Chapter Two

Introduction

Arriving in England after being away for nearly thirty years gave me the space and the time to think about what I had achieved and whether I wanted to continue along the same path. My experiences since returning to England have given me more freedom to focus on nursing and being a nurse, and this research process has brought me to the point where I am able to write about these experiences. In this chapter I will explore these experiences from both my point of view and the views of other nurses, beginning by introducing my perspective of nursing and being a nurse and then focusing on what I term the essence of nursing. In doing this I will reference nursing writers who I value for their ideas, experiences and insights. This will bring into focus nursing as a caring profession and what caring means to nurses and to society. I will then explore the genderedness of the nursing role and team work and peer support within the context of nursing.

I have chosen to include the views of only a few nurses, selected because they speak to the nature of nursing and tell about a developing understanding of the essence of nursing. However there are a wealth of nursing theorists who seek to develop a theory of nursing along either of two dimensions. There are those who seek to base nursing within social, biological, or physical sciences. e.g. Adaptation theory (Rambo, 1984; Roy, 1976); Interpersonal/interactional theory (King, 1971; Peblau, 1988); Systems Theory (Neuman, 1982); and Holistic Health (Rogers, 1970). Or alternatively there are those who seek to develop models and procedures for managing nursing care. e.g. 'Activities of daily living' (Roper, Logan and Tierney, 1988) and 'Self care' (Orem, 1980).

All these nurses, and many more, write about the knowledge and practical guidance nurses need to manage their work and make informed decisions. This is all very important to the development of informed practice and effective evaluation. However my interest is in how nurses use this knowledge and skill in a way that is 'health giving' and in doing so become expert in understanding and responding to the subtle signs of dis-ease. It is this receptiveness and responsiveness, characteristic of expert nurses, that I intend to make the focus of my inquiry.

Nursing and being a nurse

My experiences of nursing and being a nurse cover many years and explores many different contexts. It is this which has given me a wider perspective of what nursing is and what nurses do. However knowing about one's experience, and writing about it, is all very difficult because as I have come to know about nursing so I have come to know about being a women in western society. My understanding of each is intertwined with the other. It has been through puzzling out this relationship that I have discovered the genderedness of my life as a nurse. The reader should not take from this that I believe that nursing is about being a woman. I have discovered too much about my feminine and masculine self to see nursing so simply.

I am aware from the experiences I have shared with other nurses that being both a nurse and a woman incur similar expectations about roles and responsibilities, regardless of the gender of the nurse. In this chapter I intend to focus on nursing and to 'bracket off' the ever present sense of being a woman. I will entertain this concept when I discuss life strategies and gender in Part three. I now intend to explore what I have come to know as the 'essence of nursing'. To illustrate and discuss this concept I will invoke the perspectives of three expert nurses: Benner (1984) for her work on the development of the expert nurse; Binnie (1993) for her ability to demonstrate to the uninitiated the expert role; and Newman (1990) for her self-discovery while pursuing nursing research.

The development of the 'expert' nurse

I will begin this section with the following quote from **Myrtle K. Aydelotte-** extracted from the forward to Benner(1984)

> "The value of this document lies in the understanding it gives us about the mystery of expert nursing practice and in the creation of an awareness that we must respect this mystery, rather than pretend that we can dispel or standardise it by submitting it to rules, procedures and regulations."

Benner (1984) researched the question “How do nurses develop from novice to expert?”. The methods used, the process engaged in, and the outcomes achieved all inform what I have come to understand as the essence of nursing. Benner was interested in how the actual experiences of nurses uncover and create knowledge. These kinds of experiences, according to Benner, occur when “an event refines, elaborates, or disconfirms foreknowledge”. This is termed clinical knowledge, and is “a hybrid between naive practical knowledge and unrefined theoretical knowledge.”(p. 8) A new paradigm is then available to manage future situations. It is the development and use of these paradigms that interested Benner, and formed the basis for research into the experiences of nurses.

The research methods used by Benner involved the application of the Dreyfus (1979) model of skill acquisition. Dreyfus, in working with trainee aircraft pilots, produced five levels of proficiency: novice; advanced beginner; competent; proficient; and expert. These levels of proficiency correlated to five stages of development. In order to become an expert, students needed to master three different aspects of skilled performance. These three aspects of change in performance become the ‘benchmarks’ for assessing the individuals level of proficiency. To develop from novice to expert the individual must demonstrate that they have moved from:

- reliance on abstract principles to the use of past concrete experiences as paradigms;
- seeing the situation as a set of equally important bits to a complete whole, where only some parts are relevant;
- being an observer in the situation to being thoroughly engaged in the problems to be solved.

These three areas of change provided the focus for discovering the competencies at each stage of development. To test out this model Benner used paired interviews with a beginning nurse and a nurse considered by other nurses to be an expert. A situation experienced by both nurses was identified and each nurse was interviewed, thus producing two narratives for the same situation. An interpretive approach was then used to analyse the data, thus “allowing a manageable yet rich description of actual nursing practice”(p.39). This interpretive approach takes into consideration the context in which the experience occurs and the individual’s meaning making. Benner also makes the point that clinical competency level is much easier to ascertain when the assessment is made by nurses who share the same background meanings. That is, the participants can talk about them (*their experiences*) and the interpreter, who shares their knowledge and experience base, can understand them.

From this research Benner was able to identify seven domains of nursing practice and within these domains specific competencies. These seven domains are:

- the helping role;
- the teaching-coaching function;
- the diagnostic and patient -monitoring function;
- the effective management of rapidly changing situations;
- administering and monitoring therapeutic interventions and regimens;
- monitoring and ensuring the quality of health care practice;

- organisational and work-role competencies.

From this analysis the competencies to move from novice to expert within each domain can be identified.

The Narratives of Nurses

Benner found, by listening to the narratives of expert nurses, that the key to their development of expertness was based in their ability to 'experience' nursing, and to integrate this experience into both existing and new knowledge. From this integration of experience and knowledge, new paradigms are developed and available in future 'like' situations. Benner also observed that as the nurse gained more experience, paradigms were grouped together to better inform particular health care problems. However, the problem that arises from this way of becoming an expert is that knowledge gained tends to remain with the expert nurse and is only shared within the work context. Thus inexperienced nurses learn through being with, and listening to, expert nurses. Teaching the skills needed to be an expert nurse is not formalised.

One of Benner's concerns about this work-based knowledge is that nurses do not articulate clearly the knowledge they have developed, either by reporting and recording or by planned discussions with other nurses. Benner also acknowledged that:

> "many paradigm cases are too complex to be transmitted through case examples or simulations, because it is the particular interaction with the individual learner's prior knowledge that creates the 'experience' - that is, the particular refinement or turning around of preconceptions and prior understandings."(p. 9)

Although some situations do not lend themselves easily to explanation, I concur with Benner that "...adequate description of practical knowledge is essential to development and extension of nursing theory." (p.11)

From Novice to Expert

In summary, Benner clarifies the difference between a novice and an expert nurse through first identifying exemplars of nursing practice, and then by clarifying the proficiencies needed at different levels of development. The methods used highlighted the need to honour both the context and the understanding the individual makes of any given situation. Evaluation of the competency of an individual nurse must therefore acknowledge both context and meaning making, and this is one of the most important points I take from Benner's work. The ability to acknowledge the needs of the novice nurse and the skills of the expert are very important for the development of nursing in a changing society. To this end the experiences of expert nurses should be made more available to the less experienced. These ideas and challenges are embedded in my own cycles of research within the field work and will become more apparent in Parts Two and Three.

The work that Benner undertook has been used by nurses to develop learning environments within the clinical situation. I now intend to present a piece of work by one of my colleagues who explored nursing as a 'craft'. This work explores the skills and knowledge of the expert and uses narrative as a way of 'opening up' the expert's experiences to less experienced nurses.

The expert role in practice

The central reference that I have used to explore this concept is Titchen (1993). In this work the exploration of the art of patient-centred care is investigated from the perspective of the patient and the nursing staff (Binnie and Titchen, 1992). This exploration echoes my own understanding of working collectively with patients, colleagues and novice nurses. Titchen begins her discussions with this quote from Binnie (1992 in Titchen 1993).

> "For me the essence of patient-centred nursing has become developing a relationship which enables me to address my patient's personal experience of health or illness. Then, within this

> relationship I offer a special companionship and a range of practical skills which, together, if the patient is willing to accept them, have the power to transform his experience." (p 1.)

Titchen, who is not a nurse but a social scientist, uses the data derived from an action research project (Binnie and Titchen, 1993) to explore the role of the expert nurse and from this posited the idea that nursing is a 'craft' that can be learned.

The action research project undertaken by Binnie and Titchen (1993) aimed to change the methods of nursing from traditional and bureaucratic to patient-centred, based on the concepts of holistic care. This required that nurses worked with patients in partnership, honouring the range of needs that inform the individual about his/her health. Binnie, a recognised nursing expert in patient-centred care, led the nursing team through these changes. The action research data collection involved observations of nurses working with patients and other nurses. It also involved recording the stories that nurses tell about their own experiences and the experiences of their patients. It was the story telling that proved to be a rich source for professional craft knowledge to emerge. Titchen in her own words became -

> "...fascinated with Alison's professional craft knowledge- the part of professional knowledge which is acquired mainly through experience and underpins everyday practice."(p 2)

Titchen decided to rework the data from this action research, to investigate the idea of craft-knowledge as applied to expert nursing knowledge. The stories were revisited and produce new themes and sub-themes. The themes that emerged were -

> ".derived from the phrases that Alison used to capture the essence of her knowledge."(p. 4)

There were two major themes, each with sub-themes attached. The first focused on the clinical practice role (the *Skilled Companion*) and the second on the clinical teacher role (*Facilitator of Learning*). Each involved use of story telling and this way of presenting experience makes very clear the value of stories within the learning environment of both patients and staff, not to mention the person telling the story.

The sub-themes of the first major theme The Skilled Companion are:

- particularity;
- mutuality;
- reciprocity;
- graceful care;
- balance between an absence and an excess of professional detachment.

Within this major theme and sub themes, stories are told about: the intimacy of working closely with individual patients; the skills that are needed to move in and out of closeness; the ability to create a relationship where the patient has choices and is in control of his life pattern.

Titchen, in her observations of Binnie at work, acknowledges that the art of nursing is many-faceted and involves the expert nurse in -

> "taking herself as a person into the relationship and accompanying the person on his/her own very personal journey." (p 4.)

The sub-themes of the second major theme The Facilitator of Learning are:

- starting where the nurse is;

- making professional craft knowledge accessible;
- learning from sharing practice experience.

Within this theme the stories were about: modelling behaviour that encouraged stories to emerge from less experienced nurses; sharing experiences and encouraging others to do likewise; inviting nurses to work with, rather than for, the expert nurse. The following statement arose from a discussion about story telling.

> "I want nurses reading my assessment to be confronted at once with a human being who has a history and a place in society --- I select the relationships, events and experiences that seem to have been most significant in shaping the course of the person's life and will help others to relate to him as an individual, to see him in the context of his social position and background and a part of a social network. These key things will help others to relate sensitively to the patient as they build their own relationships with him." (Titchen 1993 p 7.)

Creating a Context for Stories to be Told

From my point of view, taking a more pro-active role in encouraging novice nurses to focus on each person, their needs and what their lives mean to them, is an essential part of developing that very human relationship that allows a place for caring and healing to occur. This use of the essential humanness of the nurse as a person is the most critical part of the way expert nurses make themselves available to both patients and colleagues. How this is achieved remains within the domain of the individual nurse. However, the ways in which less experienced nurses tend to use 'self' as a therapeutic tool are often unplanned, occurring most often when the usual ways of working seem inappropriate and the nurse chooses to follow intuitive thinking or feeling.

It is in these situations that expert nurses are able ‘catch the moment’ and teach novice nurses to seek out the meaning in this experience, thus encouraging a more intuitive and reflective response to their patients. The challenge to expert nurses is to develop an environment where less experienced nurses can discuss how, and why, they think and act in a responsive or pro-active ways. This will create the possibility for new knowledge to develop and create new paradigms. (Benner, 1984)

As a result of isolating these two major themes and examining the way the expert nurse manages to be a *skilled companion* and a *facilitator of learning*, Titchen concluded by considering the similarities that are present when the expert nurses is 'Engaging with the Whole patient and the Whole Nurse'. These similarities are about encouraging the development of self knowledge and knowledge of people. I recognise these two components in my own work - they are present as I and my nursing peers develop the field work together.

Having now completed my summary of the core ideas and practices developed by Binnie and linked to Benner’s work on the development of the expert nurse, I will now turn to Newman who argues that ‘research is praxis’ and has a story to tell.

The Nature of Research and Praxis.

Newman(1990), in articulating 'Newman’s theory of Health Practice', states that alongside her aim to present an emerging research methodology and its relevance to nursing practice, is the desire to tell the story that brought a sense of reconciliation between original theory and the research that unfolded. This story is about ‘coming full circle’, from being and acting as a young nurse, thoroughly involved with the patient, to being “captured by the games-like intrigue of the scientific method", before finally realising that “the process is the content”(p 37). Newman begins by explaining that in this context of scientific method she was challenged to:

> “convert holistic parameters of a person’s living experience into manipulable artefacts in the laboratory, in an attempt to test some very basic relationship of movement in time and consciousness.” (p.37)

Nursing research and self discovery

It seems that the struggle to make research relate to nursing practice went on for some time before -

> "I stumbled onto the conclusion that the important part of my research was the process involved in interacting with the patient."(p 38)

For me, both the research journey that Newman unfolds and the research ideas that she articulates are important. The journey is important because it searches for authenticity and congruence across aspects of being, and the research ideas because they express life as unfolding patterns. Newman's theory is one of expanding consciousness and is based on Roger's theory of unitary human beings. Newman states -

> "Roger's assumptions regarding the patterning of persons in interaction with the environment are basic to my view that consciousness is a manifestation of an evolving pattern of person-environment interaction". (p.38)

The Patterns of Life

This idea of patterning is extended to include a larger undivided pattern of an expanding universe. It is clear that from this point of view both health and disease are part of the pattern of a person's interaction with their environment and developing consciousness. In this model of expanding consciousness the nurse's role is one of supporting and facilitating each person to achieve higher levels of consciousness, through identifying the individual's life pattern and intervening to affirm and enhance it. The aim of Newman's research was to gather information about the evolving pattern that is manifested in each person's experience of health and disease. For Newman the most exciting part of this research was to discover that the process of interaction with the patient, and the pattern that unfolded, was the research. Thus 'research is praxis.' From this point of awareness the original methods of categorising and analysing became suspect, and a methodology consistent with nursing theory and practice became vital.

An important conclusion was reached when Newman realised that -

> "The nurse-researcher cannot stand outside the person being researched in a subject-object fashion. The researcher is part of the interaction pattern which is the process of pattern recognition and choice." (p 37.)

This process involves:

- establishing the mutuality of the process of inquiry;
- focusing on the most meaningful persons and events in the interviewee's life;
- organising the data in narrative form and displaying it as sequential patterns over time;
- sharing the interviewer's perception of the pattern with the interviewee and seeking revision or confirmation.

For Newman this process is the content of the research and is coherent and compatible with the way nurses work with patients. It also provides a framework for recognising the unfolding patterns of health and illness within the context of the patient's wider life patterns.

Personal Reflections

There is a degree of complexity and multi-stranded analysis to Newman's experiences. There is also imagery that is captivating, the possibilities being almost beyond time. The rigor applied to finding a

way through the competing demands of the research methods was encouraging to me because it resonated with my own difficulties in meeting external demands and having a sense of ‘rightness’ about my own thinking and acting. The final simplicity of understanding 'research as praxis' allowed me feel confident that what I do as a nurse, and how I do it, is worth researching. I will not include the full discussion of Newman’s theory of unfolding levels of consciousness because it is complex and written for a different purpose. It is sufficient to affirm the connection I have made with other expert nurses as I have developed a pathway to presenting my own experiences as a nurse.

I now intend to consider nursing as a caring profession. To achieve this purpose I will present the points of view of two nursing writers, each having a particular point to make about caring as an essential focus for nurses, and each speaking of their concerns for the future of nursing.

Nursing as a caring profession

For most nurses the caring relationship, where the nurse seeks to bring about 'healing’, is where the art and science of nursing is found. Benner (1989) says that this relationship intricately binds the act of caring with an understanding of the needs of people as they experience illness. She points out that the skills needed to understand the lived experience of the illness are extensive and require detailed observations and attentiveness. This is caring enriched by education and experience (p. 19). For Benner, theory arises out of, and is therefore grounded in, the experience of caring for patients. Consequently, nurses will often experience conflict between the context in which society chooses to view illness, and the experiences that both nurses and patients have of working together to ease suffering. This desire to care for patients rather than focus on ‘a cure’ is central to the care/cure dilemma that Benner and other nurses (e.g. Gordon, 1991) identify.

Benner states -

> "In a highly technical society that values autonomy, individualism, and competitiveness, caring practices have always been fragile, but this societal blindness causes those who value technological advances to overlook the ways these advances are rendered dangerous and unfeasible without a context of skilful, compassionate care." (p 399.)

From Benner’s point of view both care and cure are to be valued, but care has primacy for nurses.

The Nature and Value of Caring

Benner also promotes caring as the vehicle nurturing personhood. A person is always becoming, always realising their potential, consequently, the burden of health is on the individual. Other people and/or situations can facilitate or obstruct this potential, but the potential exists in the individual. The nurse in developing a caring relationship is responsible for eliciting this potential rather than creating a situation that solicits it. From my understanding this means that the control remains with the patient, where caring does not intrude and take away the choices that are rightly the patients. The quality of the caring relationship, if developed for its own sake, is health-protecting.

In the world of work where nurses are pressed to take on the work of other professions, there is less time to give to the caring aspects of the nursing role. Benner comments that care-giving becomes threatened and is experienced as a loss when one is unable to provide the care that is needed, or when one’s care-giver is devalued. This tension and stress that nurses experience when role expectations are not met is expressed in the stories they tell. It is through these stories that nurses share meanings and learn to cope.

Gordon (1991) begins her discussions about ‘the crisis in women’s work’ as applied to nursing by stating -

> “The crisis in contemporary nursing offers perhaps the most devastating example of how America’s traditional attitudes toward caring, combined with many women’s new goals, have affected the caring professions." (p 143.)

With some passion Gordon describes the conflict that nurses feel as they are required to manage within the new 'market forces' where patients, who are sicker when they come to hospital and sicker when they leave, receive inadequate nursing care because:

> "....caseloads are heavier and patient turnover more rapid, many caregivers have come to feel that the greatest reward for their work----seeing the healing, empowering, life-enhancing benefits of human interaction is now denied them." (p 148.)

Gordon goes on to quote the ratio of nurses to doctors, and says that although nurses are essential to the function of the health services, nursing as care-giving is being undermined as society pressures nurses to focus on tasks. It would seem that England is following this lead, we now find that the number of nurses qualifying is not sufficient to replace those who are leaving.

In presenting a very strong voice for valuing nursing as a caring profession, Gordon says that devaluing nurses as carers also devalues caring within society. She also sees this devaluing as gendered in that caring is seen as a feminine activity and curing as a masculine one. This brings me to the genderedness of the nursing role and the writers that make clear some of the ways in which this is revealed.

The Genderedness of the Nursing Role.

In discussing the nursing role and the question of gender, I intend to begin by providing my own understanding of how the expectations placed on nursing are gendered. I will then introduce Marshall's (1989) work on occupational stress from an ecological point of view in which nursing is one of the occupational groups included in the study. This work will provide a broad picture of the stress endemic within the context of nursing practice. It will also provide the setting for considering the ways in which gender operates to reduce the nurse's power. Finally in order to bring a practice point of view to the issue I will refer back to Gordon and introduce Schachtel as further evidence of how the nurse's role is gendered..

Role conflict in nursing

The role that nurses are 'given' by society is often in conflict with the way nurses perceive their role to be. Nurses are continually struggling to cope with conflicts between the expectations of others, their own internal voice of 'duty' (Benner 1989), and the ways in which they intuitively and rationally would wish to act. These conflicts are becoming more overt as nurses have greater access to higher education and are more able to write about what they do.

Marshall (1986) in seeking to understand stress from an ecological point of view focused on occupational groups where stress seemed to be endemic. Stress in this piece of work was seen as being "part of the system and not attributed to any one individual" (p.282) and an 'ecological profile' was used to examine occupational stress. Nurses were selected as one of the occupational groups to be studied, and when the ecological profile was applied it was found that stress arose around role expectations, especially with regard to the patient or public. The ways in which nurses cope with this stress was also a part of the study, and it is suggested that nurses develop defences which in turn become occupational norms. These norms sometimes influence the organisation to the degree that they are embedded in the structures.

The key to the whole process seems to be the expectations that society has of nurses, and the ways in which healthcare settings are developed and managed to meet society's needs. Nurses are seen as the carriers of society's anxieties, ones that are not easily resolved like death, birth, illness, disability and deviance. (*I would suggest that in western society women also carry these anxieties for the family and the community*) In carrying these anxieties nurses experience separation and isolation. It is this separation and isolation that can lead to protective social mechanisms in order to cope with stress. Marshall's work generates evidence towards the idea that nurses choose to manage within an organisation in a way that de-humanises, sees patients as illnesses and nursing as tasks to be done. This maybe so if one takes an organisational point of view and assumes that there is some sense of control over ones destiny, particularly if one is seen to be in a position of authority.

The Stress of Conflicting Demands

My work with nurse managers leads me to believe that they are more isolated and separated, not only in relationships, anxiety associated with illness, disability and death, but also from their own nursing colleagues because of the burden of responsibility. The idea that nurses cope through sharing responsibility with other nurses, and through losing their sense of self, has some validity. Sharing the burden of being responsible for society's ills, and denying one's own values or sense of self, allows the individual to screen out the emotional responses that are attached to human frailty and human disaster. This denying of human feeling and connectedness may relieve the intensity for the moment but is acknowledged by nurses to be damaging to a sense of integrity. The fact that this unhealthy way of coping, which is in the main placed on women, is much more sinister. The evidence that women take up the stresses and anxieties of society is not unfamiliar, and the way we construct family life is mirrored within the health care services. It maybe that the anxiety, stress and coping mechanisms, that are a part of the nursing culture, can be recognised as the organisation's response to this agenda. I would question whether this evidence is 'true' for nurses.

My experience has been that nurses have another level of 'coping' which is about understanding, at an intuitive level, the stress they and their colleagues are feeling. It is true that this intuitive level is submerged under the need to 'do', and 'keep control' over very fragile situations, and consequently leaves little space for a healthy expression of anxiety. However I have also experienced the way in which this understanding is expressed in lifelong friendships, story telling, and camaraderie, when tasks are completed and nurses are relaxed and together. Although nurses are aware of this 'other' world, until quite recently it has remained.

The dilemma for the nursing profession is that nurses are unable to change their own roles without confronting the expectations of society and the context in which we practise nursing. This seems to mirror the position of many women in our society where opportunities are available but the expectations of others mitigate against the kind of change that liberates the mind and spirit. There is also something about gendered life strategies that render women invisible and men visible; maybe it is the genderedness of occupations that favours the masculine or the feminine life strategy.

Gender and power

There is a power and an intensity in Gordon's affirmation of the caring role, and her choice of nursing as a career rather than medicine. The irony of this 'choice' is that to rationally and consciously choose a role that expresses the feminine is to choose subordination to roles that express the masculine. This outrage is encapsulated in this statement from Gordon:

> "The idea that caring is an act of assertion, strength and affirmation of course, contradicts all of our comfortable notions that caregiving work consists of little more than nodding sympathetically emptying a bedpan, writing letters on a blackboard or diapering a baby's bottom."(p.152)

In valuing her own role as a nurse, Gordon tells how the caring role of nurses is trivialised in favour of glorifying doctors, both at work and in the media. This denial of the essential feminine part of nursing, according to Gordon, is not made any easier as more opportunities become available for woman to enter male dominated professions. Young women doctors are faced with denying the nurturing, inclusive part of themselves, in favour of developing the individualistic competitive part.

Gendered Professions

As I explore the role of nursing in society, I am more aware of the way in which the changing roles of women are mirrored in the changes that I experience as a nurse. The management of nursing has been challenged, the education of nurses is now part of higher education, and nurses are beginning to challenge the role that has been imposed on them. Many more nurses are now able to cope with anxiety in ways that are more healthy. By asserting and using their skills and knowledge, they are able to increase their personal power. These changes are gradual and sometimes resisted within nursing because of the implications of change and the shift in the balance of power between the sexes. This

struggle to shift the balance of power is also felt by other women practising in the health field and is worth spending a little time pursuing in order to place nursing within the context of gendered roles.

Schachtel (1986) in her role as a psycho-analyst asks the question,

> "Do gender role differences affect how we, as men and women analysts, experience our work role?" (p 257.)

In seeking an answer to this question she discussed with student analysts their experience of being in the analyst role and being supervised. She found that expectations associated with gender were present both in relation to others (patients, colleagues and supervisors) and in the internalised ways of interacting. Women students, in particular, were more concerned about what to do with their feelings, finding difficulty in think about them. Male students, on the other hand, did not talk about their feelings but focused on formulating ideas. Schachtel's conclusion was that the role of analyst is first and foremost male because the formulation of ideas is a valued skill for the analyst. This led to the view that women are required to fit the established role without any cognisance of the different challenges facing them, or the different ways in which these challenges will present themselves.

For me, as for many other nurses, nursing requires intelligence, responsiveness and an ability to take action with, and for, others. Taking a caring role in relationship to others is about managing the complexity that is generated when illness becomes uncontrollable for the individual. This role leans very much towards the feminine. However, nurses may need to acquire some of the masculine strategies to develop their role in a more assertive way and address some of the inequalities within the health care team.

Group Work and Peer Relationships.

Nurses work in health care settings with other health workers, the most significant relationship within this context being that with the doctors. Nurses learn to develop this relationship in order to provide care to patients and manage the healthcare environment. The role that doctors require of nurses is sometimes in conflict with what nurses consider to be ‘good nursing care’ - this is the 'care/cure' conflict. To manage this conflict, and other dilemmas that are part of this setting, nurses need to work together and support each other. I have discussed previously the stress that is left unresolved when nurses are unable to develop healthy coping skills (Marshall 1986). I now intend to present some of the ways nurses have tried to address this difficulty, although they may have defined it differently.

Peer support and peer appraisal are two concepts that I link together because support alone does not, in my experience, achieve the changes needed for nurses to cope more effectively in the workplace. Nurses need to be able to give each other constructive feedback if they are to make creative and positive changes in practice and in their relationships with other professionals. This feedback should occur within a supportive environment where trust, honesty and risk taking are encouraged. Before I discuss my own experiences and ideas about this aspect of nursing, I will present the works of Kavanagh (1989) who researched the social support networks of nurses, and Liberatore et al (1988) who worked with nurse managers to explore a group approach to problem solving.

Peer support and appraisal

Kavanagh begins by commenting that interpersonal space and distance characterizes nursing. She continues by saying -

> "Nurses form a predominantly female but otherwise heterogeneous group with widely varied socialisation histories, socio-economic backgrounds, educational accomplishments, ideological approaches, role interpretations and personal lifestyles."(p 226)

This being so the questions then arise:

- Do nurses meet together and enjoy each others company in or out of work hours?

- If they do, or if they did, would there be any positive gain?

Kavanagh(1989) studied the social support networks of 35 psychiatric nurses, inquiring into both private and public roles . In this study social interaction was defined, and boundaries were set to reduce the complexity to three orders of social relationships. These were structural, categorical, and personal. Structural included the hierarchies within the institution, categorical the social features of class and ethnic group, and personal included both formal and informal transactions across acknowledged structures and boundaries. The focus of attention for this research was the ideological variation, interactive patterns, perception of stress, and support and coping strategies. Attitudinal surveys were collected from 90 members of the nursing and therapies staff and from 35 psychiatric nurses of at least four years experience. All were given focused open-ended interviews.

This piece of research re-affirms the findings of Marshall and provides evidence of significant barriers to practice-level relationships amongst nurses. In this study nurses found themselves unable to develop relationships that were supportive and ongoing because of the changes in work patterns, the inability to develop any sense of belonging to a team, and the way in which work was distributed. Realistic expectations for the development of effective networks requires management of these. The expectations of nurses within the organisation is also recognised as a block to effective peer support.

Kavanagh reached several conclusions at the end of this research:

- nursing is facing a struggle for autonomy, status and recognition;
- the image of nursing is traditional, non-feminist, invisible and non-assertive.
- nurses experience prohibitions engendered by strong cultural values and their expression within the social norms of hospital and medical systems.

The other inhibiting factors such as reward, promotion, mass production of services and survival level competition, were also identified. However the key statement is:

> "Despite significant progress, nurses and women, like other minorities, struggle against strong competition to become more than weakly influential; there is a need to examine nursing itself." (p 232)

Group work in practice

In contrast Liberatore et al (1988) studied the usefulness of small group-work settings for developing peer support for nurse managers. The principles of group functioning were used to reach solutions to common problems. The rationale was that:

> "In a small group, each person is able to relate to every other group member. There is interdependence among them because all are in management positions."(p 68)

It was expected that within this 'small group' culture nurse managers would be able to contribute to the problem solving and reach commonly agreed decisions.

> "Problem solving is defined as the process which attempts to identify obstacles that inhibit accomplishment of a specific goal."(p 68)

The focus of this piece of research is on common issues selected by the participants and the results they managed to achieve. The expectation was that the participants would select issues that had meaning for nurses in terms of clinical and management practices. This was not the case, the participants focused on very practical issues such as lack of materials to do the job, inappropriate methods being used, shortages, improperly functioning machines and inadequate manpower. One could say these were very 'safe' issues, where the rejection of a solution would not be seen as a personal rejection. Most of the

solutions were rejected because of: the cost; too time consuming; too risky; insufficient support. The reason given for the lack of resolution can be summarised by the following statement:

> "---reaching agreement was hindered by persistent differing opinions." (p 72)

This for me is the important outcome of this exercise because the idea of bringing nurse managers together as a group has both positive and negative possibilities. Positive because nurse managers often find themselves alienated from their own nursing colleagues and in need of support when difficult decisions need to be made. Negative because to bring people together who work in competing environments does not easily foster support and mutual goals. The focus was on management not nursing, consequently the task was more important than the process and the opportunity was lost for nurses to learn how to manage without ‘standing outside’ nursing. The skills learned as a nurse are as applicable to the nurse who manages, as they are to the nurse teacher or the specialist nurse. Nurses who remove themselves from nursing are often regarded by nurses as ‘them' and not 'us’ - loosely translated as ‘the management’, or 'the College'. The fieldwork in Part Two of this thesis brings to the surface these dilemmas for nurses who manage and nurses who teach.

Coping with Conflicting Agendas

The two articles above (Kavanagh 1989 and Liberatore 1988) are representative of some of the effort that is being made to encourage nurses to be open about the stress they encounter in their work, to share this and find ways of working that will increase positive outcomes. Both writers have produced some valuable information that informs the ways in which nurses conduct their lives. Two major issues are surfaced. The first is that nurses look for peer support and appraisal both in and out of the work place, and the second is that nurses are unable to disclose and work together when other agendas are not made overt.

The first issue is about the culture and climate of institutions and the powerlessness nurses feel in changing this. Again this is about being in a gendered occupation and often personally invisible. The second is about managing the environment and supporting each other to solve problems affecting the way nurses manage nursing care. There is an energy, and sometimes an imperative among nurses, to solve the problems facing the organisation and the profession. Conflict is often experienced when the demands of the profession for change are in opposition to the demands of the organisation for stability. If the focus is only on problems as they arise, and the power base is left unchanged, then nurses are unable to lead the change. They can only influence when opportunities arise.

It is also important to note that nurses attend meetings with the 'voices' of others more dominant than their own. Often nurses they do not speak on their own behalf but are charged with the wishes and concerns of others. In this kind of setting the voice of the individual nurse is rarely heard unless she/he is within a peer group committed to personal and professional support. Meetings held within the organisation to solve organisational problems tend to focus on 'safe issues' where the cultural norms can continue to operate. Unless there is agreement to create a different agenda, where trust and openness is affirmed and nurtured, disclosure about individual experience will not occur.

Nurses, as they work with their patients, are able to demonstrate their interpersonal skills and knowledge. They are able to facilitate disclosure in order to find new and powerful solutions to difficult personal and interpersonal problems. The ability to engage at this level of skill does not necessarily transfer to interactions with other colleagues or the wider organisation. There is obviously the potential for this to happen, however the context in which health care occurs does not generally foster it. The risks attached to being open and honest about what one thinks and does results in nurses, in particular, taking a guarded approach to protect their own vulnerability.

Creating a climate of trust, a place to acknowledge and express powerful emotions, and to resolve differences, is in its infancy in the organisations where nurses work. As Marshall states-

> "Unless the total system changes, adaptive coping at one level typically increases experienced stress at the other----stress is 'in the system' and cannot meaningfully be attributed to any one

> part of it alone. Stress is a system characteristic, even though it is primarily expressed through individual experience."(p 282)

If this is to be taken seriously, then nurses will need to develop their roles as clinicians, teachers and managers in ways that modify the organisation and thereby influence the way others perceive nursing. For nurses to confidently practise their professional caring role it is necessary that the colleagues they work with support this role.

Conclusions

This chapter has provided a review of nursing from the writings of expert nurses, other social scientists who have studied nurses and nursing, and my own thoughts and experiences. Much of the research and preparation for this chapter was developed as I participated in the two field work groups. Therefore it provides a background for understanding the way I and my nursing peers managed the fieldwork in Parts Two and Three.

The next chapter gives an account of the research methodologies I considered and then pursued because they seemed to be compatible with my understanding of nursing. They also gave a stronger frame to my intentions to develop an inquiry group.