Chapter Seven

Introduction

Before I begin to write about this Knowledge Seeking phase of group work, it is important I record the process that has brought me to this point. I have already made clear that this field work began in the first year of my studies and therefore should, and does, reflect changes in my own thinking and doing. This chapter more than any other, has required that I return to the original data. The meaning I made nearly two years ago, no longer makes sense. With the same purpose that was agreed with my fellow peers I have revisited the original data and extracted 'live' records that identify the issues and themes as I see them now. It is not so much a change of interpretation but rather a deeper sense of how the data speaks about the experiences we shared together and about nurses and nursing. In part this has been influenced by my realisation that setting up peer groups for support and appraisal is fraught with difficulty, and cuts a furrow across the way health care organisations regard the nurses role. [One could say that if it was easy then it would be happening quite freely!]

This knowledge seeking phase began at the point where the group members were ready to test out their own planned experiences. The three indicators that prompted me to move into the 'knowledge seeking phase' were:

- the enthusiasm to explore both personal and professional sense of self;
- the desire to use the tools of action and reflection;
- the ease with which most members were able to recognise work situations that represent aspects of nursing to be researched.

The central focus is the development of practical and experiential knowledge (Heron 1981) about nursing and being a nurse. This involved each member paying attention to particular issues at work, within themselves, and between each other. As co-subject and co-researcher, I participated fully by agreeing the issues and presenting my own personal experiences as part of each feedback session. During this phase group members requested time to tell their personal stories. All but three were given time. Some members developed support groups with their colleagues and peers in their own work setting.

Before the first group session I took some time to review the data available at that point and contemplate the possible paths that might unfold. I reviewed the research processes in terms of the patterns and ways of working that had emerged. I also assessed the group development in terms of meeting my initial criteria for a peer support and inquiry group. These criteria were:

- maintaining the balance between task and process;
- bringing into shared consciousness the tools of action and reflection;
- managing the issues of conflict, leadership, gender, trust, power and boundaries;
- establishing a pattern of working together that identified issues and themes.

I also added:-

- a healthy tension between security and vulnerability keeping in mind that support groups can stifle challenge and risk taking.

I then considered how I had coped with the conflict and leadership challenges and I acknowledged that although conflict had not prevented the group developing, there was unfinished business that I needed to address at some point. My intuition encouraged me to wait until the interaction between members was more of a 'risk taking nature' and then take up the challenge in a more direct way. I was not sure how confident I was in defining the difference between challenges to the research methodology and challenges to this style of learning. Somehow I needed to inquire into the concern within a challenge. Whether it is the difficulty in holding ideas aside to discover new ones, or whether it is about seeking grounded knowledge that is derived from practice, or something else. I expected group members to take a more assertive stance in pursuing ideas and issues. Therefore, as facilitator, I would need to pay attention to when I intervened as a facilitator and when as a participant. It was clear that we needed to have some shared understanding about nursing practice, and how working together as a group might support that practice.

Having reviewed and clarified my own ideas and intentions. I decided that certain processes, tasks, and activities were important to encourage or notice. Therefore the following became a guide to my noticing and reflecting:

- affirming and noticing the patterns and style of working together as researchers and as a developing group by using the activities of sifting information, inquiring, noticing internal dialogue and agreeing similarities and differences ;
- encouraging members to take responsibility for task and process issues;
- maintaining the two main strands of personal journey and critical incidents to produce the data for identifying themes and issues;
- presenting my own personal experiences and taking risks to support others in doing the same. (I personally consider that risk taking is more likely to produce new knowledge because the outcome is not predictable and therefore can give rise the unexpected.)

I expected that patterns and themes, similarities and differences, and issues of validity would arise in this phase where inquiry is the medium for knowledge to develop.

The Knowledge Seeking Phase

This phase of the group work included four session over a time span of four months. Each session began with creating an agenda through clarifying the needs of participants and agreeing priorities. Feedback information was framed in ways that encouraged dialogue and active participation. This in turn fostered the testing and building of ideas. As we became more focused, so the issues about being a nurse became clearer.

At the beginning of each group session we tested out some of these ideas and by the end of this group phase we agreed that the following issues held a sense of importance.

- The anxiety that arose out of using the research methodology.
- Personal lives and feeling interpersonally competent.
- The genderedness of power relationships.

Coherence and authenticity as measures of validity. was woven into the total dialogue and emerged out of actions and reflections that raised anxiety as we recounted our thinking feeling and doing.]

The dialogue that follows is organised to focus on these agreed issues and is not in time sequence. I have used the same selection criteria as defined in chapter five.

My voice is in *italics* the group members [GM] in - body text and my comments and ideas at the time are in [text].

The anxiety that arose out of using the research methodology

The appropriateness of the methodology to nursing is a theme that runs through this first cycle of research. It becomes an issue through the use of tape recordings, reflective diaries, and the idea that nursing knowledge is grounded experience. This dialogue is focused on the use of the tape recorder as a research tool and raises issues that caused anxiety and conflict.

Dialogue

> [The group began with talking about the use of the audio-tapes for feedback, reflection and interpretation.]

GM - I listened to the tapes and it was fascinating to relive the experiences again. I have also written some reflections about the last day, I experienced quite a lot of emotions, especially when I reflected about what has happened in my life to make me what I am.

> This comment is made during the beginning round of ‘placing agendas in the middle’. Consequently I refrain from inquiring and the focus moves to the next speaker. Other members give their references to the last session and then the speaker continues.

GM - There were a few specific happenings that I could remember when I reflected on my life. When I listened to the tapes I recalled incidents through reliving and remembering them. I thought about how much I was willing to share these experiences. First I recalled only bad things, and I thought, "I can't bore people with that" and, “Am I really prepared to share the emotional things?” After I had listened for a while I began to recall the positive things. What I am prepared to share are the milestones, as long as the group is prepared to listen. I think it is going to be significant either way.

> There was general encouragement within the group. However, before the invitation to continue was made clear the use of tape recordings became the focus for surfacing a range of anxieties. The first concern was about people listening to the tape of a group they did not attend. There was some discussion about this, and about confidentiality. However the anxiety seemed to be about being misinterpreted.

GM - .I had that anxiety last time, and although I think it is OK that people listen, I want to be able to say no if it is really important to me.

I have been thinking about that possibility . What would make you want to say no?

> I realised that this was an important issue, and I had a sense that for others hearing ones ‘voice’, had wider connotations. The speaker voiced various situations where it might be a difficulty and then finished with--

GM - There is nothing I can really put my finger on it is just knowing I can say no.

GM - I think it is all right for people to hear because we will know more about what we really think if we can comment openly and know that others respect this.

> There was a pause after this statement and then a few nods around the room. I then moved away from group process and made a link with managing the research process.

GM - I think the tapes are an essential part of the research process because they capture much more of the dialogue than any of us can remember.

GM - Yes, I would agree with you on two counts. The first is the importance of having a second view of the situation that we have been through, and the second is about who comes. If people do not have an opportunity to listen to the tapes they will become more and more isolated from what is happening. Then they won't feel that they can have an input into future meetings.

> This led into changes in interpretation from being in the situation and then listening again and again and possibly interpreting differently.

GM - The fact that some of us are sitting here instead of the whole group alters the way you feel and the way you think.

GM - That always happens where ever you are---

GM - Even at work there is no possibility that everyone can be present when an issue is discussed.

GM - I think a tape recording is better than relying on others opinions. At least you hear everything that is said.

> I was aware of the energy flowing, and realised that there was more than confidentiality, and tape recorders, being discussed. There were issues about decisions being made without everyone present and statements recorded and perhaps used against you. I suspected there was another hidden agenda, the fear of being wrong and held to account. Whilst I was reflecting on these issues I realised that much of my thinking was from my own experiences and my understandings about the way gender operates in organisations. While I am reflecting on the implications of this the conversation moves on.

GM - For instance, myself and Susan may violently disagree about something. If you asked us week by week about that interaction, both of us would shift our perspective in the light of new experiences. Even if it was on tape. Additional information, plus our ability to sift, filter and place that information appropriately, makes it different. So it may start off as a series of ideas that are not really very important and by reworking, becomes a much stronger idea.

> This statement was being presented in a confrontational tone but I listened and heard a logic worth pursuing. However I did not respond at this time but, on reflection now, it was quite prophetic. This person was the subject of the conflict I revisit in chapter twelve, and made sense of in terms of the issues facing nursing.

> The conversation moves backwards and forwards through the value of sharing with everyone and learning to trust each other; to the discomfort of being miss-interpreted or just hearing oneself on tape. As the dialogue becomes more personal conflict arises and one member takes the focus away from acknowledging personal feelings, to a more abstract point of view. This is counteracted with a challenge to acknowledge the feelings that accompany the interaction and not destroy it by analysis.

GM - Yes, but what if you press the tape and you hear the interaction, and the feelings that accompanied that are re-experienced? It is only when you start articulating those feelings that you get a different perspective.

GM - That's what this kind of research is about isn't it?- hearing someone else's point of view and being able to shift your own through rethinking and feeling.

It's being open to that.

GM - I am just wondering what is the point of all that if you are just shifting all the time?

> This is a person who is involved in ethnographic studies for her PhD and is beginning to doubt her own research methodology.

What are you getting at?

I think I am thinking from a research point of view. If things are always shifting what are you going to present?

> I had to stop and think at this point. Firstly about the kind of research that she was involved in. I did not want to cut across it. Secondly because at that point I was feeling overwhelmed by differing points of view and levels of communication. Eventually I gave a bland response about research being a journey and that 'looking back' I will probably make more sense of it. Others actively joined with this sense of change as the journey progresses.

GM - Any piece of research is a snap shot of what is happening at that time, however empirical it is, however hard and fast the rules.

> This was reassuring, but a statement rather than an inquiry, and brought a response from the original inquiry about presenting a coherent piece of research.

GM - Subject to your skills and abilities at that time. [Prophetic for me]

> This was followed by a testing discussion about what we really thought we were doing, and how all the different things that we were presenting could make any sense at all. I decided to re-affirm the focus and give my point of view.

If we, as a group of nurses, feel that in talking out the issues in this setting we can actually support each other in a way that helps us provide a good nursing service, then we have achieved the initial goal. If in sharing ideas and personal issues we become clearer about the strengths and abilities we have to be people and nurses this should also reflect out ability to listen to each other, shift our perspective, and develop a clearer sense of what nursing is for us. So I think that recording what we do and say, in this setting, is about who and what we are as nurses individually and collectively. That is what this research is about for me.

GM - If we can talk about differences of interpretation here, then may be that will give us strengths to confront some of the difficulties at work. But we need to test it out by being honest and open with each other, or it won't be of any use.

> This idea seemed to release the concern that underpinned the discussion about the use of tape recorders. A discussion ensued making mention of a confrontation that occurred in a previous group when one of the key members involved in the confrontation was not present. As follows----

GM - Listening to the last tape one thing that I was quite uncomfortable about was talking about Colin who was not actually present. I wondered Colin, what you felt about what I said on the tape? [This intervention is directed at Colin.]

GM - Tell me more. I am not sure I remember that bit.

GM - It was the group before last when I felt you were speaking on behalf of Susan and me. Having discussed it at the time I felt we had a better understanding of it, but I did not check with you.

GM - I remember, I often feel discomfort when I place myself in a leadership position that I don't own, but I feel robust about making mistakes. Sometimes I am embarrassed but I get over that.

> The previous discussion had been about reporting back from small group work where Colin spoke for the group. This makes me very aware about how tentative nurses are about moving across boundaries or confronting the unspoken rules about discretion and ownership of ones own thinking.

[Other members of the group joined in this discussion, elaborating on what happened from their point of view.

GM - I remember, we did talk about being able to make mistakes and learning from them.

GM - I still have a tension about talking about other people, or naming people when they are not there. Although I think you are right we should be free to talk from our own point of view.

GM - I don't think we should speak for people, or make judgement about what people say, but I think I can speak for myself, and what I felt at the time without undermining anyone else's opinion.

GM - I think I can pick up on what you are saying. If I have a problem about it - if I am feeling angry or hurt then I think it is important to say it to the person concerned rather than somebody else. If you can't say it to the person it is probably better to say it to somebody that you can trust.

This is the person who brought up the issue in the beginning and she is stating that her analysis of the situation has changed. It is also an issue that is not usually addressed i.e. What does one do with strong feelings that cannot be reflected back to those primarily involved? Is this a move towards being more honest with each other and acknowledging that we need this kind of support to cope with containing emotions? My reflections are tentative and not verbalise. The focus again moved back to the initial concern.

GM - Yes I think it is the notion that it is being tape recorded and those people may or may not hear it, and by the time they do hear it the meaning of the dialogue is gone.

And then after you have listened to what you actually said -does it make it better or worse?

GM - Worse, because I don't know how it will be interpreted.

Perhaps we could test it out on the people who were not here last week and did listened to the tape. I am seeking closure at this point.

Colin - Personally it makes me feel better hearing others perspectives. It gives me more to bring to other situations

GM - Part of that is knowing you are not the only one that is having those difficulties, but also being able to increase you 'tool kit' about how to manage those difficulties

GM - I remember it coming up on the tape and it just reminded me of the original conversation. I did not know if Colin was at the last meeting, but it did not strike me as a problem like-"Oh I wonder why Colin is not answering." When my name was mentioned I pricked up my ears, but then I thought "That is the whole point of it. We are being taped" and I felt quite happy that it could be used in any way the group wanted to. It was a strange feeling hearing my name mentioned, but it didn't particularly worry me.

This is from one of the members who does a lot of listening and often brings ideas together to re-focus attention.

GM - It is such a funny feeling hearing yourself afterwards on the tape, it is bad enough here. I thought "Oh god why did I say those things" I felt a slight discomfort at revealing about my childhood because they are very private experiences, and I think- "well were they relevant really?" It does make me fell a bit uneasy when I hear it.

GM - But surely that is the whole point. If they are relevant to you, and they contribute to what you are now, then it is important to us as a group that you have trusted us and shared yourself.

> The above dialogue was a key aspect of this phase of the fieldwork and is presented as a way of providing the reader some insight into the concerns and discussions about the research tools and how this focus uncovered other anxieties and agendas. The use of reflection for action and in action was not brought up as a problem until the final 'sense making' phase.

Personal lives and feeling interpersonally competent

This dialogue involved members of the group presenting interpersonal and intrapersonal encounters as a focus for inquiring into self and others. One member took the initiative early in this phase to present his story and talked about his life as being very positive and happy. The focus was on people who had influenced his thinking and he used my presentation as a starting point. The main focus of his presentation was not about incidents or emotive issues but more about people who gave him a philosophical or intellectual understanding of life and ways of coping.

GM - I did a lot of work looking at my life, starting at the last meeting. I used the back of an envelop while you were telling your story. [This statement is directed at me and I am not sure what to make of it.] In some ways I felt tricked, and in some ways not, because everything went out of my head when you began to talk about your life experiences. I was really impressed about what you were able to recall. It made me want to look at my own life. My life has not been negative or very emotionally demanding. I wrote quotes that I remembered others had said and what others have said about me. There are six key people in my life who have influenced me personally or through reading.

> The speaker introduces the six people, and the focus is on the lives and writings of four gurus. The story begins at 18 years and the marriage break up at aged 25 is not seen as a significant event but as necessary for all concerned.
>
> There was silence after this presentation for some time. I did not break this because I was struggling to gain a perspective on what had been presented.

GM - Some of those things I would have expected and some not at all. People are surprises when you get to know them.

> This broke the silence and there was some surprise about the story starting at eighteen, and some comment about people feeling a little over-awed by the academic perspective and influence.

GM - I am feeling a bit overwhelmed by your knowledge, my reflections are all rather superficial. I am not familiar with all your references to philosophical readings.

GM - That is exactly how I felt last time - Everyone knows much more than I do. It was only after I did some reflecting that I realised - Yes I do!

GM - I felt that Neil's story was very high-powered and I have not thought of my life like that.

> There is a temptation here to see a difference between how women and men present their life stories. The story just presented was a man's and the responses are from women. At this point I am inclined to say it is gendered in perspective. I will explore this in Part Three.

GM - That's exactly how I felt when I went away last time- "Oh my goodness every one knows so much more than me. Hearing you reflect on that I began to realise that maybe that is not true at all.

What does that mean for you Jane?

> I had noticed that during the presentation this person had withdrawn and seemed to be engrossed in her own thoughts. I wanted to pursue the meaning of this silence.

GM - It was really just a flash that came through- 'This is all really high powered here, and I have never really thought and analysed myself in that depth. I couldn't relate it to my own emotions and feelings.

Isn't that something that we discussed last time about making sense of who you are through different pathways?

> My aim was to encourage Jane to continue so that an acceptance of different ways of being could be affirmed. Jane continued to talk about her own experiences during the previous session and the emotions that were stirred as she recalled her own childhood where bereavement figured strongly,

Jane- I am amazed I am talking like this and not crying- for me it is a great step forward

Did you go away last time with those feelings?-- and was it all right for you?

Jane- Yes because I was consciously using reflection in a positive way, I wasn't thinking in a negative way . Like "I really do not want to think about this because it will give me pain." It was more, "I really do want to think about this because I really do want to understand why I am who I am".

> This introduced a new aspect of 'personal self' and it seemed that the research tools consciously used can facilitate self reflection that resolves internal distress. The issue or revisiting difficult experiences is pursued.

Jane- I listened to your enjoyable childhood (Neil) and I realised that I had an enjoyable childhood too. But my mother was very sick and therefore I did not have a teenage time, I was never able to rebel. The house was always welcoming and my mother was always long-suffering and a wonderful role model to me. My father was a very generous man who always cared for others. Both my parents died when I was young, before I married, and I missed them terribly. That is why I feel so much pain when I talk about loss, and that is why I felt so much pain when I left. It was not a problem for me it was much more a therapeutic thing.

GM - Revisiting events and revisiting the emotions is important.

Jane- You can revisit events and you can revisit feelings, and sometimes you can do this together. I find it too traumatic to revisit both the emotions and the events at the same time. I need to create a safe space to work through emotional memories.

> This remark followed with a discussion about revisiting the past and rewriting it.
>
> The next group member decided to present his professional self through critical incidents at work.

Colin - I can acknowledge that family influence me more, but what happens in my professional life reflects the things that have formed me as a nurse. Duty is important to me.

> The focus of this presentation was on the nurses duty to manage the ward, not meet the needs of the patient, and if someone put the need of the patients first, then that raises the anxiety about what terrible things might happen.- This story was about how rules for safety prevented innovative things happening with patients. Safety was seen as paramount and the needs of patients very secondary.

Colin - Then one day I was assigned a very physically ill man to look after and I stayed with him all day. I learnt so much about nursing in that day, although it is quite possible that physically and mentally he had not changed. But for me that was real nursing and it gave me immense satisfaction. This gave me a different way of looking at the rules that make institutions 'safe' and prevent nurses from really being innovative and giving patients the care they need.

There were comments from others people about the difficulty in really responding to the needs of patients and being open about it. I noticed a recurring theme of not being able to say what nursing really was all about in the work situation where highly visible tasks are valued more than care and comfort. I struggled to respond effectively to the parallel text of being challenged, taking risks and the competing meanings of the organisational demands and the internal demand to respond the needs of others.

As you painted those two scenarios I felt a sense of freedom. Some how the way you managed the situation allowed you to do more than you had thought you could do before.

Colin - Yes, I gradually learnt that nursing is really being with patients, I learnt that emotionally when I looked after this very ill cardiac patient.

GM - I think it is something about seeing the possibility and taking an opportunity to stretch the boundaries

This opened up the conflict that nurses experience when competing demands are operating and several scenarios are presented by others. The focus then went back to life stories that connected with being caught in a conflict situation.

GM - I would do anything to avoid conflict or personal discomfort. I moved from the ward because of a conflict situation, plus personal problems. It took all the fight out of me. I remember one of the consultants saying "You have either got to fight or leave." I felt "Yes, you are right, get out and go into something else." If I had been prepared to face up to things, and face the conflict, perhaps it could have been different, but anything that meant anger I avoided.------ My mother said that "People who are prone to an illness avoid conflict like you, you go to your room and read."- I wish I could say my childhood was fun. But I had a sister who completely ruled the house and I just retreated more and more. [This story continues and ends with the speaker deciding to be a nurse]

------I tried for a job and didn't get it, I really wanted it and I didn't get it. I had to get an job and nursing was the last resort.

I was aware of this persons personal health problem and my response was with this in mind as well as the ideas of accepting difference.

All of us have our limitations, although I have rewritten my own history and chosen to see it more positively, there have been times when I have not wanted to face things. It seems to me that your story about standing up for your friend when you visited her in hospital was <u>not</u> avoiding conflict but seeking to resolve a real painful issue.

This refers back to a story that was presented in one of the previous sessions.

That was different, I was fighting for someone else. I can do that, but when it is just me and something or someone else, then that is different.

Others added their voices to the difference between fighting for others and fighting for oneself . Again there was a connection between being a nurse and striving to met the needs of others, rather than being assertive about one's own knowledge and experience. The discussion moved on to revisiting and rewriting our past as a way of facing conflict now.

GM - I can relate to that. When I was eighteen or nineteen, I would have said that I had a very unhappy childhood, I was a twin and not the favourite. But now I have revisited it I interpret it differently.

I needed to affirm this stance because I believe that it (revisiting the past and rewriting our history) has the potential to liberate individuals and nursing. We move on to incidents at work and stories about relationships in the work context.

In this section I have focused on the research methodology and particularly the use of the audio-tape to record group interactions and stories about action and reflection in the work place. Critical incidents and revisiting the past, provided the focus for exploring personal experience. I have found it difficult to manage this data in a way that makes sense, and does not flow over into subsequent categories. May aim has been to highlight issues affecting group development and the way we manage ourselves at work.

Power and powerlessness in relationships

The presence of power and powerlessness in our relationship at work have been overtly or covertly referred to throughout the group work to date. In this knowledge seeking phase I intend to make overt what I believe has been covert and to highlight occasions where it was discussed openly.

Dialogue

GM - Something really bugged me at work. It was someone taking extra annual leave days, and because I have the responsibility to manage the teams and the allocation of leave, it was really important to me that it was fair to everyone.

Here is an issue where one nurse has power over other nurses and is finding some difficulty in asserting that power. It is presented in terms of being fair and not necessarily obeying rules.

GM - So it is about 'if you allow it to be go on unnoticed you have been unfair?'

GM - Yes it is something about everyone pulling together and not being selfish.

Is it about teamwork?

Here I test out another frame for managing this power relationship. It is one that I feel comfortable with because it does not exclude the responsible person from being part of the group. This leads into a discussion about the value of teamwork in nursing and being fair to everyone. Then the focus moved to developing and maintaining relationships.

GM - Just about all the relationships in organisations, including the health system, are artificial. We do not really know the people we work with because we do not chose to work with them. More often than not they are forced on us. We make no attempt to unravel where they are coming from.

This is the same agenda that was brought up previously the issue about ‘togetherness’. I am interested to find out what the real issue is, I do not interrupt the flow of conversation.

GM - I do, [attempt to unravel people] I have to get to know people before I can work with them properly.

GM - It's much easier if you work in the lower level of the organisation because you have a smaller number of people to relate with on a fairly regular basis.

I consider-what research there is to inform this statement (the speaker is a man who values facts) I decide not to pursue this line but another.

But why don't you get to know the people you work with?

The response was about the complexity of the work and the number of people that "Do not really want to know you." I pursue it to test out whether there is a personal issue that is waiting to have 'air space'.

Who are the people that you would have the closest professional relationship with?

They are named and are the team that he is responsible for and other very senior nurses in the higher levels of the Health Authority.

So how do you 'unravel' them?

GM - That's the trouble it is so complex, it is impossible to unravel them all.

So do you make choices about who you spend time getting to know?

A vigorous discussion followed about who one can work with easily; and 'being caste into a role of working with some one that we have no affinity with.' There is a sense of being powerless to make a difference to the situation and feeling of being trapped. The discussion spreads to others giving their perspectives of how they have learnt to work with others.

GM - There are only certain people you can really get to know and therefore we need to be selective. We as nurses, seem to believe that we should be responsive to everyone to achieve what people want. To be effective we can only get close to a few people, because it takes so much emotional energy to be effective communicators.

There was then a discussion of the emotional 'bonding' in groups and what makes a close group of people. Leadership and the qualities of leadership that makes a team cohesive and the effect of the organisation on being open with others at work.

GM - If nurses can work together to create a little oasis that provides a sense of control, order and purpose then that is a positive development for nurses.

Discussion about power and the negative aspects of hierarchy followed this comment

GM - I have got one team where I am trying to be in a collegiate relationship with the members, and I am having incredible difficulties with some of the members of that team. They see themselves as autonomous practitioners and not answerable to anyone.

How do you use your power in that situation?

GM - Inappropriately often, I get bolshy, and that does not work. So now I have developed the negotiating mode. This means going very slowly and gradually, building up a way that works. I listen a lot.

So you are testing out ways of using your power?

---I think so, it seems to be working.

GM - If we are really going to develop more collegiate relationships, we need to try to put aside the hierarchy, it seems to encourages coercion rather than co-operation.

This led in to a discussion about personal experiences of being coerced and bullied into conforming in the past. The fear of being coercive to others was very present as we talked.

Inevitably when discussing the problems associated with power gained by status, relationships with doctors becomes an issue and as expected the focus turned to the power doctors have to influence the way nurses are able to work.

GM - It is always difficult working with doctors as colleagues.

GM - The expectation is that doctors will be controlling, insensitive and unresponsive to the needs of others, especially nurses.

GM - The difficulties centre around language and their pre-occupation with academic achievements. Even if they are female it does not make much difference. It is difficult for women in medicine to break the established role. They tend to join rather than question, and then they go 'off the handle' when a crisis occurs.

GM - They mostly retreat from conflict or 'follow the party line' and then feel bad about it.

It is funny how you know who you can trust and who you can take risks with. It is something about the way they (doctors) interact their language and their non-verbal messages. When you can break through the 'fog' sometimes there is a really genuine person . Then it is possible to have an equally reciprocal relationship. From my experience it is the nurse that has to do the work of opening up and developing trust.

GM - It is interesting that you should say that, I have just been in a meeting of 40 people - a primary care forum and the GPs were all down one side and us, the occupational therapists, speech therapists, and community nurse, down the other side. It was so interesting because the GPs were doing all the talking. I could see the chairman looking at all the nurses because they were saying nothing. Then the GPs drew people in. They actually wanted to know what the nurses thought. That gave us all the confidence to speak out. But to begin with there was a real cultural difference.

> This short scenario presents the situation where nurse and others allied to medicine are the largest professional group. Yet they will wait for the doctors to beckon them because it is too risky to guess where the doctors are coming from. The consequences of a wrong move are not clear. Even very senior nurses are careful about testing it. (Again chapter 12 will take up some of these issues. My own story will highlight some of the issues about differing cultures, trust, and speaking out.

Coherence and authenticity as measures of validity

Being aware of oneself and feeling that one is authentic in what one does has been something that I have struggled with. Allowing the questions to be asked when one feels very vulnerable is not easy, and paying attention to all the different levels of awareness required is equally demanding. Not everyone in the group talked about their own experiences in ways that spoke to a conscious awareness of coherence and authenticity. However, there were times when the intense questioning of actions, thoughts and feelings, could be 'read' in his way. The following dialogue has been selected because the level of questioning, or presentation, might indicate this awareness.

Dialogue

> This dialogue begins with a discussion between two members about the way their careers have developed. They are male and female, I make this comment because this difference is one of the threads of the conversation.

GM - What sparked me off in your story, was when you said that you came into nursing late having had your family first. Where as I did it the other way round, I was nursing 10 years before I had a family. My children are six and four and I can date a certain loss of drive and interest in work to when my children were born. Although I did change my job, so that might be relevant. The colleagues that I went through training with were mostly women, and have taken time off to have their children. Most of them have worked part time, and have often suffered for their 'lack of commitment to the service'. I do wonder whether there is a link --'How much caring can you do as a human being?' For me there is just not enough to go round for family and work, given that caring is a big component of both. Is it actually reasonable to expect people with very young children to have that amount of caring left over for a full commitment to work? I do think that a lot of young women with children are criticised in the work arena for not paying attention to their careers. Or not really 'being there' at work.

GM - Or for just being a care taker?

GM - That's right for not having that drive that people without children do have.

Discussions about the stress of caring and the need to have breaks that help to 're-charge the batteries' is entered into by those with and without children. This was not just about the quality of work, but the expectations that nurses will be always there and always ready to put others first.

GM - I enjoyed going out to work for self esteem, the money, yes I needed that. I was in touch with nursing and the children got to know their father. Then when the children were nine and ten I began to see the possibilities.

GM - Exactly, you don't let the resentment grow, there is an end point when you will have more time. I can't have it both ways. I cannot have the salary and the advantage of mothers who can make the children the priority. It is not possible for me to take a job that is less demanding because we need the salary.[this is a man that shares the care of the children now that they are at school, there are issues of gender here that I recognise.]

GM - I never thought of a man being slowed down by having young children. I just thought they went on regardless.

GM - It is specifically the emotional bit about caring for people who are not particularly loveable. For example if one of my patients throws a temper tantrum, I have got one of those at home waiting for me. Where as five years ago I might have had the energy to deal with it better.

I was very attentive during this piece of dialogue and it seemed to me that those involved were beginning to be very open about their actions and the feelings that were a part of these actions. There was also a sense of noticing the possibility for misleading self or others. This thinking through and making the feeling connections is a part of managing the interplay between thought feeling and action in a coherent way.

GM - Is it something about expectations? Do we have very high expectations of ourselves?

GM - Yes I think we do, and I think it is because nurses historically has been predominantly female, and mostly unmarried. It's like the nursing role. It is not a role it is three or four roles and there has been so much caring needed, too much perhaps. Now things are changing and we have still got those standards to live up to.

GM - I think we are expected to be bottomless pits of compassion and energy. Quite often we do not know ourselves, what our limits are.

I hear this as a warning about ignoring our humanness in favour of being all things to all people. This way of being would work against coherent and authentic behaviour.

GM - Nurses have always managed, but now we are being asked to compromise our values about caring for people and being able to respond as is needed. If nurses are not able to make the decisions and manage the resources then patient care is compromised.

This conflict of making choices between the direct patient need and the needs of others is intertwined with women's work, because it is usually about responding to a complexity of demands, and working hard to keep everyone at least OK, if not happy. The conversation then moves to individual experiences of nursing. Ann talked about her childhood and being different from her peers. She illustrated this by presenting her feelings of guilt when she did not feel the emotion that others felt about death and dying, being different was in some way a threat to belonging to the group. Her way of coping was to pretend to feel as they did so that she was not left out. In discussing these experiences Ann came to the conclusion that her experiences of death as a young person made her more able to cope. This set her apart and now she feels she has come to terms with it.

We discussed the mythology about managing death, and recognised it was one of the 'initiating rights' into nursing. However we also recognised that it did not help young nurses to

value their own thoughts and feelings and come to terms with the whole situation. This moved into another life story. This person talked about her struggle to be a nurse against her families wishes and how she finally succeeded after she had married and had two children.

GM - I would like to say that what you had to say was a marvellous way of opening up your life to us. I felt I had a stronger sense of knowing you when you talked of your personal struggles.

The things that you have been concerned about as a nurse, that I have known about, made more sense to me as you described them

Carol - I was saying in the car coming down, that I sat down with this piece of paper and I said "I will write everything down" and I wrote it all, and then I wrote "balderdash its all rubbish," and I threw it in the bin.[this refers to the life story]

GM - I think we feel uncomfortable when we find ourselves in focus.

Carol - That could well be but you think "Is it relevant to anything?"

But when you wrote down first of all it was relevant

I am concerned about the meaning behind the lack of confidence.

Carol - Oh yes, but I don't know whether I picked out points I wanted to focus on, or whether the points were just coming freely. It was very difficult to find which came first. [Here seems to be a concern for drawing out a 'true' story that is not contrived] But I have just kept quiet here because I feel I am really naive. I feel I have taken because I have listen and learnt a lot about people and how to cope with some of the issues I face at work, and I wonder what I have to give. I am very much in my infancy as far as nursing goes, I actually only started my training ten years ago.

This was the first time that this person had taken a central position in discussing an issue. This contribution made it clear to me to me that thinking. about being authentic and coherent in thought, feeling and action, is important to members of the group, but hard to locate in discussions. It seems to be a case of searching inside oneself, and listening to the feedback from others, that brings this kind of coherence and authenticity into focus.

Interpretations and Reflections

Group developments

During this phase of the cycle there was a much easier flow of focus from feelings and ways of coping to tasks that required inquiry and exchange of ideas. The process for managing the task became more established. One person presented their personal story and included both content and feelings. Time was then given for reflection and sharing both personal professional concerns. This provided a springboard for sharing experiences and noting differences and similarities. I did not take a strong facilitative role as the process issues related to group cohesion and integration because they were managed by the group members. There were times when there was a struggle between a focus on propositional, intuitive and practical knowing (Heron 1981). The differences that surfaced were both about content and about whether feelings or academic prowess were valued more or less.

There were also acknowledge differences in our own personal stories and why we decided to take up nursing as a career. This was only made clear by the women in the group. My interactions within the group were most often part of the process rather than working towards a particular 'group' purpose. I felt quite confident that appropriate issues would emerge and my agenda was to contribute to this, make my own sense of it and inquire. The seeking of knowledge as a group activity was very available. However the inquiry did not challenge the way ideas were presented. A sense of respecting difference prevailed.

The research process

I did not chose to rigorously following cycles of action and reflection because issues and experiences were presented as part of the dialogue rather than each individual owning some space to present their experiences. The process was emergent and flowed across ideas and issues e.g. people tended to enter straight into explaining the experience with an initial internal dialogue and then to associate this experience with the thought feelings and actions. After this there tended to be a move towards the past, where this experience might be attached to. Or to the future and what they intended to do as a consequence.

The pathway to the issue, and the meaning for the person concerned, became apparent as the dialogue progressed. When it seemed appropriate I inquired into the process that had generated the ideas. Sometimes it was clear that action and reflection, had played a significant part in clearly identifying the experience and the understanding of it. More often than not I observed but did not question. To interject would have stopped the natural flow of ideas.

Some sense making occurred in a natural way as the process unfolded and members reflected on the recurring ideas and issues. I tended to provide reflections that I believed would be most helpful for both the group as a whole and for individuals. e.g. 'People seem to arrive at a similar points in their lives, with all the skills to cope, having travelled along different pathways.' I paid some attention to the generation of ideas, experiences, and affirmed knowledge gained from practice.

I recorded my reflections after each session and paid attention to my own reflecting in action. In the text I have made some reflections available. These reflections have helped me to build up my sense making about the issues and the themes that seem to be emerging within the context of the group and practice setting.

My personal responses and actions

On reflection I realised that the development of our ability to key into each others ideas and keep an idea moving and developing, was more important at this stage than closely monitoring the use of the research tools. I came to realise that the first cycle of research introduced the method, and encouraged a familiarity with the tools through discussion and use. The next cycle of research should produce some reflections on the use of these tools and the ability to use the method in an authentic way.

Members (including myself) sought validation about seeing things differently and affirmed the need to revisit situations and 'truth seeking' from a different vantage point. This personal and professional interweaving of memories and experiences seemed to be liberating. We were all able to state our positions on an issue and relate it to situations that we were confronting and learning to handle. Most of my reflections about possibilities, and analysis, I did not bring into the group situation. .....opening up possibilities can be very confusing. I did not consider confusion to be useful at this time. There was enough difference and competition for the space and time available. I did not need to bring more diversity.

> Conflict arose in this phase around people not attending all the groups and not arriving on time. The question was raised about individual commitment to attend all the sessions. Again this issue was raised by the same member as the other challenges to leadership, to my style of facilitation and to the agreed goals. This time other members of the group took responsibility to provide a counter point to the statements made. "What happens when nurses are asked to make choices between attending meetings and responding to the needs of a distressed patient or relative?" This led into a discussion about how we, as nurses, manage the conflict between responding to the work demands and taking time to reflect, discuss, and exchange ideas with colleagues. I notice I have energy around not placing ultimatums on people if what is being asked of them is not congruent with the way in they chose to work. Particularly if it confronts their values in an inappropriate way. I also reflect that this is exactly how I experience being a nurse and is therefore not irrelevant to the purpose of this research.

The conflict that arose around the use of tape recorders, and the sharing of information with all members of the group, was an important issue and took some time to resolve. The anxiety around this issue seemed to be related to confidentiality as well as the concern that people hearing may misconstrue what the speaker had in mind at the time. My reflections led me to link this concern to the need for nurses to maintain 'good relationships' with each other. Not to speaking ones mind avoids the risk of being misjudged. This fear is also about being isolated and unsupported when needs, or crises, arises.

There is something else that might be significant and that is about the 'silence of nursing'. It seems to me that this is not necessarily a negative quality but has some interesting concepts embedded in it. They are about the intimacy that is part of nursing practice and relationships that are based on that intimacy. However the cultural setting in which nursing is practised does not acknowledge the personal qualities of many of these relationships that sustain nursing. Perhaps intimacy can only be sustained where there is silence. My personal stories about nursing practice explore these idea and will be presented in Part Three where the themes of intimacy, and the cultures of caring and curing, were very much part of the stories I shared during the second research cycle .

Proposals for the final stage of the research cycle

At the end of this phase we summarised all the issues that had emerged and agreed that some issues kept recurring and held our attention, generating energy and feeling. These issues were about :

- The anxiety that arose out of using the research methodology;
- Managing our personal lives and feeling interpersonally competent;
- The genderedness of power relationships;
- Understanding coherence and authenticity as measures of validity.

We decided that these issues should go forward to the Sense making and Communication stage of the research cycle as beginning statements about themes and issues. We also decided that as the next group session would begin the process of finalising the first group the following purposes would provide the necessary focus for concluding the group and managing the transition to the second research cycle. These purposes were to:

- identify the issues and themes that emerged out of our work together and assess whether working together had provided a context in which we were able to share our work and improve our practice;
- decide whether we as a group or part of the group, intended to commit our energies to a second research cycle. If so how would we manage it?
- decide how we would close the group and communicate what we had achieved.

I sent these themes and issues as a summary to each group member together with my expectations for the final stage of the research cycle and group process.