Chapter Five

Introduction

This chapter presents the first phase of group work and with in this the 'thinking' focus of research for each co-researcher/co-subject. The main components of this chapter are:

- The dialogue which highlights common issues and group decisions;
- My reflections and comments during the group sessions
- My reflection and analysis about the research progress and group development.

The Joining Phase

This phase includes two group sessions of each of two hours. The first session seeks to clarifying the research purpose and foster some sense of group cohesion. The second session opens up ideas and experiences about nursing and being a nurse, and establishes a way of working as a group. My central concern was to raise the activity level so that both task and process were addressed with energy. As facilitator, my intention was to be alert to the contributions each person made and the degree to which members were able to resonate with the research methodology. My aim was to give information and a sense of direction without being too directive This involved keeping an interactional orientation and an alertness to opportunities that allowed clarification of the task. At the end of each group session I employed the Interactional Tool (Pfeiffer and Jones 1977) to review the group process. The group members made a commitment to recording their own research activities between each group session. It was clear to me then that we were keen to encounter the world of work, and to test out the issues that concerned us. Paying attention to 'critical incidents' [issues that gained attention because of the possibility of negative outcomes if an appropriate response is not made] and using action and reflection to notice personal interactions and decision making, became the stated intention as the joining phase developed and ideas were tested out for significance.

The two groups were held in a comfortable venue with refreshments available. The first ten minutes were taken up with social interactions about work, home, and world events. I moved the group into the group process as the initial energy level subsided and attention became focused on beginning the group process. We began with each member providing a statement about their concerns and expectations for the first session, and I framed the introductory question in terms of feeling comfortable together, and having some clarity of purpose. I re-affirmed that being a nurse and nursing was central to the research purpose and individual experiences the source of information. The following tasks emerged from this introductory information sharing:

- to clarify the research purpose and methodology;
- to share the ideas about workplace activities between the group sessions.

I welcomed this clarity and presented once again the research purpose and methodology and then encouraged a discussion. The key points presented and discussed were:

- It is a personal journey, it brings about change, it has cycles of reflection and action and a research cycle of thinking, project, encounter, and sense making;
- This kind of research leans on ways of knowing that resonate with the nursing process and peer appraisal;
- It is important to adapt the research tools to suit the way each person works;

- Nothing that we do should be excluded because we think it 'might not be nursing' being open to noticing experiences is the key to locating the data.

Developing a 'life' as a group gained attention at the beginning of the group work, and the co-subject role in the work place was questioned and debated. A sense of stability gradually emerged and this set the scene for the dialogue to focus on testing out personal experiences of being a nurse. The following dialogue illustrates the key issues that arose, beginning with a discussion about the use of the research tools, then opening up into issues of:

- Developing the life of the group;
- Power and powerlessness;
- The meaning of nursing for nurses;
- Critical incidents in the lives of nurses.

I have not identified individuals within the dialogue unless they present a significant issue that requires 'tracking'. This is because the data selected represents ideas that gained focus for a considerable time, or were visited on several occasions. At times I have linked issues together to provide an ease of reading. I do not believe this has altered the sense of the dialogue as originally spoken.

My voice is in *italics* the group members [GM]in - body text and my comments and ideas at the time are in [text]. **If the voice of a particular group member is identified a pseudonym is used**

Dialogue

Using the Research Tools

GM-What I really imagined was that we would do what we normally do, but be more attentive, paying more attention, so that you can describe it more freshly.

GM-But being more attentive to it, does not necessarily mean that you will do things the way you normally do, does it?

> This opens up general discussion about what it meant to pay attention to one's own actions in the midst of action. There was a general enthusiasm to try it out. However, I was concerned that people should not be restricted at this point and that divergence was important. I was physically and emotionally cued in to watch for any closure and it came

GM-You said that we as a group would agree on a topic or something to look at. Is that what we are going to do? Decide on something like dealing with relatives, or some activity and then concentrate on that?

The research model does not require a single choice of focus, we don't have to do everything the same. We just have to agree about the next step of taking the research ideas into our work place, and then making a decision about what activity each of us will pay attention to.

GM-So as a group we could decide to do different things?

Yes, but it should be part of your work because it is about reflection in action, so we need to teach ourselves to reflect while we are acting, as well as reflecting afterwards and before.

GM - And if we went out there and found it difficult, could we then bring it back to the group and talk about it?

GM - Yes we need to pay attention to what happens to us as individuals and as a group. What happens between us is as important as what happens to us at work.

> The conversation involved a few more people before changing focus. My intention was to link the research in the work place with the work in the group so that eventually a flow of information and activity would develop between the group and the work context.
>
> I felt that this piece of interaction had helped to clarify the action and reflection that was needed to produce the data, and to give us a group focus for talking about our work, and the contexts in which this work takes place.

Developing the 'Life' of the group

> We then went on to discuss the way we would work together as a group. Members were testing out possible ways of relating to each other and what might, or might not be acceptable within the group context. At this point conversation flowed quite easily. However, conflict arose for the first time and is important to record because it exposes the group process, issues within nursing, and the validity of this kind of research.
>
> It began with the question about the sense of togetherness in groups and how that can be achieved. One of the group members had commented on feeling more relaxed and together as a group. Thus the next statement cut across the open supportiveness that had begun to develop.

GM-It might look like we're together but deep down there is an amazing, well not divisions, but people aren't really together.

> I noticed at this point the focus of this statement was not the group but personal experience, it seemed to be about not trusting the appearance of trust or the word trust.

---It is a fact that we find it very difficult being in a group, we can't actually keep up.

> This seems personal and is 'short hand' for some feeling state.

---I think that whatever meeting I go to in my life there are stages that I cannot keep up, my attention comes backwards and forwards and in and out of it. That sense of togetherness is actually fairly unique and doesn't happen that often. It's nice to think that it does and that we make some consensus decisions. I would suggest that the majority say that is a good idea [the topic] because they are with it, but there are other people who will go away and say "I wasn't really agreeing with any of that", and it's this sense of- "Is there any togetherness in our lives or how do we get this togetherness together?.

> There were several levels of communication going on at the same time in this statement. I observed members showing differing non-verbal responses all with some degree of withdrawal. I noted that this 'cutting across' the simple statement of 'being a group' with a really complex set of ideas, felt like a challenge. Maybe it was aimed at my leadership, or the sincerity of the people in the room, or something else. I chose not to inquire. As I simultaneously tracked my own thinking and paid attention to the group, I noticed the tension rise and the energy ebbed as eyes were lowered and people moved back in their seats. I let some silence pass and then I responded,

My first response to you is that those sorts of questions are part of the ways in which we need to validate some of the ideas that we generate. ----The other side of your question is about how much we are a group here, and how much we are individuals?

> I then follow with a short statement about my understanding of what we bring to groups and who we are in different groups. I wanted to open up the opportunity for a discussion about work groups. This opened the way for others to participate

GM-I think groups come much more together as they work together. When we are apart we are not a group, and when we are here we are not necessarily together. But if we go on working together, and if we develop more empathy, then the group will be more together.

> Some more comments were made about personal understandings about groups and group work and then the initiator of the challenge to group cohesiveness brought another dilemma into the group.

GM- Quite often teams are reaching the wrong sorts of goals i.e. we're actually together because we're very good at generating conflict amongst ourselves, but that's not the intention of a group working together. If we know what we are expected to be doing as a group we're much more likely to do it. What you [referring to me] are saying is that maybe it is the process we need to look at, but for me if we know what we actually are supposed to do, we feel much more confident about it because we are more likely to succeed.

> I noted that conflict, goals, success and clear outcome measures, were surfaced in this statement, a preference for tasks. I did not need to respond as there was no silence this time.

GM- But is it not a good idea for us to identify what we're going to do and how we're going to do it? Both are important to me.

> Without making or allowing further comment the original speaker went back to his concern about togetherness

GM- All of us deep down have this fear and panic about togetherness. One of the essential reasons why we panic about it is because we're not quite sure what the goal is.

> I noted my own tension rising and a clear sense that I was being challenged about the priorities between task and process, Another member took up the challenge.

GM - I personally do not agree with you Neil because I don't feel panicky at all, intrigued because it's unique and it's never been done before, I've never done it. It's a process we can go through where we can all learn. Panic does not really come into it. A feeling of doubt perhaps about my own ability to do what is required of me, but then we can decide as a group what is comfortable for each other.

> Others took the initiative and I had time to consider my position on what had been said, keeping in mind that this was the first group and my role was to ensure that all the members felt heard and engaged. I did not intend to test out too directly at this point. Finally the interaction slowed and I decided to use the opportunity to affirm divergence.

I think this is a healthy challenge to us as a group and I would like to tell you what I am thinking. I am pondering whether we create a group that can achieve what we are all wanting to achieve. That is becoming researchers and learning about ourselves and our work in a very positive way, and affirming and maintaining our differences?

> A lively discussion began about the importance of being different without feeling outside the group. One member commented on feeling outside the group because several members in the room had worked together, and three members still did. We then discussed how we would test out our own ideas about what we did as nurses using an action and reflection model.

Power and Powerlessness

> The next dialogue occurred during second session. The first extract is a centred around the issue of working with other disciplines, particularly doctors.

GM-I think one of the things I agreed to do was to reflect on the issues that arise when I try to negotiate with members of other disciplines.

This is a nurse manager negotiating with general practitioners.

----I think the only interpersonal skill I had to adopt was not to say too much. I had to stop myself leading into any discussion that may lead on to argument.

This led to an inquiry about what was meant by "an argument" and why it needed to be avoided, Other members shared their difficulties in working with general practitioners particularly when it involved allocating nursing resources. It was agreed that the use of power was a concern in this relationship.

A natural pause occurred and a group member picked up the theme. I noticed that it was easier to allow silences because members of the group seemed to be more comfortable with picking up the issue, or introduce a new one.

The next dialogue was more about powerlessness and the feelings and emotions attached to being vulnerable and not 'in charge' of ones own future. Or unable to relieve the discomfort of others.

GM -I thought I would like to concentrate on an interaction that causes difficulty--

A pregnant pause - the speaker is a senior tutor that has been through a very traumatic time of watching the nursing school diminish with no real personal future security.

---I was going home yesterday and I realised that the experiences I have had in the department have been very powerful and very painful.

This was the first time that a group member had introduced personal pain and nurses not being able to take care of each other.

The speaker was encouraged to talk about the changes that had occurred, and the insecurity and conflicts that arose as jobs were redefined, and people who had worked in teams together had to compete with each other. The issue of change, and nurses being powerless to manage this in a positive and proactive way was affirmed. Others members produced examples of situations that held the same sense of being at the mercy of another's will. However one member presented a story about changes that seemed to be more proactive

GM-Since the last time we met I have had one or two experiences that have made me aware that I am actually handling situations in a totally reverse way from the way I was handling them, say five or even two years ago. I tend to confront where I used to be more tentative, and be more subtle where I use to be aggressive.

This begins a story about managing teams in the community and brings to the surface issues about developing interpersonal skills that encourage positive relationships. An open discussion about the changes in styles of work that occur when nurses move to a management position, follows this story. People who have management responsibilities share their ideas about facilitating the work of other nurses and being accountable for the management of a service. This open discussion involves some of the more silent members.

The next speaker had said very little until this point. However she contributed with energy and enthusiasm as she talked about the hospital services she was responsible for.

GM-I like to try and discuss with people and change attitudes by agreement, but I was so fed up the other day with a situation where the client was suffering physically. In the end I told the staff that this was the way it had to be done, and felt very uncomfortable afterwards.

GM-That's interesting because in a completely different setting there is someone who has actually insisted that I do something, and that has put me in a very difficult position because I do not think that she has the authority to tell me what to do.

> This is a community hospital manager who is in conflict with the new District Manager, about how the serviced should be managed. I realise that all these issues are about power or powerlessness and are played out in very close ongoing relationships.

GM-But relationships are both ways aren't they, because you neither want to be telling or be told what to do. Particularly when it affects clients and colleagues.

> The conversation continues to circle around power and powerlessness with out actually naming it.

GM-It's funny this conversation has taken me back to when I was a charge nurse doing student reports----I really hated denying the student the right to move on and it was a real struggle because I did not want to use the authority I was meant to have.

> This statement seems to connect with the kind of 'unfair' authority that is being used to decide the future of teachers like herself. I chose not to raise the relationship but follow the theme as it emerged - authority that gives power to harm another is not welcome.

GM- For me the issue is about knowing the criteria for judging somebody and being sure that the student understands isn't it?.

> This is logic but does not acknowledge the context in which authority and power is located.

GM -That's the logic of it, but it is the intuitive side, the feeling side that gets in the way.

What do you mean?

GM-Well you knew that you were going to upset the person, and that you could destroy their future. The problem is, although you have the criteria you can never be really sure. There is always that doubt about the whether the decision is justified.

GM -One of the things that is thrown at nurses is that nurses do not want to be out of favour and that is why they do not make important decisions. I think it is about whether you can be sure that this person is not capable.

GM -But I think it is about wanting people to succeed and wanting people to do well.

GM -Well it is interesting because it raises for me the whole question of ownership of power.

> This is the same person who challenged group cohesion and he is now ‘naming’ power.

GM - ----You may be exercising authority there, but you may not feel that you are fully involved, and really have the power to shape the situation so that it is satisfactory to you. So really you may have felt more able to exercise that authority if you had been part of the process from the very beginning. The question that comes to my mind is, On whose behalf are you acting, and do you truly take ownership of what you are doing?

> There is silence and I test to see if the concept could be taken further.

-Yes a lot of it is actually acting under other people's power. A considerable amount of the nurse's power is delegated power from the doctor or administrators.

This is a new dimension and I notice the energy flowing more freely as people engage around the issues of power and powerlessness

GM -Yes a lot of what I do is not from a position of power, it is personal power or power from others.

This person is owning their use of power however the challenge is not taken up but a connection is made with a familiar ideas about nurses and nursing.

GM -I certainly think that nurses are socialised into behaving passively. It is quite clear to me that this is a trait that grows as time goes by. People entering nursing do not start out passively. I do not think they are picked because they are passive, but I think it is something that grows.

This is the member who began the discourse on power by discussing the changes in the school of nursing. The field of focus has widened to include the wider context of the organisation and the role of nurses in maintaining the institutional culture. Is this a more liberating analysis? I asked myself at that time.

GM - It is not really that people have power over you, it is just that their power encroaches.

GM - But that is still power over because if they can wield power that stops you doing what you need to do, then it is power over isn't it?

This interaction only involves a few members, and while I am pondering over whether I should try to slow the pace down, and bring in one of the quieter members of the group, another member interjects.

GM - Ann we rode over your comment what was it you were trying to say?

GM -It was the thing about people being passive and passive people being nurses. I was thinking about the use of power, and how personalities use power, and how people respond to situations where they feel dis-empowered. Like having to follow instructions and not interpreting those instructions whether they agree or not. It seems to me that nurses don't necessarily follow through instructions in the way that they were written. They put their own interpretation on it in order to exercise their own power and authority.

But it is not overt is it? In some ways whether we are passive or pacified we do not usually address the situation directly.

My intention is to test whether members feel they have any real choice about how they cope with situations that are power related.

GM -No being active and authoritarian isn't a useful trait for nurses. If you are powerful with your patients you end up with a passive unhappy and more ill patient, so maybe non authoritarian nurses are better for patients.

I notice the shift in focus to the nurse patient relationship and how that, in some way, determines how nurses manage their own power. I decide to shift the focus from power per se and test out another frame.

Doesn't it go beyond individuals? Isn't it about being given the responsibility to do things but not the authority to do it well?

GM - So it is not just about personalities and personal issues, it is about the structures that we work in?

GM - Yes, I think so. I was just toying with the notion that it is powerful to be passive, but voluntarily facilitative. You have to be very confident to sit back and allow other people to be what they want to

be, and to feel that you can live with the consequences of that. I know when I am most offensive and active is when I am feeling most vulnerable, and least competent. I react aggressively to hide it.

> The focus on the organisation as the context for feeling powerless seems to have provided a space for sharing vulnerability and ways of coping with interpersonal stress. There is an acknowledgement that nurses behave in ways that give inaccurate messages.
>
> This led into a discussion about how much we express our feelings honestly and in what settings it is possible. There were some comments about needing groups of friends and colleagues to be able to 'let go' with, and some comments about not being able to trust people with ones weaknesses.
>
> The focus then moved to the difficulties in managing nursing in a climate of continuous change. The dialogue was between three members and I noticed that other members seemed to be passively listening. I decided to invite one of the listening members to talk about her position because she had just given up a management post. I was also aware that illness was a significant factor in the job change.

The meaning of nursing for nurses

Julie, you have been in that situation in the past and you chose to leave . Is it very different for you now?

GM -I am very isolated at work, it is a new job and I am working away on my own. I always thought that nursing was working with people on the ward, but in this job I could actually lock myself away and no one would notice. I did not think nursing was ever going to be like that for me.

> Julie goes on to tell a short story containing many of the anxieties that GM's have covertly expressed about moving away from 'hands on' care.

GM - I was having a conversation with one of the business Managers the other day and explaining to him that I was a Clinical Practice Development nurse. He said, "Oh are you a nurse?" I took a breath before I answered, and then I felt I had to justify myself. Afterwards I thought "Why am I doing this? Am I really a nurse?" I always thought of nursing as 'hands on' care for people who were sick.

> I had taken a risk inviting someone to talk and I was re-assured when it opened up an important issue that was shared by others. The remark caused a great discussion about what nursing really was. Ideas ranged from 'hands on care' to a wide range of things that nurses do. When the interaction had widened and then centred around the core ideas of, 'activities that promote, facilitate or provide the care that people need to move towards health' I sought some closure.

It seems that we could discuss for a long time and not really feel completely satisfied. Perhaps we should keep our minds open to accepting that nursing is what nurses do. Then, when we have brought together enough information we may be able to find some common threads in all our various activities and roles.

> After some more discussion it was agreed that to keep the concept of nursing open would be more in keeping with a research perspective. The focus then moved to presenting critical incidents from our personal records and rememberings.

Critical Incidents

GM -I have got two situations I would like to illustrate. I can't really call them critical incidents because they keep on recurring. Although I do have strong feelings when they occur. It is about wanting to collaborating with patients and families and other team members, and working with clients

where my power and authority seems to act against the client wishes This is because the client is wanting to do something illegal.

> This statement created a very lively discussion about how much we tended to respond to demand and how much we made judgements about need. It also brought out the difficulty nurses feel when they have power that is delegated by doctors and is therefore dependent on medical decisions and judgements.

GM -That is very similar to my dilemma. I want to work alongside people and make decisions collectively, and collaboratively, but I do not want to get into power games.

> The discussion then moved to issues about managing people. The previous speaker then presented his second critical incident which was about being able to delegate to less skilled team members.

GM - I really want to work with people in a team, so I set up these meetings in the morning with my little team to discuss nursing care planning. I thought that the nurses would come up with the problems that patients have, and then we would all bring in our ideas and find solutions. It wasn't at all like that. I didn't realise how complicated these clients are (drug addicts) and how inexperienced the nurses were. I ended up by telling them what to do and that did not feel very good at all.

GM - That happened to me too. But my situation was a bit different because I did not have the time to explain and help the nurses through some of the possible difficulties. It always leaves me feeling 'run off my feet' and guilty because I have not been really helpful.

GM - I just feel a bit hopeless about it all. There is a real sense of being responsible but also knowing you can't do every thing.

> This focus held attention for some considerable time. The conflict between being responsible and wanting others to be competent was echoed across the group. There was a real sense of not knowing the best way to encourage competence in more inexperienced nurses because it can't be 'told' in straightforward ways.

Interpretations and Reflections

My interpretations and reflections are centred on my role as a facilitator of both the group development and the unfolding of the research process. Of necessity I will also reflect on my own experiences and the decisions I made for action and in action during the group process. To make a circular and interwoven process simpler to understand I will present this section under four headings:

- The group development
- The research process
- My personal responses and actions
- Issues that need to be held aside for further information

I would like to begin with group development because it caught most of my energy during the group sessions. It is also important to the research process, because this methodology relies on members of the group being able to share ideas, and work together in an authentic way.

The group development

My thoughts and interventions at the beginning of this phase were more interaction oriented than task oriented. I encouraged the group members to voice there ideas and concerns before making an intervention myself. I did not allow tension to continue very long before using an intervention that

would have a good chance of increasing cohesion. I observed an emerging pattern of changing focus and energy as the group moved through engagement, focused activity, and disengagement. At the conclusion of each session group members reflected on their own experiences. We did not question each other about our contributions to the group task or process. In the second group session further risks were taken by some members in presenting interactions that had the potential for conflict and/or strong feelings. I was aware of the risk, but I did not comment openly because there was acceptance and sufficient support to keep the interaction flowing between more than two members. Once these interactions faded I tended to be active in encouraging new topics, or making connections between one topic and another.

Non verbal communication was more actively used and received and subgroups emerged, providing affirmation and support. I considered that the group had established a way of working that encouraged an exploration of ideas and self exposure. However, because some members remained silent for the central part of the group, I raised my concerns during the final feedback session. I asked the group as a whole what being 'non-verbal' meant as a way of communicating. The ‘silent’ members were able to state their positions quite confidently e.g.

GM - Sometimes I have something I would like to say and someone else says it. Then I sit back and listen to the conversation.

GM - It is encouraging to hear some one say the things I have been thinking.

GM - I need some time to work out what my ideas are and what are some one else's.

GM - I do not know people very well. I need to wait until I feel I know where people are in relation to me.

There was some discussion during this feedback. This led to an acceptance that people made choices about actively participating or not.

The research process

The research focus for the first group was to engage in 'thinking' about what we do as nurses, and what we need from each other to explore our nursing practice. We agreed that much of this thinking arose out of 'being’ and experiencing our own feelings, ideas and energies. My role was to encourage ideas to be expressed, questions to be asked, and information to flow. The first session set the scene for thinking about the research and the ideas and practical possibilities that might be appropriate to pursue. I used opportunities to link ideas about research with actually clinical activities. The skills of reflection in action and for action were discussed and practised, and there was a high degree of energy around seeking out the issues important to nurses and nursing. I found, on reflection, that these issues ranged from actual experiences of conflict, to looking at the influence that the organisation might have on nursing. I found the level of thinking and discussing deepened as possibilities were generated that complimented ‘beginning’ ideas.

I started to create a bridge between the group process, and the research development, by probing and testing out ideas that related to activity within the group and the work place. It appeared to me that issues were emerging that gave nurses choices about their role and the way they might address some of the incongruities within it. These choices held within them potential for conflict and anxiety. Not being clear about what one actually does, and needing to be seen to act responsibly, has advantages as well as disadvantages.

My personal responses and actions

Four issues gained importance during this first stage of the research cycle. They were:

- a stated commitment by members to working on the research project;

- ways of working and interacting that maybe gendered;
- managing the research boundaries within a group context;
- challenges to the group cohesion and leadership.

These issues deserve some comment because they provided a marker for taking both the group and the research forward. Very briefly I will present my personal responses and actions in relationship to each,

Stated commitment by members to work on the research project

At the beginning of the first group meeting I was anxious about whether members of the group were participating out of loyalty to me, or because they were genuinely interested in this way of researching. I felt a sense of relief when members demonstrate a keen interest in the principles of the research and stated their enthusiasm about being a member of the group for their own sake. I have reflected about this sense of obligation versus seeking experience and knowledge. Although I know that some of my colleagues are concerned to support me in the things I do, in retrospect I am convinced that this reciprocal support is part of being a nurse. Being able to rely on other nurses for support is part of belonging to a wider community of people who understand the issues of one's working life.

Ways of working that maybe gendered

Three different aspects of group interaction contained a sense of genderedness for me. The first was a questioning about group cohesion. This arose when a quieter member of the group mentioned that they felt a sense of belonging in the group. The challenge was by one of the men in the group who presented a doubting stance. His intervention could be seen as a useful test of the group and the research process. However, it silenced verbal interaction between members and raised the non verbal. there was no direct response to either the content, or the possible messages within the challenge. The second was the a challenge to my bid to pay attention to the group process in order to provide a climate of trust and risk-taking. Again the member concerned presented an alternative agenda, one that emphasised task and goal. The rationale seemed to be the need to know, absolutely clearly, what is to be achieve in order to be successful. Group members responded to this bid for certainty by using interactions aimed at harmony and cohesion. The third issue was about the use of power. This issue was pursued from different perspectives but illustrated a common dilemma of feeling powerless even when power was delegated, or a part of status. With this issue it was the quality of the power that seemed to be unacceptable. People did not express power as instrumental in liberating self or others, but rather a burden or a dubious asset.

Each of these issues could be viewed from a gender stance, process and cohesiveness are aspects of the feminine. Not wanting to stand out as having power over others is also about a feminine stance of being a part of, rather than apart from. These issues will be revisited as each research cycle unfolds. I will also consider the role of gender and power as they relate to life strategies in chapter ten.

Managing the research boundaries within a group context.

Boundaries around the research question arose when it was suggested that the 'research would be more interesting if it was about working in organisations, rather than nursing. At the time I thought,

> "Yes I have considered that in some detail and have put it aside. The main focus of my attention is the nurses role and the function of nursing within the organisation. Clearly the organisation can be addressed as a context that influences the way nursing is practised."

I realised that the context in which nursing is practised is changing. Therefore the way nurses cope with this change and support each other is important to the research questions. My assessment was that if the boundaries were not made clear in the beginning stages of the research, then I might get swamped with the needs of others, and the complexity of the data gathered. I was also aware that researching my own nursing role was important to me. Therefore I did not want to get submerged under a plethora of other possibilities. I did want to maintain my focus.

Challenges to the group cohesion and leadership.

Throughout the group session I took a facilitative role and others responded to me as leader. I noticed that people settled down quite quickly when I suggested that we begin the session and although most of the dialogue was directed at me, this was not a problem at this stage in the group's life. It was my knowledge and ideas about what kind of involvement was possible and what I was expecting of them as co-researchers, that held me central.

The challenge occurred around the dilemma between making goals clear and outcomes predictable, and the need to keep the possibilities for surprises open so that new ideas and different ways of working emerged. I am aware that my style of leadership produces discomfort in people who need to have the task very clear before they can commit themselves. This is a dilemma that I have learnt to live with, and consider it to be part of the challenge when new ideas are being encouraged. I have become acquainted with the discomfort of managing chaos and know that I will feel the tension as others challenge this. Receiving challenges can be seen as a validating process. Being comfortable and sure of the future does not allow the unexpected to emerge. However I did not expect the challenge to come so soon and I 'felt' the impact before I was able to reason with myself. There was an added impact of surprise and anxiety because the challenge came from one of the few men in the group.

Issues that need to be held aside for further information

Some issues that were surfaced during these groups allowed the reflections and feelings that occurred for me at the time, to be recorded. However I realise that noticing when I participate in the research and when in the group process, was important to the continuing group development and data gathering. The key questions that need to be kept alive at the end of this first phase are:

- *how conflict is managed within the group;*
- *the role of gender in group interactions and decision making;*
- *how well I balance the tension between chaos and order.*

I intend to keep alert to situations that inform these questions with the aim of achieving some clarity by the final phase of this first research cycle

Issues that need to be held aside for further information

At the conclusion of this 'Joining Phase', I reflected on both the content and process of each group session and my own personal records. I decided to record some of my ideas to share with the members of the group for several reasons:

- To continue the process of developing a cohesive group by extending the dialogue into the working lives of us all;
- To begin the process of identifying the common issues;
- To encourage action and inquiry in the work context, by presenting questions, ideas and dilemmas;
- To practice being open with regard to my own thoughts and understandings about being a nurse and to invite feedback.

The issues that I chose to reflect back to the group concentrated on the task we had set ourselves, and did not cover any of my tensions anxieties or conflicts. At the time of writing I reflected about this and decided that dialogue within the group is more appropriate to opening up these feelings and issues. I also felt that there needed to be some agreement about how we would work through the more personal

ways of knowing and working together, rather than 'setting the pace' myself. I therefore focused on summarising some of the points that we covered. These were:

- Nurses are sometimes caught between taking on a role that places them in an authoritative position in relationship to the patient, and a role that allows a co-operative and collaborative relationship to develop;

- There is often conflict around responding to the cues as a nurse within a given context, and having a particular role of teacher, manager or health visitor within that context;

- Nurses often find themselves working hard to maintain a comfortable climate by looking after and supporting the needs of others, often without recognition, support or a sense of equality;

- Nurses who are managers fluctuate between being supportive and encouraging, and ensuring that confidence is addressed and the job gets done;

- Nursing hierarchies are often in conflict with the authority each nurse requires to do the job well.

- Nurses who manage people often do not have all the information and the decision making power to decide who can, and who can't, do the job of nursing.

This summary of my reflections included a message that I expected the next meeting to focus on developing a clear plan about the encounter phase of the research process, both within the group and in the workplace. This intervention was to punctuate the end of the 'joining phase' and the beginning of the 'working phase'.