were returned. Scanning abstracts revealed a plethora of literature relating to curiosity in biotechnology, biomedical science, bio ethics and aeronautical subjects.

An advanced search utilising resources including Embase, OvidSp, Ovid Medline, PyschARTICLES, PsychINFO, CINAHL, Google Scholar and Leeds University Library's Journal@Ovid full text were searched and limited to peer reviewed journal articles, with abstracts, written in the English language, published at any time and was also conducted using the generic term 'curiosity'. Limits were applied which sought to extract articles from the following disciplines: behavioural and social science, health professions, nursing, medicine, education, alternative and complementary medicines, arts and humanities, psychology and psychiatry. A total of 1459 articles were returned. Scanning abstracts revealed 45 articles, which directly or indirectly pertained to research or scholarly analysis on curiosity and were mainly derived from the behavioural and cognitive social sciences. These articles constituted the main reference points for this study at this point in time. Inclusion criteria consisted of the following and were restricted to articles which:

- Provided an understanding of the structure and function of curiosity
- Provided a history of the theoretical and conceptual development of curiosity
- Provided distinctions of what has been done from what needs to be done
- Discovered important variables
- Related theory to application
- Identified the main methodologies and research techniques
- Provided scope of application to and across other disciplines

Appendix ii

Our Ref: 2013/412/L

2 April 2013

Mrs Helen Chin

PhD Student

School of Healthcare

Room 1.09 Baines Wing

University of Leeds

LS2 9JT

Dear Mrs Chin

[redacted] NHS Trust Research Governance

Project Title: A narrative research study to explore the use of epistemic curiosity in nursing practice in the NHS

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within [redacted]

The final list of documents reviewed and approved is as follows:

This approval is granted subject to the following conditions:

- You must comply with the terms of your ethical approval (where applicable) Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive changes to your protocol you must inform the relevant ethics committee and us immediately.

- You must comply with the Trust's procedures on project monitoring and audit.

Document	Version	Date
Protocol	**SHREC/RP/315**	

Participant Consent Form	**3**	**19 March 2013**
Participant Information sheet	**3**	**19 March 2013**
Invitation email to participants	**1**	**February 2013**
SHREC Approval Letter		**24January 2013**

- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care[1](RGF). Failure to do this could lead to permission to carry out this research being withdrawn.

- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines.

- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance. Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. R&D staff are also mandated to do this in line with requirements of the RGF. Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using Trust incident reporting procedures in the first instance and to the chief investigator. They should also be reported to: The R&D Department, the Research Ethics Committee that gave approval for the study (if applicable) other related regulatory bodies as appropriate. You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution. Changes to the agreed documents MUST be approved in line with guidance from the Integrated Research Application System (IRAS), before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D. Projects sponsored by organisations other than the Trust are reminded of those organisations' obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project. The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were

taken and the plan for further action. Details from: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv [2]
SUSARS – this must be within 24 hours of the discovery of the SUSAR incident

The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time. May I take this opportunity to wish you well with the project.

Yours sincerely

[redacted] Research Governance Manager

Cc Professor Dawn Freshwater, University of Leeds and Claire Skinner, Research Governance Manager University of Leeds

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UNIVERSITY OF LEEDS

24 January 2013

Mrs Helen Chin
PhD Student
School of Healthcare
Room 1.09 Baines Wing
University of Leeds LS2 9JT

Dear Helen

Re: Research Project for Ethical Approval SHREC/RP/315

Title: A narrative research study to explore the use of epistemic curiosity in nursing practice in the NHS

Thank you for making the requested amendments to the documentation for the above project following review by the School of Healthcare Research Ethics Committee (SHREC). I can confirm a favourable ethical opinion based on the documentation received at date of this letter.

Document	*Version*	*Date*
Ethical Review Form	1	03.12.12
Consent Form	1	03.12.12
Participant Information Sheet	1	03.12.12
Email to Participants	1	03.12.12
Risk Assessment	1	03.12.12
Consent Form	2	14.01.13
Participant Information Sheet	2	14.01.13
Response to SHREC	1	14.01.13
Consent Form	3	22.01.13
Participant Information Sheet	3	22.01.13

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The SHREC takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, and may be subject to an audit inspection. If your project is to be audited, you will be given at least 2 weeks notice.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

The committee wishes you every success with your project.

Yours sincerely

Dr Ruth Brooke
Chair, School of Healthcare Research Ethics Committee

[redacted]

Ref: [redacted]

04/04/2013

Mrs Helen Chin

University of Leeds
Room 1.09 Baines Wing
School of Healthcare
University of Leeds
LS2 9JT

Dear Mrs Chin

Re: NHS Permission at [redacted] for: A Narrative research study to explore the use of epistemic curiosity in nursing practice in the NHS
[redacted] R&D Number: NU13/10685

I confirm that *NHS Permission for research* has been granted for this project at The [redacted] Hospitals NHS Trust ([redacted]). NHS Permission is granted based on the information provided in the documents listed below. All amendments (including changes to the research team) must be submitted in accordance with guidance in IRAS. Any change to the status of the project must be notified to the R&D Department.

Permission is granted on the understanding that the study is conducted in accordance with the *Research Governance Framework for Health and Social Care*, ICH GCP (if applicable) and NHS Trust policies and procedures available at http://www.leedsth.nhs.uk/sites/research_and_development/.

This permission is granted only on the understanding that you comply with the requirements of the *Framework* as listed in the attached sheet "Conditions of Approval".

If you have any queries about this approval please do not hesitate to contact the R&D Department on telephone [redacted]

[redacted]

use the NHS Number

WTA280

Indemnity Arrangements

The [redacted] NHS Trust participates in the NHS risk pooling scheme administered by the NHS Litigation Authority 'Clinical Negligence Scheme for NHS Trusts' for: (i) medical professional and/or medical malpractice liability; and (ii) general liability. NHS Indemnity for negligent harm is extended to researchers with an employment contract (substantive or honorary) with the Trust. The Trust only accepts liability for research activity that has been managerially approved by the R&D Department.

The Trust therefore accepts liability for the above research project and extends indemnity for negligent harm to cover you as investigator and the researchers listed on the Site Specific Information form. Should there be any changes to the research team please ensure that you inform the R&D Department and that s/he obtains an appropriate contract, or letter of access, with the Trust if required.

Yours sincerely

[redacted]
Director of R&D

Approved documents
The documents reviewed and approved are listed as follows

Document	*Version*	*Date of document*
NHS R&D Form	3.4	21.03.13
SSI Form	3.4	01.02.13
Directorate Approval		12.03.13
REC Letter confirming favourable opinion		24.01.13
Protocol		
Patient information sheet (REC approved)	3	22.01.13
Consent form (REC approved)	3	22.01.13