

Story telling: is it really research?

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Story telling: is it really research?

In this paper I will suggest ways in which you may consider a story as a legitimate research product. I view the story as interpreted work communicated through writing as the research product. 'Doing' interpretive research is not an easy option in research. In this paper I will focus upon some of the complexities in creating an acceptable and accessible research product. I will cover five interrelated areas: journaling, observing, listening, writing and rigour. The term 'research product' refers to the outcome of the research process. By that I mean the dissertation, the research report or the published article. The notion of legitimacy is informed by Gadamer's philosophical hermeneutics which does not show us what to do, but asks us to question what is 'going on' while researching. In this paper I ask you to consider the entire research process as a reflexive exercise which provides answers to the question: 'What is going on in methods?'. I claim that if the research product is well sign-posted, the readers will be able to travel easily through the worlds of the participants and makers of the story and decide for themselves whether the story is a legitimate research endeavour.

Keywords: interpretive research, story, journal, observation, writing, rigour, credibility, reflexivity, research product

A STORY AS THE RESEARCH PRODUCT

Story telling has been used for centuries as a powerful vehicle for communication. If you explore the construction of a story in literary texts, you are likely to find that it involves events, characters and what the characters say and do. A point of view signifies the way the story gets told and the mode established by an author by means of which the reader is presented with the setting, characters, dialogue, actions and events which constitute the story. Although this description is useful I will suggest ways in which you may consider a story as a legitimate research product.

The approach in this paper is to view the story as an interpretation and as a research product. The interest in an alternative approach to research is motivated by a desire to

secure authentic information about people and situations studied. This interest is spurred by developments in philosophy, feminism and multiculturalism.

I view the story as interpreted work communicated through writing as the research product. By that I mean the dissertation, the research report or the published article. My theoretical and interpretive position is informed by Gadamer's philosophical hermeneutics (Gadamer 1976). Informed by Gadamer, this position influences the shape of the stories I tell and how I read the stories of others. My understanding is that research is an interactive process shaped by personal history, biography, gender, social class, race and ethnicity and those of the people in the setting. Interpretation as story telling may privilege any number of different positions and like authors who produce literary texts, their readers are

subjects who are shaped and positioned by the conditions and ideological formations of their own era. My understanding is that researchers give accounts which are framed within a specific story telling tradition, often described as a paradigm. I will describe this paradigm as living within the hermeneutic circle.

In this paper I ask you to consider the entire research process as a reflexive exercise which provides answers to the question: 'What is going on in methods?'. Gadamer's philosophical hermeneutics (Gadamer 1976) does not show us what to do, but asks us to question what is 'going on' while researching. Monitoring 'what is going on' requires that a reflective journal be maintained throughout the research process.

I will continue to use the term 'research product' to refer to the outcome of the research process. Whilst I acknowledge that a hermeneutic account resembles an ongoing conversation, in the outcome driven world of the health care industry and the need to produce publications for the university's research quantum, it is possible to compromise and produce a product.

STORY TELLING

The claim that we are all telling stories has led many researchers to move away from specific topics in favour of looking at how we put the research product together. Interpretive studies in nursing and social sciences are prolific. How can we secure readers and engage them in stories we tell? How can these projects move beyond the story into a better understanding, and if appropriate, action.

This means developing tools for listening, seeing and writing. People live stories, and in their telling of them, reaffirm them, modify them, and create new ones. Constructions of experience are always on the move. Stories, when well crafted, are spurs to the imagination, and through our imaginative participation in the created worlds, empathic forms of understanding are advanced. I suggest we look at the humanities and in particular, traditions in which story telling is the core activity of play and critique (Bartlett *et al.* 1993, Huggan 1994).

I propose that nursing work's wealth is found in the intensely personal, highly emotional, often brutal stories of everyday life as lived by clients and witnessed by nurse practitioners (Gorman 1993). Stories can make nursing practice visible. In the health care service delivery area, so much depends upon quantifying practice so that core activities of nursing are known only to its practitioners. By core activities I refer to care that matters to clients, care that makes a difference (Benner 1984, Jacob 1995, Kirkpatrick *et al.* 1997). Stories can make us proud practitioners. Often core activities of nursing are taken for granted by nurses themselves and sometimes these activities are undervalued by its practitioners (Nelms 1996, Hendrick

et al. 1996, Annells 1997). Stories can research health problems (Reitmaier 1992). Stories can show where we as health care professionals have gone wrong. Listening to the voices of clients may show us what to do to improve practice (Sherman 1994, Koch 1994, Koch *et al.* 1995). Stories can be used in evaluating community development (Rappaport 1993, Traynor 1993, Dixon 1995). Story telling can be therapeutic (Sedney *et al.* 1994, Heiney 1995, McDaniel *et al.* 1995). Stories can inform social policy (Van der Staay 1994). Stories can facilitate change in organizations (Gabriel 1995, Yanow 1995). Stories can allow marginalized groups to have a voice (Mellina 1992, Zinnecker 1994, Bartlett & Font 1994, Dean 1995, Biddle 1996, Turton 1997). Stories can address diversity through understanding (Harvey 1994, Debeljak 1994, Kelly 1996, Greene *et al.* 1996). Stories can facilitate self-help groups (Steffen 1995, Appel 1996).

TELLING STORIES: IS IT REALLY RESEARCH?

'Doing' interpretive research is not an easy option in research, in this paper I will focus upon some of the complexities in creating an acceptable and accessible research product. I will cover five interrelated areas: journaling, observing, listening, writing and rigour.

Journaling

Maintaining a journal helps to locate the personal in a health care environment which is increasingly dominated by technology, and the collection of impersonal 'information' against a background of market forces and competition. This environment alienates nurses from each other, and from their patients/clients, leaving them emotionally impoverished and distanced from the basic humanity of their craft.

Recently a group of Royal District Nursing Service (RDNS) clinical nurse consultants working in palliative care developed a research project which was to illuminate advanced clinical nursing practice. Maintaining a daily journal was central to the study.

In talking about her journal keeping, one clinical nurse consultant said, 'Initially I had my doubts about writing every day'. Six months later she said to me, 'the journal has become part of me'. Originally I had a section of her journal in this paper but I have removed it as it was feared that the client and her family would be recognized. It was a powerful piece about one young woman for whom she provided care until her death. Referring to this experience she said; 'I can visualize the depth, complexity, sensitivity, sadness and even humour experienced as the journey unfolded'.

Maintaining a daily journal offers a strategy that can help clinicians address some troublesome practice-based issues. The point here is that research questions are often

born out of practice. The phenomena of interest to nursing are those identified by nurses and patients in the course of their everyday encounters. Clinical narratives illustrate how dialogue could be, and already is, engaged by practitioners (Gorman 1993). It makes practice visible. It shows that clinicians or researchers are part and parcel of the setting, context and culture we seek to understand. Data generated from practice has the potential to bring nursing practice, research and action into harmony.

Journal keeping can become a central activity in both clinical and research practice. However, this process requires analytical skills to move it beyond mere documentation. Writing, analysing, reflecting and rewriting is a skill which does not come easily to some practitioners. There is some literature on reflection to guide the novice. Reflexivity, in its various guises, occupies a central place in participatory action research, ethnography, hermeneutic and post-modern approaches to inquiry, taking different forms and raising different questions. The point I wish to make is that keeping a journal is an essential part of interpretive research.

In a hermeneutic inquiry the journal serves to locate the self in the research process. Whilst researchers can be accused of self-indulgence, by returning to our personal history we can raise our situation to consciousness and monitor the way in which we deal with the research process, the story and traditions. Such reflexivity is the critical gaze turned toward the self in the making of the story.

Observing

In the 1960s, as an apprentice nurse in the Nightingale wards of the Royal Adelaide Hospital in South Australia, I was taught that observation of the patient was the beginning of the care process. So observation in a research setting builds upon skills that are already central to nursing practice. In some interpretive traditions generating observational data is a crucial aspect of the research process.

My experience with Munro comes from unpublished observational notes generated in 1990 for my PhD study. For 7 months I participated in the wards as a nurse and researcher. I observed and talked with older patients admitted to the acute care sector in wards assigned to the care of elderly people in the United Kingdom (UK). Here follows an excerpt from my journal.

Munro

Munro, an Irish man, admitted to the care of the elderly wards for assessment following a stroke, developed a very nasty rash. The rash reported one week ago is still undiagnosed. Munro is dysphasic, able to say only a few words, all expletives. He has waited six days for a bath.

I ask why he has not had a bath. I am told that the taps over the bath have been removed because a month ago a person with dementia had turned on the hot tap, resulting in burns.

Today Munro yells out to the nurses. When I stand next to his bed he points to something (a bottle). I notice his locker is on the wrong side and he cannot reach it. His exasperation is expressed loudly through swearing, at the same time agitating for attention. I give him a urinal and he almost swipes me with his good arm! Jesus Christ, he mutters as he uses the bottle. When he is finished he points to his left arm, to the red cracks of the skin between his fingers, to the oedema, and to the yellow crusts. He needs something to relieve the itching. He needs someone to take off some of the thick yellow patches on his unshaven face. So I draw the curtains and look closely at his skin. I ask him whether he would like a wash. 'Yes! Yes', he said!

I spend nearly one hour with him, talking gently and cleaning off the scales from his face. One after the other they come off, much to my surprise. When cleaning around the edges and inside his nostrils, I say something about him being able to breathe through his nose again. He smiled for the first time. When I had finished he reached for my hand, his eyes told me that what had happened between us was significant.

A day later

As soon as I walk past his bed he nods, holds up his good arm and shouts 'hey'. A new word. Today I find that the bathroom taps have been replaced. I ask would he like a bath? Yes he said.

OK, I will ask someone to help me. None of the equipment works, and the wheel chair brakes are not functioning. As the chair moved under his weight I saw fear in his eyes.

'Jesus Christ! Jesus Christ!' I wheel him through the ward, he holds his legs up (the wheel chair foot rests have disappeared). He seems to be frightened. It is an obstacle race in the ward. The transfer into the bath is equally perilous. A third nurse is called in to help. He shouts. As he is lowered onto the chair lift and into the bath he shouts louder, he is terrified he will fall. At last, in the bath, his breathing slows down, he relaxes.

His total body is covered in a red rash with patches of scales. The smell is sweet (from the ointments) and sweaty mixture, decidedly unwashed. The parts of his body that he is able to reach are scratched and are bleeding. We proceed, shampoo his hair, a shave with a dinky disposable razor that could not do justice (he had not been shaved for two weeks). He is quiet whilst I shave him, except for the occasionally soft whimper as he scratches skin he can reach. I say the itching must be terrible.' Yes, itching, itching, itching, itching', he wails, louder each time, as if I had pressed a repeat button. He has found a new word to describe his agony. His face is quite contorted, and out of his mouth oozes the residue of the tea and biscuits he had just consumed. He sobs.

There are no towels with which to dry him, so we use sheets. We cover his body with ointment. By the time he is back in bed a whole hour has past. I shift his locker to the correct side of the bed once more. He collapses into bed, and when I leave the ward at 6 pm he is still in the same position, exhausted.

The aim of this project was to locate patients' voices as a preliminary step toward fourth generation evaluation. I wanted to know 'What is it like to be a patient in a care of the elderly ward?'. I also wanted to know what it is like for those who could not talk.

Here an attempt is made to show how close observation can work to make sense of the world as it is lived by Munro. Can you imagine what it was like for Munro? What it is like to be a patient in a resource deprived and unsafe ward? Can you feel my outrage? You are right, I want this observation to alert practitioners, to move them into action. At the same time I suggest this excerpt tells you more about the way I construct myself as a nurse and the way it makes transparent my values, ethics, humanity and morality.

Listening

So far, keeping a daily journal to incorporate reflections and observations has been considered as a pivotal research activity in the making of a research product. I now turn to the skill of listening and suggest that it is something we, as health care professionals, do not do well. Listen to Ada:

It was my first time in hospital and six women died while I was there. I found that difficult, emotionally. One woman died just after I had been talking with her. I cried. One of the young nurses said to me, 'What are you crying for?'. I explained that I was upset because that lady had just died. 'How do you know she has died', she said. I answered that I was aware of these things. The nurse said 'Well I don't know what you are crying for, you don't even know her'. That made me feel worse. It was the younger ones there, the untrained ones. It was as if they thought 'You are old and you are going to die anyway'. They didn't treat people very well, not as human beings anyway. I had never seen anyone die before. I was very, very upset. And the nurses appeared so matter of fact. I couldn't understand how they could be so cold. First I thought they were not caring, later I thought you have to be tough to be a nurse.

Listening to Ada's voice shows us what this older woman thinks of nurses, and how she describes being depersonalised. I will not analyse this excerpt; like my experience with Munro, I will rely on your interpretation for the moment.

In a hermeneutic inquiry, we, the researchers, thrive on the tension about what is unique but what we rely upon is shared and vividly expressed. In listening to the voices of older patients common concerns were identified. What mattered most to patients interviewed was being acknowledged as a responsible adult.

Patients wanted nursing care that would allow them to make their own judgements based on adequate information, participation and self-direction. In the research wards, which were age-segregated, there were few human or material resources when compared to other sections of

the same hospital. There were few registered nursing staff and the quasi-Nightingale wards had few amenities. Staff claimed they felt powerless to change things. This resulted in the mutual oppression of staff and patients. The notion of heterogeneity and diversity of older people and their right to individual care was only given lip-service. In the 'real' world of the care of the elderly settings, dehumanized, objectified care prevailed.

One important reason for this research approach was to locate voices that had been marginalized. Action did follow this research. My publications on this topic provided information to a UK Health Service Inquiry and contributed to the closing down of the segregated wards.

Critics of hermeneutics or phenomenological approaches claim that story telling is not enough, the world is waiting to be transformed! I would say to these critics that change comes about indirectly, perhaps through working with research participants, in my case with older people themselves, or through the publication and presentation of the research.

Arthur Frank (1991) writes that he reserves the term 'caregivers' for people who are *willing to listen* to ill persons and to respond to their individual experiences. He writes, 'Caring has nothing to do with categories; it shows the person that her life is valued because it recognizes what makes her experience particular. Care is inseparable from understanding, and like understanding, it must be symmetrical' (Frank 1991 p. 48). Yet in the 'real' world of health care, empathetic listening to our clients is something we do not do well. There are numerous studies which support this contention (Reiman 1986, Drew 1986, Swanson-Kaufman 1986, Spitzer 1988)

Hear what Arthur Frank (1991 p. 51) has to say about even basic information giving:

After the ultrasound a physician said. 'This will have to be investigated'. Hearing this phrase I was both relieved and offended. The relief was that someone was assuming part of the burden of worrying about what was happening to me. But I was also offended by his language, which made my body into medicine's field of investigation. 'I had become medicine's 'this'. I, my body, became the passive object of this necessity, the investigation... To get medicine's help, I had to cede the territory of my body to the investigation of doctors who were as yet anonymous... I had to be colonized.

One day I returned to my room and found a new sign below my name on the door. It said 'Lymphoma', a form of cancer I was suspected of having. No one had told me this diagnosis. Finding it written there was like a joke about a guy who learns he has been fired when he finds some else's name on his door.

As researchers we have grown to appreciate the importance of clients' storying and our own experience. Listening is characterized by the openness of the exchange (Gadamer 1976). Forester (1980 p. 220) has this to say:

We can be responsible for listening or failing to, and we make a difference as a result. Listening is an activity of being attentive; it is a way of being in a moral world... Hearing on the other hand, has an object, a message sent and to be received. Hearing subordinates the uniqueness of the speaker to the formal meaning of her talk, her utterances; listening understands the meaning of what is said in the context of the speaker's life.

As with journal keeping and observation, this openness of interview style requires practice. Asking the right question is also essential in gaining rich data.

Arthur Kleinman (1988) writes of his learning experience in this way:

The first patient was a pathetic seven-year-old girl who had been badly burned over most of her body. She had to undergo a daily ordeal of a whirlpool bath during which burnt flesh was tweezed away from the raw open wounds. This experience was horribly painful to her. She screamed and moaned and begged the medical team, whose efforts she stubbornly fought off, not to hurt her any more.

My job as neophyte clinical student was to hold her uninjured hand, as much to reassure and calm her as to enable the surgical resident to quickly pull away the dead, infected tissue in the pool of swirling water, which rapidly turned pinkish, then bloody red. Clumsily, with a beginner's uncertainty of how to proceed, I tried to distract this little patient from her traumatic daily confrontation with terrible pain. I tried talking to her about her home, her family, her school almost anything that might draw her attention away from her suffering. I could barely tolerate the daily horror, her screams...

Then one day I made contact. At wit's end, angered at my own ignorance and impotence, uncertain what to do besides clutching the small hand, and in despair over her unrelenting anguish, I found myself asking her to tell me how she tolerated it, what the feeling was like of being so badly burned and having to experience the awful surgical ritual, day after day after day.

She stopped, quite surprised, and looked at me from a face so disfigured it was difficult to read the expression; then she told me. While she spoke, she grasped my hand harder and neither screamed nor fought off the surgeon, or the nurse. Each day from then on, her trust established, she tried to give me a feeling of what she was experiencing. By the time my training took me off this rehabilitation unit, the little burned patient seemed noticeably better able to tolerate her debridement. But whatever effect I had on her, the effect on me was greater. She taught me a grand lesson in patient care: that it is possible to talk with patients, even those who are most distressed, about the actual experience of illness, and that witnessing and helping to order that experience can be of therapeutic value.

The existential question 'What is it like being...' is often the only question needing to be asked. This approach is distinguished from others primarily because the interview style is open. Openness is crucial. In Kleinman's excerpt, making contact with the child relied upon continuity of

presence, that is, ongoing involvement. But Kleinman is a story teller, not story analyser. Again we learn more about the author than the child. We still do not know what it was like being so badly burned. We know how Kleinman felt but what of the voice of the child?

I believe that the voices of those marginalised in our culture need to be heard and here I refer to children and older people in particular. There is continuing debate as to the age when children can articulate experiences meaningfully in interviews. Deatrack and Faux, in a review of this issue, conclude that children of around 6 years old and above can give meaningful information during research interviews (Deatrack & Faux 1991).

It is clear from Kleinman's example that sharing an experience needs to be recognized, valued and promoted within therapeutic communities. In Eichblat's (1996) study 'One woman's experience of living with chronic pain: a phenomenological study', one of the most powerful statements is in the final thesis paragraph, when the woman said '... it gave me a warm feeling to be involved in this process.... I feel validated somehow' (Eichblat 1996 p. 27). Potential therapeutic effects for participants in our research is a significant insight not yet adequately explored.

Critics of these approaches often comment upon sampling. One of the most common questions is 'How can you generalize from so few subjects?'. The point to be made is that generalization is not the aim of such work, reaching a new or better understanding is. What matters is gaining rich data, data which illuminate the question you want answered or explored. In addition to the therapeutic effects for the participants of our research, there is a large literature to support story telling as therapeutic. But now we must seek new forms in which these stories can emerge.

So far in the construction of a story (or research product) I have considered maintaining a reflective journal in which our experiences and observations are recorded and analysed. I have talked about the kind of question which may encourage rich data to be brought into dialogue. I have also referred to listening skills as essential and suggest this has a therapeutic component. I will now turn to writing and rewriting so that we can communicate the product of our research.

Writing: seeking new forms of story telling

To guide our writing, it may mean turning to the reading of exemplary literary texts. I turn to the novel for inspiration in the writing and rewriting process. In the excerpt of *Love's Work* (Rose 1997), a story is told by a woman who has cancer, She attempts to put into language meanings derived from this experience. This is an example of phenomenological writing at its best, but it is also more than that. In a few paragraphs she moves through

biomedical discourse (the physical and anatomical description) to an experiential discourse. This story lived and told, informs the self and others about what it is like living with a colostomy. The section I have chosen to include is rich with the infinite texture of living. Here I ask you to read Gillian Rose (1997 pp. 72–73):

To the bearer of this news, the term ‘cancer’ means nothing: it has no meaning. It merges without remainder into the horizon within which the difficulties, the joys, the banalities, of each day elapse.

Dare I continue?

Nowhere in the endless romance of world literature (my experience, needless to say, limited) have I come across an account of living with a colostomy.

A colostomy is an opening of the colon on to the abdomen: it is usually performed for people who have chronic bowel disorders. For them it is a great relief, a new lease of life. I have no history of bowel disorder. The remaining ‘seedlings’, tiny pinpricks of cancer, were located in the lining of the bowel, so that, when 20% of it was removed, together with the other organs infected by metastases, the bowel was not rejoined.

Let me make myself clear: the colostomy — stoma means ‘opening’ — is a surrogate rectum and anus. Tight coils of concentric, flesh, blood-red flesh, 25 millimetres (one inch) in diameter, protruding a few millimetres from the centre left of my abdomen, just below the waist. Blueness would be a symptom of distress.

This is comparatively easy to put into prose... But how to inscribe my relation to its operation? ‘Changed body image’ has already become an overworked cliché, which, anyhow, relates to motor and imaginary self-representation, and not to the re-siting of bodily function.

I want to talk about shit - the hourly transfiguration of our lovely eating of the sun. I need to remove the discourse of shit from transgression, from sexual fetishism, from too much interest, but equally, from coyness, distaste and the medical storybook. My interest is in the uncharted: my difficulty that I will inevitably enlist, by connotation and implication, the power and grace of the symbol. I need to invent colostomy ethnography.

What having a colostomy makes you realize is that normally you bear hardly any relation to your excrement. It is expelled from the body from an invisible posterior organ, and, with its characteristic solidity and odour, descends rapidly into the water and oblivion. It is the sphincter muscle which affords the self-relation of retention and release. To exchange this discretion for an anterior cloaca and incontinence....

I am frequently asked whether I nourish the rancorous sentiment, ‘Why me?’. The unemphatic truth is that I have trouble imagining, publicly or privately, that everyone is not made exactly as I am myself. Thus I handle my shit. I no longer employ the word as an expletive, discharging intense, momentary irritation into its void of meaning.

I now turn to Audre Lorde (1980 p. 11) who uses journal entries to describe her experience with breast cancer and mastectomy:

I have come to believe over and over again that what is most important to me must be spoken, made verbal and shared, even at the risk of having it bruised or misunderstood. That the speaking profits me, beyond any other effect.

Lorde describes the necessity to transform silence into language and action. Her shared experiences are particularly moving, as she is determined and vigorous about herself, stating that ‘with one breast or none, I am still me’. It embodies the recreation of self and the qualities and triumphs of living. This is the voice of a writer and poet, few can write in this way.

Even if few can write as well as Gillian Rose or Audre Lorde, it is possible to take on Denzin’s (1996 p. 32) suggestions which may help us to write. He presents seven understandings which shape the work of ‘new journalists’.

Denzin (1996) suggests that:

- Facts are treated as social constructions.
- Blurred writing genres are acceptable (e.g. literary and autobiographical).
- Use of the scenic method (show rather than tell) is advocated.
- Construction of ‘real’ and composite people is made.
- Multiple points of view are used to establish authorial presence.
- Multiple narrative strategies are deployed and writers position themselves as moral witnesses to radical societal change.

I have attempted to incorporate some of these suggestions in this paper. So far I have explored the story as research product as the combination of journal data, observation and listening fused in writing. But how do we convince others that telling stories is a legitimate research endeavour?

Rigour: plausibility and vitality

Researchers in interpretive traditions are often called journalists or soft scientists. Story telling work is described as unscientific, full of bias or entirely personal. The writers’ place (the fusion of researcher and researched) in the text is often challenged. Stories are criticised for not being generalizable. Writers of stories can be accused of fabrication. There appears to be no agreed upon method for ensuring rigour. I have thought a great deal about rigour in qualitative research so here I will summarize my position.

In the effort to satisfy demand for rigour within story telling traditions, researchers in the 1980s struggled to apply criteria from quantitative research to qualitative work (Bailey 1996, Koch & Harrington 1998). Then in the late 1980s researchers adapted the parallel criteria, credibility, transferability and dependability for assessing

qualitative work (based on the work by Lincoln & Guba 1985).

In order to demonstrate 'credibility' it is important to show that multiple constructions are represented adequately. That means showing how interpretations are arrived at during the inquiry. The argument is that a study is credible when it presents faithful descriptions. It is considered credible when co-researchers or readers confronted with the experience can recognize it. In order to enhance credibility it is often a good strategy to include a transcript as an appendix to the study. If differences are observed, it should be clear that the researcher can show how the interpretation was derived from the descriptions. This can be done by inviting readers to return to the original text (or appendix) to make sure that all conclusions are firmly grounded in the data or explained by the researcher's interpretive scheme.

Transferability is dependent upon the degree of similarity between two contexts. I will give you an example of the concept of transferability. If I were to give you additional contextual information about the Care of the Elderly wards. One patient whilst we were at hand-over report, called out 'Could I have the commode please?'. The loud response carried across the entire ward. 'Sorry L... it is in use at the moment!' was the reply. Ten minutes later this patient repeated his urgent request and he was told, 'It is still in use, sorry'!

The setting in which there is one commode between 22 patients, one in which there are no call bells and untrained staff yell what could be a private response across a public space. And if I write that that these wards were resource deprived and its patients victims of unwitting ageist policies, then it is likely that the experiences and accounts given by the older people themselves would be similar in wards that are organized similarly. And if I were to tell you that age-segregated wards such as these are common in the UK. Could I claim that the findings from this research can be transferred to other, similar settings? I believe it is possible, but the original context must be described adequately so that a judgement of transferability can be made.

One of the ways in which a research study may be shown to be dependable is for its process to be audited. An inquiry audit of this type is based on the fiscal audit undertaken to authenticate the accounts of a business. In the same way that the auditor examines the process by which accounts are kept in order to exclude the possibility of error or fraud, the decision trail can be established as a means for the researcher to provide audit trail linkages. This is what is meant by dependability. Leaving a decision trail entails discussing explicitly decisions taken about the theoretical, methodological and analytic choices throughout the study.

These are just some of the possibilities for enhancing the rigour of the research product. I firmly contend that

the researcher needs to locate the vast literature on rigour and decide upon suitable means for their own inquiry. Even in the 1990s much of the vast literature surrounding rigour is concerned with 'rule governed approaches' (Healy 1996 p. 156).

My position today is one that emphasizes a reflexivity which acknowledges that interpretation exists in a complex matrix of alternative representations and 'derives its critical power and insight from this awareness' (Marcus 1994 p. 571). Its focus is upon reflexive awareness of the historical connections that already link it to its subject matter; such representations become an integral part of field work. Gadamer does not provide us with a method, he suggests we record what is going on whilst we are researching and this is exactly what the process of keeping a journal does. It provides the context for our decisions as we move through the process of research.

So I argue for an expansion of rigour to include moral, political and ideological value-commitments in the research process. This goes beyond 'merely a set of methods for gathering and treating data', to a rigorous approach of the entire process (Ratcliffe & Gonzalez-del-Valle 1998 p. 388).

In addition, I believe we can address the question of rigour through creating stories that are vital. Telling a vital story gives context and information that captures and aims to hold the readers' attention. It attempts to recreate the mood of the setting. It presents voices that make the experience come alive (Mitchell & Charmaz 1996). It presents multiple points of view. These elements do not come automatically from fieldwork, but are instead the result of careful organization, creativity and time (Stowe & Igo 1996). It is here we find ourselves writing and rewriting.

SO: IS IT REALLY RESEARCH?

The emergence of alternative conceptions of knowledge and method have challenged traditional views of what research entails and have escalated our consciousness of its unexamined assumptions. I cannot do justice to these conceptions in this paper. In my way through this debate it is useful to use the summary provided by Grenz who writes that 'the old objectivist position is no longer viable, that there is no single, timeless truth existing "out there" independent of particular perspective or method waiting to be discovered by means of scientific procedures' (Grenz 1996 p. 109). Following Gadamer, the interpreter cannot come to grasp the mind of the participant. Nor can the researcher recover the past as it actually was. Once more guided by Gadamer, in treading a path between the two alternatives, I draw on the ontological concept of 'being in the world'. Because we stand within the world we can never escape our historical context.

This does not lead to relativism but a world of competing interpretations. We have a shared reality — a world, a

tradition, a language. Because of this common dimension we can experience a 'fusion of horizons'. This occurs through a kind of conversation in which we compare and contrast our various interpretations. Meaning emerges as the text and the interpreter engage in a dialogue, in a hermeneutic conversation (Grenz 1996 p. 110).

The goal of this dialogue is an intersection of the horizon of the author and the horizon of the interpreter. The aim of hermeneutic inquiry is understanding, reconstruction, advocacy and activism.

I believe that careful, reflective, systematic study of phenomena or experience taken to advance human understanding can count as research. It depends on how that work is pursued. Throughout the process of research we need to deal with the issues of representation and legitimation. The aim of telling stories (or creating a research product) is to gain another or a different understanding, which at its best can influence the way we care for clients. Organizing a story means making decisions about what will be written about, how it will be represented and so on. Journal observation, methodological, theoretical and personal notes can be kept to enhance delivery. In terms of representation careful consideration is given to voice, audience, the 'other' and the story teller's place in the story. Because narratives are local productions, they depend instead on the particular context and organization of the story for their political effect. I suggest that evaluation criteria can be generated within the research product itself through detailed and contextual writing and a reflexive account of the actual research process. I ask writers to incorporate a reflexive account into their research product by sign-posting to readers 'what is going on' while researching. I claim that if the research product is well sign-posted, the readers will be able to travel easily through the worlds of the participants and makers of the story and decide for themselves whether the story is a legitimate research endeavour.

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