Chapter nine

Introduction

Our agreed intention as we entered this second cycle was to pursue our own research within the workplace. We also whether meeting together to reflect on each person's research experiences created a deeper understanding of nursing, and ourselves as nurse. To achieve this we intended to use a Co-operative Inquiry methodology to explore our own practice and to present these research experiences within the group context. In planning for this second cycle we expected continue with the ways of working we had established in the first cycle.

The first cycle was centred on testing out ideas and feelings in the group setting, and noticing more fully our own actions and reactions within the context of work. The second cycle was more about refining our research ideas within the group context, by sharing dilemmas, and possible ways of interacting within the worlk context. These differences generated a process in the second cycle where thinking about issues, sharing ideas,, inquiring about experiences, and listening to each others accounts became more important than identifying and agreeing cycles of action and reflection. This does not mean that we did not use the processes of action and reflection to notice consider and act, we just did not use the time together to evaluate or present these activities in any planned way.

This chapter is an account of the second research cycle from the perspective I held as I entered into the process, collected field work data, and made sense of the research experience. Therefore I will begin with the first session because it was here we agreed to rigorously pursue cycles of reflection and action within a Co-operative Inquiry methodology. I will then outline the patterns that emerged as each person presented particular issues and developed personal strategies to meet perceived challenges - contextual and interpersonal. However, the degree to which each person's research is described in this chapter is limited to the material that was either shared within the group or shared with me in some other way.

Beginning the second Research cycle

The first group session was held in a community hospital and ‘hosted’ by one of the group members. The group began with an exchange of ideas about co-researcher and group participant roles. In discussing these roles we revisited the Co-operative Inquiry methodology and agreed to use action and reflection as a way of noticing and recording our experiences. This discussion was a useful exercise and clarified the way a Co-operative Inquiry approach could affirm both personal support and a critical awareness of our own subjective experience. During this process we also considered some of the patterns that had emerged during the first cycle of research, particularly self- disclosure and coherence between our intentions and our actions. We decided to continue raising these issues as a way of testing out personal integrity, and the effectiveness of our interventions.

These discussion uncovered some concerns about how rigorous we needed to be in using the tools of action and reflection, and how we would share our efforts. After some debate we decided to focus on reflection for action in the world, in action in the group, and about action as experiences were recalled and discussed. At the time this decision was made it seemed to 'fit' with our individual research intentions, however the process that emerged did not represent these different ways of reflecting and acting. In retrospect I realise that inquiry was more tentative, reflection more personal, and experiences were recounted in story form; only in part were the processes of action and reflection identified and commented on. However, by the end of this first group session each member of the group had re-affirmed their research intentions, set dates for future meetings and agreed to:

- share the management of the group meetings;

- inquire into our own practice and experiment with new ideas ;
- develop cycles of action and reflection based on practice in the work place;
- bring our own sense making and ways of knowing to the group;
- support and critically appraise each others practice;
- share ideas and personal experiences of our research endeavours.

This process of agreeing together as co-researcher and co-subjects, required that I adjust my role and develop a different mode of activity. My focus of attention and energy moved from the group and research process to my own personal experiences, and as I began to take a more participatory role within the group so my own stories emerged and in part were shared with others. This change in focus allowed me to explore my own thinking and acting in a more experimental way.

It was here that I increased my understanding of life strategies, gendered roles, the work of expert and innovative nurses, and organisation development. This exploration of ideas and understandings was achieved both experientially and through reading relevant texts. Consequently, as we developed a more participatory way of working together, and as I paid more attention to my own research and inquiry process, so I experienced a research journey that altered my way of viewing the fieldwork. Before exploring my own experience of this part of the research journey, it is important to attend to the way we worked together to support and inquire into, each persons research intentions.

Developing a pattern of working together

Each session began with an exchange of information about our personal lives, common interests, or work concerns. Time was then given to hearing each persons' need for time to talk about personal research related experiences. At the first session it became clear that several members of the group wanted to present issues related to their research intentions. We spent time discussing how involved each issue might be, and the time each person might need to present the issue and receive ideas and support. The process of agreeing priorities was very interesting because it was more about people ‘stepping back’, rather than stepping forward. Several members made clear their wish to present relevant issues; yet when it came to deciding who warranted time, each person seemed to be saying "others’ needs are more important than mine." Consequently our decision to share the time between two people left me with an uneasy feeling about those who seemed eager to talk about their issues but had 'stepped back'. I realise now that 'stepping back' when others have a need to discuss their personal experiences is a way of being that I share with some of my peers. This way of working with others is part of my own research experiences in chapter 12.

Reflecting now on why certain people were selected to present their experiences I realise that the degree to which each person seemed to be coping, or not coping, created the priority. A sense of being overwhelmed or forced to make ill considered decisions, was the cue for focusing all our attention on that person’s experience. It is clear to me now that we were all ‘tuned in’ to situations that produce conflict or feelings of powerlessness; this became the established pattern for deciding who would tell their story. We made adjustments to this focus on problems and difficulties by creating a space at the end of each group session to share something humorous, or successful.

This pattern of beginning each session with mutually sharing something of our lives, then creating a space for one or two people to focus on important issues and ending with sharing our reflections, became established at the first session. However, this way of working created a different dynamic as we paid attention to one person’s experience and acknowledged its uniqueness and potency. This change in the way we worked together is central to the

dilemma I faced when I attempted to make sense of both process and outcome in terms of the chosen methodology.

After this first session I considered the process that had developed and the issues that were presented, and realised that I had become fully engrossed in the presentations to the point where my own experiences had resonated and created a new experience for me. I did not know how much this was the case for others, or whether contributing my own experiences would have been useful at the time. To probe this question I decided to record my thoughts and feelings in and about the group experience, and send it to each participant for their response. My rationale was to test out whether this way of expressing thoughts and feelings was a valid way of communicating what was not communicated within the group.

This act could be seen as me not wanting to let go of the facilitator role, I considered this and decided that if it is so then any response to my letter would enlighten me. In the letter I stated my concerns for those people who had intended to present issues and did not, and I reflected on the stories that were told. These reflections included my own experiences that resonated with those expressed, and my thoughts about the issues presented. I realise now that this way of communicating is familiar to me as I often write to colleagues in a similar way, the content may be different but the process feels the same. The response to my letter at the next session was an inquiry about meanings and a discussion about whether others felt able to share their thoughts and feelings in the same way. Other ways of sharing ideas and related experiences were also discussed briefly with different members affirming personal possibilities. However, the process of reflection within and after the group was left entirely to the individual, the agreed focus of the group was each person's experience of pursuing their research intentions. Therefore it is timely now to recount the work each person did share within the group, or provided in other ways including writing, discussing between group session and engaging others in their work.

Understanding the nature of our research experiences

This section has been the most difficult to write because it is almost impossible to set aside what I now understand in favour of what I was struggling to represent at that time. In order to write this section in a way that is credible to me and informative to the reader, I have decided to consider each person's research in terms of their work context, experiences shared within the group, ways of engaging with the research and the tangible outcomes. I will follow this with my own interpretations and reflections at that time.

> The information I am providing has been shared with group members and is not personally sensitive

I realise, as I prepare to write this section that I contributed to this second cycle in a similar way to my peers, therefore my account of my research experiences needs to be written in the same form. I will begin with a profile of my own work context, and then present those experiences I shared with my peers, albeit not in their fullest form. This account is limited to the purpose we shared at that time, some of my personal experiences are in story form in chapter 12.

An account of my own research experiences

The work context

I began this second research cycle intending to focus on the role of nursing within a changing environment, paying particular attention to differing treatment and care perspectives and differing role expectations within a multidisciplinary context. My personal goal was to develop interpersonal relationships that encouraged a climate of inquiry. At that time I was working in a small addictions department within a mental health care trust. My role in this department was two fold, I was the senior nurse responsible for the nursing services and the service manager responsible for business planning and management.

In this duel role I worked closely with William who was, and still is, the Clinical Director responsible for both the delivery of clinical services and meeting the contractual agreements. The other key people in the department with whom I had a collegiate relationship were: David, Consultant Psychologist (also my husband) and Andrew , Drugs Consultant. The nurses in the department were at a different level of decision making, consequently my relationship with them was of a different nature and although important to achieving my goals within the department, they are peripheral to the focus of my research intent. Two doctors, one psychologist and myself having a dual role, constituted the 'Core Group'.

As a ‘Core Group’ we held the responsibility for making decisions about service developments, education and training, and managing resources. Each core team member had particular agendas and ways of managing the new style NHS. William became interested in management issues and enrolled on a six month management course for Clinical Directors. David was studying for a PhD and took an interested in developing psychological treatments through collaboration and teamwork. Andrew was interested in harm reduction and health promotion related to drugs and HIV. I was involved in re-organising nursing work to meet the changing needs of the combined drug and alcohol services and developing community services. These different interests created colour and texture as well as difficulties in making decisions. In order to optimise the positive attributes of this group we met weekly, not necessarily to make decisions but to discuss and find some common ground on which decision might be made.

During the time I was involved in the second research cycle significant changes were implemented within the NHS, the Mental health Trust, and the Addictions department. The work culture was not receptive to the NHS changes mainly because these changes were seen as placing controls on clinicians that were not viable in the long term. Most people believed that if they were ignored they would go away. As a consequence I concentrated much of my energy on developing a relationship with William that fostered openness, honesty and a supportive stance to other members of the department. It was within this framework of role relationship and role expectation that I pursued my research intentions and shared these experiences with my peers. I realise now that it was the nature of this relationship that allowed me to be instrumental in bringing about changes within the department.

Experiences shared within the group.

The experiences I shared within the group were mainly in response to others' presented issues. This occurred when my own research experiences informed or mirrored the issues being discussed. My focus for developing cycles of action and reflection was my relationship with William and my intention was to develop this personal relationships by:

- engaging in a way that fostered trust and honesty;
- being clear about each others expectations within the relationship;
- An understanding of the others' purposes and aspirations;
- establishing a language that allowed meaning to be exchanged;
- an ability to manage the closeness and distance within the relationship.

I anticipated that this relationship would pass through stages, from engaging, to regulating the closeness and distance. In some ways this is so because I began with thinking about, and paying attention to, the process of engaging. However in the actual process of engaging I inquired into William's purposes and aspirations and this opened up an exploration of expectations of each other, the services, and the wider organisation. Creating a context for ongoing dialogue allowed me to experiment with ideas and to surface a language we could share and use to make management decisions. However, in contributing to the group process

with my peers I selected experiences and ideas in accordance with their 'fit' in terms of the issues being presented. Before I begin to discuss these contributions I will briefly describe the way my relationship with William developed, and the strategies I used to achieve outcomes acceptable to both of us.

Beginning the joining process

I first met William at the monthly business meeting I attended as part of my orientation to the department. I came to this meeting with opinions from a number of people about the department and the Clinical director. One interesting piece of information was that William considered Senior Nurses to be unnecessary and expensive, the money he declared would be better used to employ other staff. I thought this was a valid point and decided to use this information to test out his attitude to nursing and to me.

When I arrived at the meeting I found a very different person than I had expected, he was friendly warm and welcoming, so I decided to risk saying what I had heard. His response was to laugh and say, "Well I expect you to be different than the last one!" We then both agreed to wait and see what I was able to contribute and how well we could work together. My understanding at that time was that I would need to engage him in some real change fairly soon if our relationship was to be of any consequence to the development of the services and the staff.

Clarifying expectations

Before I began to establish a sense of direction within the department I spent some time with William trying to understand what his professional goals were. At first he said his goals were very simply, to see a few patients and to do some research. I accepted this statement, and with this in mind I began to re-organise the department in line with his and others' goals. Gradually William explored other possibilities with me, and during these discussions we shared our professional backgrounds and why we did what we did. In time we achieved a sense of balance in the way we worked together, with William taking charge of medical matters and particularly any differences between doctors. Whilst I took charge of nursing and any problems between nurses.

This acknowledgement of who took charge of what, was an important issue because conflict between nurses and doctors often emerges when roles are not clear and expectations are in conflict. This was a major step forward and as a consequence we were both able to discuss difficulties related to the clinical services and to find acceptable solutions. The management issues were a little more complex because at the outset William was not interested in the details of managing the department. However he did want to be involved in decision making in and outside the department, the task of presenting unity to the 'world' was a challenge that required a shared sense of purpose, this was not easy to develop.

Understanding purposes and aspirations

Developing a relationship that explores personal aspirations is not something that can be prescribed and often develops by accident. As we did not establish regular meetings outside the structured management meetings our work together tended to be informal. This informality created an easiness of access and a straightness of talking, and although we came from different backgrounds and life experiences, we could accept and understand each others point of view.. However this was not always the case as we sometimes fought quite vigorously over developing an appropriate strategy for the changes needed within the department. We were also at very different stages of our own life cycles, William had a very young family that he was devoted to and I had children who were adults and almost independent. Our connectedness came from an interweaving of our experiences that allowed our different perspectives to find a balance. I was aware that William was ambitious to achieve a position of some authority and needed to be affirmed as a competent clinician and leader. I, on the other hand, did not aspire to any personal career ambitions apart from

meeting my own internal values, however I did aspire to supportive and satisfying relationships.

This difference in personal goals encouraged a working relationship that gave William the public leadership role and allowed me take the supportive, facilitative role. I was at ease with this arrangement provided my integrity was not compromised and 'public' presentation were owned by both of us. I found a sense of purpose in developing a well managed department where people inquired and listened to each other. Being ‘on stage’ was something I was happy to leave to William. Most of my attentiveness to my own behaviour related to the interpersonal quality of this relationship and the effect this had on the achievements of the department.

A shared language for exchanging meaning

It is interesting to note that although doctors and nurses work within the same organisational culture they do not share the same professional culture. One could say that they represent gender opposites with doctors taking the lead in curing and nurses in caring. Curing being from an objective stance where treating is the norm, and caring being from a subjective stance where nurturing is the norm. Given these basic differences it is not surprising that the language of nurses and doctors often causes confusion when planning treatment and care is shared. My way of resolving this confusion is to use the language of doctors in ward rounds, when reporting back to doctors, and when writing patient notes that medical staff will read.

In working with William I began from this position because it allowed me to be ‘heard’. However, when discussing management and organisational issues, I realised there was a gap in my knowledge about how William understood management. I explored this gap by inquiring into the frameworks he used to understand and make decisions, I found that often they related to his own experience of being managed. Sometimes he would reflect on the techniques of people he admired, sometimes his experiences with his children or with patients, and sometimes we would discuss books he had read. This gave me some ideas about the areas of thinking and understanding we might share. At a certain point in our relationship I decided to take a risk and test out his receptiveness to new frameworks that might resonate with his own.

I introduced Torbert’s developmental model as it related to managers and organisations, by offering him a copy of the first part of Managing the Corporate Dream (Torbert 1987).

(This work is related to life strategies and will be in the next chapter.)

William found this developmental framework matched some of his understandings about how people behave in organisations. We spent some time discussing the possibilities of the framework and it became a 'working' document that both David and I shared with William. Torbert's language became a vehicle for understanding ourselves and others we worked with, it also provided a structure for planning interventions in the wider organisation. It is worth noting that from my point of view understanding the concepts and the outcomes associated with the different levels of development does not produce competence, understanding why, and knowing how, was something we wrestled with. The situations where this confusion became evident are contained in some of the incidents I shared with my peers.

Managing closeness and distance

This part of our relationship is difficult to write about because it could so easily be misinterpreted. However, I need to write it because I valued, and still value, the relationship we developed and because William's message to me when I left the department was - "Thank you for all the caring and control". This, I believe deserves some notice and response from me; this is my attempt to respond with honesty.

From my experience, the degree of closeness and distance in a relationship becomes an important issue when there is an intentional openness by one or the other, to the other's needs. Developing a relationship where it is acceptable to inquire into another persons feeling state necessarily encourages closeness. Acknowledging the difference in life strategies, and life paths, and giving space for this to be pursued in turn creates distance. Carrying these two important aspects of any continuing relationship will at times create misunderstandings and painful experience, as well as new knowledge about oneself and feelings of being 'at one' with another.

My beginning relationship with William was one of 'touching' occasionally but treading different paths{distance}. I was busy managing, and he was busy treating patients, we met to exchange a little about those two worlds. Sometimes I would request time with him to discuss budgets and plans, his restlessness would cue me in to his level of interest and attention span. As we moved towards implementing changes we also began to share an understanding of how we could support each other and get the work done. This encouraged more frequent meetings for shorter times.

We met to inform each other of developments, changes and possibilities, and to some degree this was about mutual support and personal consideration. At times we shared our personal backgrounds and the conflicts we were experiencing at work, often our discussions were fleeting. However, I was aware that William was becoming more interested in the art of management and critical of some of his medical colleagues. I was watchful of this development because some of the initiatives we were pursuing could have ultimately place William at odds with the medical fraternity. To counter this I supported and encouraged him to keep this relationship open, acknowledging that the medical culture is a closed one. If one is a doctor it is important to be inside the medical culture not outside.

Our ability to talk together about our professional cultures allowed me to share the tensions I hold in relationship to maintaining my own integrity and coping with feeling vulnerable. William, on the other hand could talk about his anger and feelings of alienation when defending the rights of young doctors and the resultant criticism by his own colleagues. Reflecting back on these experiences I realise that in listening to another's experience and inquiring into the meaning they make of it, has an intimacy of knowing that cannot be set apart from one's sense of being. I recognised this sense of knowing as caring for and with another. It was not until my departure and William was not able to achieve his particular ambition that I realised the degree to which I cared.

Managing closeness and distance in relationships where a sense of trust and honesty is intended, will inevitably pose some problems. When caring for patients nurses learn to manage this, usually by withholding personal self. In colleague and peer relationships personal disclosure is more likely to enhance the relationship by freeing up each person to contribute fully. The intimacy that this creates is managed on a daily basis and rarely acknowledged or even named. It is the ending of a relationship that brings the depth of caring, for and about the other, to consciousness.

<u>My contributions to others research</u>

The personal relationship that I developed with William was central to my own research and provided experiences that I was able to share within the context of others experiences. The issues that were presented encouraged us to explore

- relationships that risk vulnerability and powerlessness;
- managing changes where conflict is a part of the process;
- role expectation and role conflict;
- creating a context where inquiry and working together is affirmed.

Link to: http://www.bath.ac.uk/carpp/publications/doc_theses_links/j_quinlan.html

I also contributed ideas about nursing, personal life strategies and developing interpersonal competence. I offered these ideas to provide a frame for managing particular issues, as a way of making sense of our own thinking and knowing or as affirmation of a particular experience. Some of these ideas have already been discussed in chapter 2 (the primacy of caring, research as praxis and the genderedness of nursing). The ideas associated with personal life strategies and interpersonal competence (chapter 10) will provide the theoretical stance for revisiting experiences and creating a different understanding.

Ways of engaging with the research.

Engaging with the research took the form of:

- recording my understandings, feelings, uncertainties and personal experiences in letters to group members after group sessions;
- keeping a diary of my own reflections and other's sayings that seemed to hold some significance, either because they resonated with my own experiences or because they caused a jangle in my head;
- reflecting in action as I worked with William and reflecting on the actions that were taken as a result of this reflection in action;
- discussing issues and ideas with others to tease out an idea, or make sense of an experience;
- writing as a way of sharing ideas and crafting a consensus understanding of an issue. This kind of consensus was often achieved after a common vocabulary had been decided and a sense of purpose had been reached.
- taking different points of view and 'feeling' what it is like.

My use of a variety of methods to probe an idea or a situation is about my need to understand different perspectives and to 'take people with me' if that is at all possible. I am aware that I submerge my own understanding of a situation or idea in favour of valuing collaboration, teamwork, a sense of belonging and an affirmation of difference. My own life strategy stands before me as I write, suffice to say now that I was unclear about this relationship when I first attempted to write an account of the second cycle. My strategies were clear to me at that time but not clearly linked to my understanding of myself and the way I approach and live life.

Colin's research experiences

The work context.

Colin had recently been involved in developing a services aimed at harm reduction and health promotion within a drugs service. The focus of his work was a group of homeless people with severe drug problems, and generally troublesome to General Practitioners, drug services, and the general population. Most of these people were using crime to finance their drug habit, as a consequence they were not easy people to work with. Colin found the work both challenging and very wearing, it required that he work closely with doctors, because prescriptions were a vital 'currency', and with the chemists, police and probation because the service was open to abuse.

Colin's research focus was the clinic where the people came for their scripts, doses of methadone and/or education about harm reduction. The services provided by the clinic were set up in haste, however the ability to recruit people with an interest and experience in the work was difficult. At the time we were meeting Colin had recruited a group of registered and

unregistered nurses and was supported by a junior doctor and consultant. His wider network included other professional and voluntary workers involved with the homeless.

Experiences shared within the group.

Colin intended to develop a Co-operative Inquiry approach to working with both the staff and the customers. He decided to focus first on developing an inquiry group with the nursing staff and later to involve the customers. This field of nursing was new to most of us in the group and required some understanding of the issues and the problems before we felt comfortable about offering ideas. Colin told us how he wanted to develop a team able to share ideas and take responsibility for managing individual care plans. He also talked about his own experiences of working alone in transient accommodation, and the issues of control that are ever present with this group of customers.

However it was the difficulty in developing an appropriate way of working with very inexperienced staff that became the focus of the first cycle of action and reflection. Colin decided to begin with providing educational sessions for the staff. These were aimed at promoting confidence so that agreeing ways of working together, and the protocols needed to manage the service, became possible. Colin intended to use an inquiry approach to achieve this and a shared reflective diary for all the team to recorded ideas, problems, issues, and difficulties.

Later in the research cycle Colin gave an account of how he had developed the group and what they had achieved. He told us that the first stage worked well with discussions arising from the teaching sessions. However when it came to making the ideas happen, and reflecting on practice, the nurses did not feel confident to take an active part. It seemed that this team of inexperienced staff were unable to contribute to developing a service in the way he had envisaged it. In his words - "They let me do all the talking and just wanted to follow instructions." Colin shared his anxieties about delegating work, the risk of customers getting violent or getting more drugs than they should, was a constant worry for him.

When this was pursued it appeared that Colin was not sure if the junior doctor would 'stand by him', and he wondered how much commitment the nurses really had to this client group. We explored this and discussed possible ways of managing groups and delegating tasks, we also suggested that a closer observation of his own role might be a useful way of understanding what he could, or could not do. At the next group meeting Colin was much clearer about his own role and expressed the tensions he felt working with drug addicts, and doctors who did not want to work with this group of clients.

Colin developed another strategy for managing the group. This involved being clear about the decision that he needed to take and the decisions the nurses could reach amongst themselves. This way of working together provided a context for discussing and inquiring into different ways of working. Involving the customer in the process, Colin considered, was more difficult and could not be the responsibility of inexperienced and unsure staff.

Ways of engaging with the research.

Colin used a team diary to record meetings, what happened within the clinic on a daily basis, and the comments and ideas of team members. He also used a Dictaphone to record his own ideas and concerns, and shared these with the consultant that he worked closely with. This relationship with the consultant, was also an area of work that Colin paid attention to, however he did not discuss this within the group.

Jane's research experiences

The work context.

Jane had recently taken up a nurse manager position in community hospital providing maternity, minor injury, short stay medical and long stay elderly services. The hospital adjoined a health centre and therefore some facilities, resources, and services were shared with general practitioners. As nurse manager Jane was involved in managing the hospital including all the staff, according to Jane this new position held both opportunities and problems. Many of the staff lived in the community and had been employed in the hospital for a long time, consequently customs and practices were well established. The doctors also had a sense of ownership and expected to place elderly people in the long stay beds without considering the length of stay or the quality of life.

Jane shared with us her vision for the hospital in terms of working relationships with General Practitioners, and encouraging staff to work in teams so that the patients had full benefit of all the resources. She envisaged every one working together to achieve a good service to the patients and their families. However there were many obstacles to achieving this, the one causing most difficulty was the conflict that surfaced between different disciplines when each held fast to traditional ways of working and saw no reason to change.

Experiences shared within the group.

Jane presented her ideas about the nature of team work and the way people were functioning within the hospital. Many of us were able to share similar situations of conflict between people with very different agendas. To help Jane develop her approach to this conflict we inquired into the roles of different people and how they did, or did not, work together. This encouraged Jane to develop a map of the people involved and to test out the degree of support for multidisciplinary team work. This took some time, as Jane made interventions into the system and noted her own thinking and feeling in different situations.

Serious conflicts occurred when Jane took the initiative and decided to change the way day patient services were provided so that patients were not sent home earlier than appropriate. Planning to change the way people worked in order to meet the needs of patients brought resistance and personal criticism. Jane managed this by using the ‘map’ of people that were for the changes, she also used the tools of reflection and action to monitor her own thinking and acting. Sharing the stages she went through with us and tested out her integrity, and authenticity, by inviting us to inquire into why, and how, she had decided to make particular interventions were part of this process. We were all able to identify with this situation as many of us could recall past experiences where our own integrity and sense of 'right' was pitted us against the wants and wishes of others.

Ways of engaging with the research.

Jane engaged in the research primarily by recording her own reflections in a personal diary. This became the resource for clarifying her own personal agendas and the actions that needed to be taken to test out the decisions made. She also consulted with colleagues and senior nurses outside her own hospital services. Team building exercises, and problem solving groups were used to managing the change process.

Mary's research experiences

The work context.

At the point of joining the first research cycle Mary was a staff nurse working with the elderly in a community hospital. At the time we began the second cycle she had been promoted to sister. Mary expressed her intentions to develop a team of nurses who were able to work together in a co-operative way, sharing the workload and providing individualised care to all the patients. Mary had achieved some changes already but felt that there was no cohesion within the staff group and this led to some patients receiving better care than others. Mary's staff were a mixture of trained and untrained nurses, and a ward clerk. Some of the nurses, particularly the untrained, had worked in the ward a very long time, however most of the

trained nurses were new graduates with very different ideas about caring for patients. Mary's difficulty was in viewing all the staff as equally valuable because her natural inclination was to give responsibility to the new graduates. and yet she knew that experience was particularly important when caring for the elderly.

Experiences shared within the group.

There were a number of issues and experiences that Mary shared with members of the group. These included:

- points of view that staff held about changing the way they worked on the ward;
- ideas she had about individualised care and her experiences of this practise;
- discussions with General Practitioners about the use of the beds in the ward.

Mary decided to begin the change process by bringing together small groups of nurses who wanted to work together and explore team decision making. She gave people responsibility and encouraged team leaders to manage care planning for each patient. This promoted individualised care plans and teaching sessions which in turn promoted standard setting. Mary brought to the group small scenarios of success, challenges and failure. She did not take a central role in presenting an issue but something of what she was doing seemed appropriate to the issues and concerns of others. It seemed that through her own planning and paying attention to her own and others' interactions she was able to create a context for team work.

From Mary's point of view the one intervention that made the difference was an 'away day' planned to bring all the staff together to affirm the changes to individualised care. To achieve this Mary successfully convinced the General Practitioners to manage the ward with help from 'bank' nurses so that all staff could attend the 'away day' and be part of the decision making.

Ways of engaging with the research.

Mary used a reflective diary, voice activated tape recorder, consultation with peers, team meetings, an 'away day' and research into the way other nurses have managed change in nursing care. Mary also wrote an account of the 'away day' and sent it to me. Twice during the second cycle I was invited to discuss teamwork with her staff.

Eve's research experiences

The work context.

Eve was a nurse manager with responsibility to develop close working relationships with general practitioners. Eve also had teams of midwives, health visitors and district nurses within her span of responsibilities. The NHS reforms and the move to GP fund holding brought considerable changes to the work of people like Eve. In the past she had developed very good relationships with her staff and with general practitioners, the market economy seemed to produce a negative effective on her role.

Experiences shared within the group.

Eve stated that she wanted to understand and work through an ongoing conflict involving her new sector manager. From Eve's point of view an integral part of this conflict was about shifts in power and authority and a reduction in resources to do the job. To help our understanding

of the situation Eve talked about the changes that were occurring in the services. These changes were causing a high degree of stress as pressure increased for more activity and at the same time resources were difficult to access. Eve described her own vulnerability as nursing positions were being cut, and non-clinical managers appointed to manage the services.

Eve became very emotional as she recalled the letter she had just received telling her that she had been replaced on the Family Health and General Practitioners committee. There had been no discussion with Eve We explored this episode inquiring into the difficulties that we were all aware of. Eve then made reference to the conflict around her relationship with the new Chief Executive and I noticed during the discussion Eve moved between frustration, sadness, anger, outrage and vulnerability. We all made efforts to understand the dynamics, share some of the feelings of powerlessness and respond to her feeling state. Gradually we focused on possible interventions and considered the people who might support or conflict, this provided a clearer perspective for suggesting ways forward.

During the session members of the group were able to bring different points of view to bare on the situation, each of us could identify with aspects of her experiences. Clare was able to join with Eve around the issue of the Chief Executive and said that she is well known for having her favourites. Jane was able to explain some of the issues that were going on with the General Practitioners and how they were beginning to 'flex their muscles'. I inquired about what was driving the waves of feeling and despondency and found that it seemed to be about a fear of really losing control. Handling the chief executive seemed to be the major issue distorting her ability to manage the day to day nursing issues.

We all agreed that the life of a nurse manager is not easy at the best of times- "everyone wants you to do for them no one wants to respond to your cries for help". My concerns during Eve's presentation was about how a situation emerges that places nurses in conflict with nurses and then old stereotypes emerge. I found that I identified when Eve talked about -

> "dropping what you are doing to make life smooth for others, and the sense of satisfaction knowing you have the ability, the networks, and the authority to get things done. In contrast is the inevitable feeling of frustration and let down, when others have left work unfinished or lack the skills or knowledge to do the job, and are unconcerned about the confusion they have created."

I shared some of the ways in which I have learnt to survive change, and even turn it to an advantage, however bleak it seemed at the time.

Eve decided that she needed to focus her attention on her position vis a vis the Chief Executive. We understood this relationship to be important to her future and her ability to function, therefore we offered support and information outside of the group setting. Eve fed back regularly and others who worked in the same field supported her through some of the difficulties she faced. Eve's presentation engaged the group for a major part of one group session, the difficulties she faced were not unfamiliar to many of us and we all knew that we could be in a similar position in the future. Anxieties were heightened during this session and we took some time to disengage at the end.

Ways of engaging with the research.

Eve used a personal diary to record her thoughts and feelings and peer relationships to reflect about her actions in the work place. Members of the group also provided support in carrying out actions and Eve selected an experienced nurse as a mentor to guide her through some major decisions.

Clare's research experiences

The work context.

Clare worked in a School of Nursing recently transferred to a university programme. This transition was very difficult for both students and tutors, and for some caught up in the final phase it is still a traumatic time. The process of change involved a five year period and for some tutors job security was affirmed very early, while for others anxiety about the future is still present. This occurred because some tutors already had degrees and a secure role, and others were sponsored to complete undergraduate or post graduate degrees. Clare had completed an undergraduate degree but as yet not secured a lecturer post on the new course, instead she had responsibility for working with the students completing the 'old' course. During the time we met as a group Clare had not secured a permanent position. She had however become involved in working with clinicians who were mentoring the 'new' students, and in validating the final examinations for the 'old' course. During this second cycle Clare enrolled for a PhD in education and intended to research the effects of the changes on nurses completing their training under the old system and beginning under the new system.

Experiences shared within the group.

Clare presented the conflict endemic in being a validator for nursing examinations and providing personal support to students. During the discussion Clare formulated the question:

"Can a team of external examiners assert their responsibility to ensure that the rights of students, and tutors, are represented when resources are allocated so that their contracts are honoured and the past is not devalued for nursing?"

Clare talked about her work with the team of external validators and the possibility of addressing some of the unanswered issues about the changes. This was explored from both student and tutor's point of view, gradually ideas linked together. Clare then posited the idea that she should write to the other validators requesting a meeting to discuss this possibility. We all agreed that this would be a useful first step and even if there was little that they could do it would bring people together to explore the issues students were presenting.

My thoughts were that this could be a very difficult situation to get into because it relied on others to carry out the proposals, external validators have no real influence on the way students are treated outside their educational programmes. The resource issue was more about implicit statements of the value placed on each group of students and the tutors who taught them. However, it seemed to me that by taking the risk and putting thoughts and concerns in writing a more helpful solution might develop.

The questions then arose around the idea of bringing external validators together:

> "Could this be a nucleus of a support network across the schools of nursing?"
>
> "Is it possible to surface the needs of the students and tutors so that priorities can be set, and some negotiations entered into?"

Having discussed her concerns and issues Clare went away to find out the answers to the questions posed. Clare returned to the group having made some decisions about the way forward. She had developed a network of nurse teachers, some in a similar position to herself. She had also made a firm commitment to work towards a PhD in education. Within this degree she intended to research the effects of the changes on both new graduates and past students. Not long after this decision Clare left the group to develop her own research group, we all agreed this was a good choice. Clare is now taking a lead role in developing a new post graduate degree in education within the Nursing Institute, this is still not a permanent position but it does allow her to pursue her studies.

Ways of engaging in the research

Clare used a reflective diary and taught students to do the same. She also set up student groups to inquire into their perceptions of being a student on a programme that was closing.

In writing to her colleagues she developed her own thoughts and feelings about her own position and established a support network. Most of the results of this work went towards developing the groundwork for her own higher degree.

The Research Experiences of Sara and Linda

The remaining two group members did not present their own research, and because each was involved in very personal work I did not inquire within the group setting. Therefore their contributions were responsive to others agendas rather than accounts of their own. I intend to mention these contributions when I revisit this second cycle and explore a different perspective.

Interpretations and reflections

As I gathered together all my field work notes and records and paid attention to the different representations of this research cycle, I experienced a conflict between my intentions to write about our research experiences and my personal experience of our activities together. The tension was between identifying the way we developed cycles of action and reflection as we managed the research cycle and assessing whether working together as a group enhanced our ability to practise effectively as nurses.

At this point I decided to put aside my experience of being in the group and focus on each person's account of their research experiences. Therefore at the time of writing this chapter I did not intend to create another dimension for understanding the way we shared our experiences. I was strongly attached to giving an account of the way we met our research intentions. However, in doing this I found it difficult to identify cycles of action and reflection because each person made their own sense of their research cycles. I could only make sense of what was shared within the group and this left me with a vacuum; exploring this vacuum led me to a new way of understanding our work together.

Although we had brought together and pursued many shared issues I did not take account of this flow of ideas as I reviewed the data. I asked myself - Why not? - It is clear to me now that I ignored or failed to notice the importance of the way we shared and explored our experiences, and the conclusions we came to about our actions. Having now acknowledge the value of what we achieved, both individually and collectively, I am able to create a different research text, one that considers the research journey, our capacity to research our own practice, and our ability to develop and sustain an inquiry group.

I now realise that the first cycle developed some shared understandings about nursing, an ability to use the group to discuss personal experiences and an understanding how to inquire into our own practice. The second cycle emerged out of the first, and provided a context for sharing and discussing personal experiences about our professional practice. These activities were planned and managed by individual members as they pursued their research intentions and the group provided a context for exploring and developing our practice.

In truth I suspect this was more about colleagues acting as a reference and support group to inquire into practice, rather than planned and evaluated cycles of reflection and action. This brings into question whether we were participating in cycles of action and reflection within a Co-operative Inquiry methodology, or participating in an inquiry about our own experiences of reflection in action in Torbert's terms. Whether we actually paid attention to experiences in action, or whether we created possibilities, took action, and reflected upon it, is not transparent. From my own experience, situations where we reflected in action and altered our behaviour as a consequence, were brought to the group, as also were reflections about actions that led to decisions about future actions.

This debate brings into focus the methods I explored in chapter three, and highlights the overlap between Torbert's Action Science and Heron's Co-operative Inquiry. It seems to me now that these forms of human inquiry rely on self awareness, self consciousness,

interpersonal skills, and a life strategies actively receptive to others, to oneself, and the world. These were the skills we were struggling to develop as we researched our own practice, and shared our experiences.

In Part 3 I intend to illustrate the way we achieved this by revisiting the second cycle, and giving a second account of the way we worked together and managed the research cycle. However my plan for achieving this required that I begin with how I have come to understand the connection between life strategies and gender. This is necessary because it was at this time in the research journey that I began to see the way our life strategies were interwoven with the genderedness of our roles. Once I have provided this 'backdrop' I will then discuss story telling as a methodology for understanding experience, this will provide the frame for revisiting the second cycle.