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More Than a Good Gossip?  
An Inquiry into Nurses’ Reflecting in the Ward  

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A thesis submitted in partial fulfilment  
of the requirements of the  
University of the West of England, Bristol  
For the degree of Doctor of Philosophy  

Faculty of Health and Life Sciences,  
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Abstract

Reflection-in-action is a complex concept, proposed by Schon (1983) to describe practitioners’ tacit knowing and ability to work with uncertainty and value conflicts in the midst of action. Its existence is widely accepted in the nursing literature and is a requirement of many healthcare professions. Yet it remains underexplored, especially in the context of the hospital ward.

This inquiry used poetry to support a collaborative action research approach, to explore the tensions and possibilities of reflecting during care giving in a hospital ward. Three levels of inquiry: personal, relational and organisational informed the multi-stranded design that involved a co-inquiry group of practising nurses, participant observation in a ward and action learning sets with senior nursing staff.

Bourdieu’s concepts of habitus and fields of practice, wider fields of power and various capitals were used with feminist and systemic inquiry perspectives to explore nurses’ ability to use reflection to influence their workplace. The text uses stories, images, metaphors and poetry to generate powerful new insights into the conscious and unconscious ward learning culture and nurses’ embodied dispositions that enable and inhibit reflecting.

This thesis presents the reality of reflecting by highlighting some unconscious games, paradoxes and contradictions present in the ward resulting in reflecting inaction. These included: we do it all the time, the paradox of the busy syndrome, the waiting game, whinging creating an emotional orgy, feeling unsupported by managers and talking behind your back. Those nurses, who embodied reflexivity, reflected spontaneously which sometimes appeared as gossip. They developed systemic and political agency, noticed their body and used relational processes in the midst of action. They influenced change systemically, gaining resources,
demonstrating effective leadership and challenging policies. Relationally, they created improved collegial working relationships with managers and staff overcoming collective negativity in the ward. Personally, they managed the complexity of emotions in the ward, encouraging patient centred care, reducing job stresses and improving job satisfaction.
Special Thanks

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Chapter 1: Roots and Muddy Footprints

Roots

I sway
In the breeze
knowing my roots are everything

Clare Hopkinson 12/11/04

Reflection and reflective practice are popular concepts in nursing education and more recently throughout the NHS (National Health Service). It is a requirement of virtually all health and social care professionals to act as reflective practitioners and is cited in the NMC (Nursing and Midwifery Council) code of professional conduct (NMC, 2008). Arguably, reflection has influenced a wide variety of healthcare professionals so as Rolfe (2001 p.22) points out “it is easy to forget its radical origins”. Nurses are asked to develop their reflective skills through reflection-on-action i.e. reflecting away from their practice and reflection-in-action i.e. during their practice (Schon 1983). Reflection-in-action is a complex concept, originally proposed by Schon (ibid) as an epistemology of practice describing practitioners’ tacit knowing in action. In other words, it describes how practitioners contend with “uncertainty, instability, uniqueness and value conflicts” in the midst of their practice (ibid p.50). Its existence is widely accepted in the nursing literature. However, it is underexplored in nursing especially in the context of the ward.

Mirroring the process of reflecting, this thesis uses a narrative style that unfolds gradually to explore the tensions and possibilities of reflecting in a ward during care giving. Consequently, partial stories emerge, are recycled and inquired into so that I aim to bring the reader alongside my journey of this inquiry. As part of this process I have used poetry, imagery,
stories and metaphor as ways of reflexively inquiring into reflection-in-action.

This chapter addresses the background to the inquiry resulting in the research question: What are the tensions and possibilities of reflecting while giving care? Here I situate and present my key experiences, influences and values, in other words, my roots and muddy footprints that led to this inquiry and have left their mark upon it. I show through my own past nursing stories and one as a patient, why I believe reflective practice is fundamental to improving nursing care. I propose stories from the past are the muddy footprints which provide the foundation for understanding our current practice. From my experience nurses often have powerful stories to tell about their practice but I question if learning is always extrapolated from them. I believe passionately that learning from everyday experiences encourages nurses to develop and unpick the complexity of nursing care.

A surprising emergent and important aspect several months into this inquiry has been my poetry writing. Previously, I had not written a poem for 25 years. The poems represent my reflexive voice that lay bare my experiences and emotions while also transparently showing my values and interests. They too act as muddy footprints throughout this thesis. Sometimes the poems speak for themselves, being raw and obvious. At other times I give a background to their conception with my own interpretation. I invite the reader, to make the connections and interpretations for themselves since I have been influenced by post-structuralism that values contested partial knowledge containing multiple ‘realities’ and interpretations.

While poetry writing was new to me, I have been drawn to storytelling for as long as I can remember. I was first introduced to it as a small child at home; my grandma lived with us and my uncles would entertain her with their stories. Often, though I had heard many of them before, I loved to
hear the re-telling of their stories with the customary change of emphasis, exaggerations or embellishments. I would be fascinated and absorbed listening to every word. And then my Grandma would say “Go on with you John – that never really happened” and Uncle John would say “Of course it did, as sure is sure, and as sure as I am sitting here now!” So it was hardly surprising that I was drawn to reflective practice during my degree course in 1991, because it emphasized stories of practice and practical knowing. And I have been facilitating reflective learning processes ever since.

“You should be continually learning….from your own experience, reading and reflection, to do everything you have to do, better today than you did yesterday. And see that you practise whatever you learn…” Wesley (Outler, 1980 p.245)

Ali, a post qualifying student gave me the Wesley quote above, which I use in teaching reflective practice. It captures the link between reflection and learning. Yet it fails to show the social learning¹ that is possible through telling stories of experience which I use as the central tenet of my facilitation of reflective practice. In small groups I facilitate a range of healthcare professionals telling stories of their practice. Through the group process of challenge and support new practice insights and improvements are encouraged. I see reflective practice as valuing the experiences gained in practice and using them as a vehicle to target learning where it really matters to nurses.

**Stories from the Bedside**

In the eighties, the phrase usually expressed by ward nurses about learning from experience was: ‘being thrown in at the deep end’. For example, I was left in charge at night on an eye ward in my first year of training. Teaching took place in small study blocks in the classroom but

¹ By this I mean how others can connect and learn through the sharing of stories not necessarily their own story
mostly learning happened through placements on the wards. I learnt through word of mouth or ‘Sitting with Nellie’ as we called it, that is, watching and being with experienced senior nursing and medical staff. The internet had not been invented then and books and research for nurses were treated with caution and suspicion. Evidence based practice was still over the horizon. It was in the ward where real learning took place not college. You had to get your hands dirty; practice was important.

When I was a newly qualified staff nurse, Donald Schon (1983) had not written his influential work The Reflective Practitioner. It was 1982, and I was working in a busy London intensive care ward. I was the most junior member of staff working on the unit for only a couple of months. The ward was designed with individual rooms where the nurse allocated to the patient worked for most of the shift on her own. One day I had been allocated a male patient, John. He had severe surgical emphysema which meant he had gained and retained air throughout his body during a surgical operation and required chest drains to help remove the air from his lungs into a water bottle. He was artificially ventilated, receiving essential fluids centrally, and was monitored for the usual vital signs. He had been poorly, but stable when the physiotherapist came in to give him his chest physiotherapy. In keeping with the routine and if I’m honest, without thinking, I automatically clamped the chest drains before moving John. This meant the air could not escape from his chest causing his heart to stop. Subsequently John went into a respiratory and cardiac arrest. Of course the physiotherapist and I commenced cardiopulmonary resuscitation, immediately releasing the clamp from the drains. We carried out extensive cardiac arrest procedures including defibrillation from the unit’s team. We tried to give him adrenaline via a cardiac needle but this could not reach his heart muscle because of the surrounding air. Can you imagine the anguish and guilt I felt when John subsequently died? I was distraught and even now nearly 25 years later I find it difficult to retell this story, without becoming upset.
I felt hugely responsible for his death, completely incompetent, guilty and ashamed. I was so distressed I was sent to the staff room where a medical registrar was having coffee. He asked me why I was so upset and my story poured out of me. The doctor told me the patient would probably have died anyway because people rarely survived when they were as ill as John. He asked me why I had clamped the drains; wasn’t it obvious the air could not escape? I said I didn’t think; I was following the unit’s policy to clamp drains when moving patients. I was in automatic pilot mode. Clamping the drains before moving a patient was seen as a safety precaution. Clearly, this was not usually a problem when fluid was draining. I told him I was going to pack in nursing as obviously I wasn’t cut out for it. He said if he always focused on his mistakes he wouldn’t ever be able to function effectively as a doctor and told me not to worry. He urged me to focus on the positives and to learn from my mistake. He warned, “If you aren’t sure, ask; never try and bluff it.”

I realised during this conversation away from the bedside I had made an awful error of judgement. I should have thought about John’s condition rather than following the routine procedure without thinking. The registrar tried to comfort me; “it wasn’t as if you had deliberately tried to kill him!” The joke fell on stony ground! I was silent but still tearful. He persisted “You have to hang onto the successes where you know you’ve made a difference. Don’t wear your heart on your sleeve; toughen up a bit. Don’t take it to heart so much! Everyone makes mistakes; that’s part of being human. It’s just in our business there are sometimes dramatic consequences, life and death, but you have to get over it. It’s not your fault. Remember, you didn’t cause the emphysema in the first place!”

I know he was trying to reassure me and to some extent it worked. I don’t remember having a conversation about what happened with the nurse in charge of the unit, although it may have taken place and I have just forgotten about it. I remember being called out of the coffee room to relieve someone for their break and being told to stop crying. There were
other patients on the unit who needed looking after; just get on with it. I don’t remember seeing the registrar again. I came to realise opportunities to talk like this were unusual - not part of normal ward life; the emphasis was on doing nursing not talking about it. Talking could be saved for the pub later but it was the funny stories that tended to be recalled and shared not the emotionally difficult ones.

As a consequence of my error, the unit decided to change its policy about clamping chest drains before moving patients. Eventually about six months later it was deemed an unsuitable place for newly qualified staff nurses to work because it was felt that junior staff needed more experience to work more independently in the single rooms. Supervising inexperienced staff placed a large burden on the senior staff. Certainly, I remember feeling alone and isolated in the single room unable to ask questions of the more senior staff and I worried that I knew enough about the patients’ complicated conditions to nurse them effectively. I continued to work on the unit but this incident inspired me to apply for an intensive care course to develop my theoretical knowledge underpinning my practice.

In the course of this PhD inquiry I have realised this was my only experience of a debriefing session (informal as it was) after a clinical event. When I became a ward sister I had the autonomy and power to instigate them for my own staff. I have also come to realise that I successfully blocked out this experience from my memory until I was pressurised during my progression exam, again during this inquiry, to show how a personal story could have an impact on an organisational system to influence change.

I felt destroyed by telling this story publicly and even here I still hesitate to present it. This is not because I am unwilling to own up to making mistakes because even at the time I remember doing this. It is because the emotions stirred by it are still painful and powerful; much easier to keep them buried in my subconscious! Nevertheless at the time, I was lucky to
have had a sympathetic registrar to help me, at least partially, process this experience. I was also lucky to be working at a time when litigation and mass media coverage were rare. Nurses were still seen as angels. Unions went on strike on the nurses’ behalf. At the same time, I worked in environments where the tacit message from senior staff was that one’s own needs didn’t matter, the patient’s needs were to come first, and we had to be strong. A show of emotion tended to be viewed as a weakness. Professional nurses did not let the pain and sufferings of others affect them; they just got on with the job.

However, from my experience with John, I learnt to question more, to identify the gaps in my knowledge base, to read around conditions I was unfamiliar with and not follow rules blindly. I always wanted to know why I was being asked to do something rather than accept the word of another nurse or medic. Nevertheless, while there were no repercussions personally, in the sense I was not held accountable for John’s cardiac arrest and death, I carried with me the emotional cost of that experience. I think this experience subsequently allowed me to notice and question the unintended consequences of cultures that support the implicit denial of the emotional experiences of nursing, although these insights were to come much later when I was teaching and away from the bedside.

Eventually, I was to explore through my master’s research, nurses’ stories of providing emotional support to patients and relatives and I was to value the theory of emotional labour and its impact which continues to influence my thinking (Hochschild 1983, Smith 1991). I was also influenced by Menzies-Lyth’s (1960, 1970) seminal work on the functioning of social systems against anxiety. She observed nursing structures and processes were used to avoid feeling the tension, distress and anxiety generated by both the simplicity of many tasks and the complexity of nursing ill and dying patients.
The next story I present also had a profound emotional impact on me but I was eventually able to process some of this on my own. Again, like the story with John, this was much later after the event. By now I was a ward sister in a different London hospital. One afternoon I was teaching in the school of nursing. While I was away from the ward there was a challenging cardiac arrest. A young man, Victor aged 17, who had recently had a splenectomy, (the surgical removal of his spleen), unexpectedly arrested. Because he was excessively obese, the arrest team were unable to resuscitate him effectively. Again the cardiac needle could not reach his heart muscle.

Victor’s parents were telephoned and asked to come to the ward. On arrival the staff nurse broke the bad news that their son was dead. Victor’s mother reacted with such desperation that she became verbally aggressive with the staff. I was urgently called by my junior staff nurse and asked to return immediately because the nursing team did not know how to ‘handle’ Victor’s relatives who were extremely upset.

When I arrived, both parents were alone with Victor in a side-ward opposite the nurses’ station. Victor’s mother was in the process of banging her head violently against the wall with some force. I remember not trying to stop her. I stayed calm and moved close to her. I said “I can’t imagine what you must be going through”; I had not had children of my own then, yet suspected that Victor’s mother must always have been fearful that Victor could die as a result of the surgery. Now her greatest fear had come true. What must she have been feeling?

I asked if both parents would prefer to be left alone with Victor. Her husband, I remember, said he would prefer me to stay as he tried to hold his wife. But she wrestled her way free and continued to hit her head against the wall for what seemed an eternity yet in reality was only a few seconds. I tried to touch her by putting my arms on her shoulders and encouraging her husband to also touch her. Eventually, after what seemed
an age she fell into her husband’s arms and sobbed so hard that I also started to cry. For many nurses this would have seemed unprofessional to show my distress in front of those requiring my help. (Don’t wear your heart on your sleeve, toughen up; be strong!)

Then in the time honoured tradition of caring through action, I made them a cup of tea! It seemed even at the time a futile gesture of caring but it gave me an excuse to let them be alone with Victor which I guessed at this stage would be important for them. By the time I came back with the tea, Victor’s parents were sobbing and I quietly slipped out of the room.

I can’t remember how long they stayed with Victor; I remember it being quite some time. When I emerged from the room I then wanted to focus on my distressed staff nurse. We talked the incident through and I remember reminding her the anger wasn’t personally directed at her. Instead, she had been on the receiving end of overwhelming grief and for Victor’s parents she was seen as representing ‘the hospital’ which, in their eyes, had let them down. I called a brief meeting with the rest of the staff before sending the staff nurse home. All this while, I was convinced I had done nothing for the parents. I interpreted what I had done as merely ‘being with them’ and criticised myself for not actively doing anything that really helped them. Instead, I was challenged in this assumption because Victor’s parents sent a lovely letter thanking us for our support which they had greatly appreciated sending gifts for the staff on the ward.

All the staff were very upset by Victor’s death as we had grown fond of him. He had been a patient for 10 days and was due to go home the day after the arrest. It was 1987, and reflection was not part of my nursing vernacular then. I would like to think I was influenced by my experience with John, although I am not sure I was really aware of the influence of that experience on my practice until during this inquiry. Perhaps the real driving force was that I wanted to support my staff. Therefore, I arranged for another ward meeting a few days later with a clinical psychologist to
help us process the experience. I decided not to attend as I felt that my role as sister may unwittingly inhibit the staff’s discussions so I stayed out on the ward responding to call bells and relatives’ inquiries.

I guess I was feeling pretty pleased with myself for this supportive initiative until a couple of days later I was to discover my ward receptionist had broken down in the photocopy room because she was very upset about Victor’s death and had witnessed the distress of his parents. This was a salutary lesson to remember: in future I would need to extend the debriefing to every team member, not just the nurses.

The powerful emotional impact of this incident continued to haunt me throughout my career prompting such reflective questions as: did I manage this situation in the most effective way? Should I have stopped Victor’s mother from hurting herself? Was this a caring act? Did I act in a professional way? Did I justify my actions to make myself feel better? Was I a good enough ward manager? What kind of a role model was I? I tried to talk all these questions through at home but found no-one really understood how this experience had affected me. I still use this story about Victor, in my teaching to show the need for embedding reflective inquiry into everyday nursing practice and to enable nurses to explore and develop effective interpersonal communication skills.

However, not all of nursing care is as dramatic as these two stories would suggest. In fact much ward work becomes repetitive and routine often encouraging the patient to be lost in the habitual nature of the work. As I have shown in my story of John, it is very easy in the repetition of nursing tasks to go onto ‘automatic pilot’, to not consider specifically what we are doing, and to make assumptions. In practice it is not uncommon to hear “we’ve always done it this way” suggesting potentially habitual and thoughtless practice.
I experienced this personally when I was having my first hip replacement in 2001. I had been given a spinal anaesthesia and consequently was incontinent post operatively. The nurse wanted to catheterize me but I refused. The lady opposite who had also been operated upon that day unfortunately was catheterised and the urinary catheter was not removed until she had had her bowels opened, 4 days later. Consequently, she contracted a urinary tract infection, was not able to mobilise as easily and ended up staying in hospital for several extra days. When I asked about the evidence underpinning the catheter removal after bowel evacuation the nurse answered: “We have always done it that way because Sister has always insisted upon it”. This experience confirmed even more the need for reflective inquiry and prompted me to question whether and how it might occur during care giving. We were increasingly emphasising reflective practice in the nursing curricula but to what extent was reflective practice really happening in the wards?

Clearly, this story demonstrates a lack of reflective inquiry and shows how the power of an individual can help to inhibit the learning and practice within the nursing team. I believe it is important to be aware of the choices we make in practice so that we can articulate them to others. For me, going even further to explore and then communicate the consequences of those actions is at the heart of reflective practice. Retrospectively, I was lucky having a doctor help me deconstruct the experience with John so that I could reframe and reconstruct the incident in order to learn from it. However, I did not remove the obstructing negative emotions as Boud et al (1985) would suggest were vital for a changed perspective. At the time I saw it as reassurance, now I see it as a form of spontaneous reflection. As the story of Victor showed, I tried to provide the emotional support for my staff that had been so crucial to me remaining in nursing, but I still ignored my own emotional needs.

In my experience, most nurses have encountered some challenging incidents during caring for others and sometimes they have experienced
emotional and difficult events in their own personal lives, which often remain unprocessed. What effect might that have on patient care? I believe if the emotional aspects of caring for others remains unprocessed then the nurse-patient relationship formed can be affected. This may result in detached and uncaring attitudes, communication or behaviour. Therefore, from the patient’s perspective, a potentially less effective therapeutic encounter is experienced.

During my degree, I was influenced by Carper’s (1978) patterns of knowing. This legitimised personal knowing as part of the knowledge needed to support nursing care. Therefore, equally, central to my practice both as a nurse and teacher has been the belief that everyone has a story to tell. The work of Stockwell (1972) about the unpopular patient and Menzies-Lyth’s work (1960) about defences against anxiety both had a big impact on my practice. Therefore, where possible I try to hear the story of the person I have been caring for. It involves listening to the stories of their lives, how their illness and experiences have shaped them while at the same time providing physical care. In hearing their story I am also learning about myself. Stories are a two way process. If I could have processed the two experiences with John and Victor further, through reflection away from the bedside, I now believe I would have been able to maximise my learning opportunities much earlier. Prior to starting this PhD inquiry and based on my experience and conversations with other nurses in the classroom, I assumed that in the ward, stories would be shared. I imagined at best, stories might be shared in the coffee room or later in the pub with other nurses. Alternatively, they might be shared with family and friends who may or may not have any experience of healthcare, or perhaps they were never processed at all. Was reflective practice really happening where it mattered?
**Roots of this Inquiry**

I have facilitated reflective practice for about 16 years and found many nurses valued the opportunity to talk about their stories of practice. Invariably, these stories contained a strong emotional component. Sometimes the stories went as far back as their training days. They talked about the dilemmas they faced in the clinical setting or the problems encountered with other staff or difficult choices of delivering care when there was no clear cut research to back up the choices. I was facilitating student nurses as well as two post qualifying modules which I had also written. These modules were always well evaluated with several students claiming that it had been the most valuable part of their degree. Consequently, this prompted me to investigate further their claims.

In 2000 Brenda Clarke, a colleague and I carried out a small scale qualitative research project to evaluate the two post qualifying reflective practice modules I managed, designed and facilitated. The study involved 15 nurses and explored the nature of the nurses’ reflections. We used diary analysis and semi-structured interviews (Clarke & Hopkinson 2000, Clarke & Hopkinson 2001, Hopkinson & Clarke 2002). We found reflective practice helped the participants develop empathy and working relations through greater awareness of their prejudices, assumptions, values and practices. However, it became apparent on interviewing participants, that the nurses’, although enthused by the modules, had great difficulty in obtaining regular reflection opportunities in the real world of practice.

There were political drivers for nurses to be engaged in clinical supervision i.e. a process which uses both reflection and problem solving to develop practitioners’ skills. These included clinical governance, the knowledge and skills framework and the Agenda for Change policies (DH, 1999, DH 2004a, b). Yet for many of the nurses I had contact with, it seemed that clinical supervision had not been adopted consistently.
In the Classroom
I won’t do this bloody role play
You’ll not catch me giving anything away
The work situation’s different, see
What I present here isn’t really me

Tell me the answers, that’ll do
I’ll sit here expecting it all from you
It’s your fault anyhow, you’re not teaching me right
I’ll sit here silently wanting a fight

Teacher’s challenging me now, how bloody rude
I’m keeping shtumm and ignoring this dude
The discussion’s too boring, next time I won’t show
She says “ask for what you want” – I say “Go to Hell, No”!

Clare Hopkinson 13/10/05

In the university, the tide was turning along with the language of reflective practice. Reflective practice became absorbed into work-based learning and embedded in the curriculum so that student nurses were now reflecting on their practice one day a fortnight in class. Reflection was becoming codified with a plethora of reflective models to guide nurses’ learning\(^2\). Students on all kinds of modules were writing reflective essays and producing portfolios of evidence about their practice. All teachers were suddenly facilitating reflective practice; in my faculty it was not seen as a specialised process. At the same time cohorts of students were becoming much larger. Learning was mostly via lectures rather than experiential. I was experiencing a lot of resistance from student nurses’ sharing their stories of practice. Even, my post qualifying modules which had always been full were now dwindling with less students signing up or the module not running at all. What was going on?

These apparent contradictions between practice and classroom, led me to wonder how easy is it for nurses to reflect while giving care, and provoked a growing curiosity and spark for this inquiry. A research question began to

form more clearly: What are the tensions and possibilities of reflecting while giving care?

In the following chapters I explore this research question through a multi-stranded collaborative action research approach. The thesis will demonstrate reflecting-in-action is a nuanced complex process concerned not only with the nurse’s inner thought processes but also her relationship with those with whom she works and the culture and organisational structures that support and inhibit her reflecting. Thus reflecting is political. The interplay between structure and agency is explored through Bourdieu’s (1990,1993a, b) concepts of habitus and fields of practice. Hence this thesis inquires into the learning culture in the ward which both enables and inhibits reflection. I have used Bourdieu’s work and interwoven it with feminist and systemic inquiry perspectives. I make no claims for absolute truth rather provide a partial, contested and contextualised perspective.

In Chapter 2 I present how the collaborative action inquiry was undertaken and discuss underpinning epistemology, ontology and methodology. In Chapter 3 I show how the poetry emerged and became central to this inquiry as a deliberate reflexive process that bridged ontology, epistemology, methodology and the inquiry findings. Chapter 4 focuses on one of the major contradictions of the inquiry: that nurses were too busy to reflect yet claimed they reflected all the time. This phenomenon is discussed with reference to the historical nursing culture based on class distinctions and the status of nursing through Bourdieu’s notions of habitus and field. Chapter 5 portrays the culture of whinging and gossiping as spontaneous reflective and quasi-reflective processes. In Chapter 6 I explore developing systemic agency and political resilience through reflecting highlighting how challenging it is to influence a fragmented organisation such as the NHS. There is an exploration of systems which encourage reflecting to order. In Chapter 7 I explore embodying reflexivity through bodily awareness, process and context in the moment of practice.
through an avoidance of the body/mind dichotomy. This includes an understanding, awareness and resilience to the emotions present in the ward. The final chapter 8 reflects upon the inquiry and returns to storytelling, highlighting the unique contribution this thesis has made and the organisational learning for nursing practice and nurse education.

The format of this thesis uses italics for direct quotes from the co-inquiry and for key concepts.

📖 This sign and font refers to my diary entries.

🗣️ This sign and italics is dialogue from the co-inquiry meetings or interviews.

I have also used the convention of referring to the nurse as a female since using the ‘he/she’ process is somewhat cumbersome.
Chapter 2: A Collaborative Inquiry

The last chapter focused on the roots of the inquiry. I showed through stories my values and interests and how I came to facilitate reflective practice with healthcare staff. I tried to demonstrate the power of storytelling showing how past experience can be the muddy footprints that impinge on future practice. Here, I begin with another spark for this inquiry from the classroom which was the mismatch between how some students viewed reflective practice as purely an academic exercise unrelated to the reality of practice and Schon’s notion of it as practical knowledge. I provide a short review of the literature on reflective practice and reflecting-in-action to situate the inquiry before telling the story of designing the inquiry and discussing the methods used.

The underpinning values and philosophy associated with collaborative inquiry are explained and the central concepts used in this thesis of *habitus* and *field* and *doxa* from Bourdieu are discussed. I focus on why I chose a multi-stranded approach that included the formation of a collaborative inquiry group, my return to practice as a staff nurse on a surgical hospital ward, and a reflexive inquiry into my teaching practice. Therefore this chapter presents the epistemological, ontological, and methodological aspects of the collaborative inquiry, which is situated in the wider paradigm of participatory action research. In keeping with the action research paradigm, emerging processes included production of a storyboard as our data and sense making, interviews with co-inquirers, collaborative work with modern matrons from two different hospital Trusts and finally the formation of an action learning set for modern matrons.
“Real knowledge is to know the extent of one’s ignorance”  Confucius

Throughout this inquiry I have read consistently, making it difficult to isolate all my starting influences. Perhaps this is down to my lack of systematic record keeping but also reflects the plethora of published material relating to reflection and reflective practice in healthcare. I have facilitated reflective practice across a range of healthcare professionals for so long that I came to this research with reading dating back to my first degree in 1991.

The origins of reflection lie in philosophical thought. Consequently, reflection is variously understood as ranging from casual ways of thinking about practice at one extreme to structured processes based on the philosophical underpinnings of, for example, Dewey, Habermas, Gadamer (Taylor, 2006, Kember, 2001, Johns, 2000) at the other. In the social sciences research literature, reflection forms part of the concept of reflexivity and is associated with action research, critical pedagogy, critical theory, critical social theory and several qualitative research methodologies such as feminism, heuristic research and ethnography. The research definitions of reflexivity will be discussed later in the chapter.\(^3\)

The literature is further complicated by the variety and diversity of terms associated with reflection including: ‘critical reflection’, ‘reflective practice’, ‘critical incident analysis’, ‘praxis’, ‘reflection-on-action’, ‘reflection-in-action’ and ‘reflexivity’. While sometimes these terms seem to describe the same process, a plethora of authors provide differing definitions adding to the complexity of the phenomenon (Hopkinson, 2009). Kember (2001) argued that formal definitions of reflection are hard to find in the overabundance of reflective practice literature, because reflection is

\(^3\) See section Establishing Quality in Collaborative Inquiry
diversely and disparately used by a wide variety of professions in different contexts. Nevertheless, it seems generally accepted that reflection without some form of action and a changed perspective is a sterile activity (Hopkinson, 2009). Indeed, the vast majority of the literature on reflection focuses on personal stories of practitioners’ experiences as a way of creating, modifying, developing and thus improving the individual’s practice.⁴

Before this inquiry, the literature I used and read to inform my facilitation, was predominately from the fields of education, nursing and included, to a limited extent, feminist writings. The most important influence on my facilitation and understanding of reflective practice was the work of Paulo Freire (1970, 1998a, b) whose writing was inspirational. I absorbed much of it into my practice; especially to constantly remain curious while encouraging students to use their reflections to develop and change their own practice. In particular, his concept of conscientization or critical self-consciousness, which is a core tenet in critical pedagogy and participatory action research, helped form my understanding of reflection. Therefore for me, reflection entails a conscious search to become aware of one’s actions and any unintended consequences of those actions, through reflecting either by oneself or in relation with others, in order to challenge the social, political, economic, cultural and historical structures that can make a difference to peoples’ lives. For Freire (1970, 1998a, b) this forms the basis of all human learning from experience and has the potential for social change, emancipation and transformation.

As shown in the last chapter, I preferred to use storytelling to encourage students to learn from their practice. I wanted students to use their stories to develop their own practical knowledge and to change and influence their work environments. It was by telling their practice stories; the stories that

mattered to them and were relevant to their day to day work, that change and learning could happen. As Clandinin and Connelly (2000) note:

“experience is the stories people live. People live stories and in the telling of these stories, reaffirm them, modify them and create new ones. Stories lived and told educate the self and others” (p.xxvi).

I prefer to use the terminology of “stories of practice” which I took from Bolton’s work (2001). Previously, I struggled with the language of ‘critical incident analysis’ (Benner 1984, Brookfield 1995) because I felt it inhibited students’ learning from the ordinary events in their practice. ‘Critical’ in health care terms implies an emergency and a possibly dramatic event requiring immediate intervention whereas I found over the years most nurses struggled particularly with practice events that had a managerial, ethical or emotional aspect (Clarke & Hopkinson 2000, Hopkinson & Clarke 2002). In contrast the term ‘critical’ in the language of reflection refers to a process of challenging the values, contradictions, distortions and assumptions embedded in practice which I now see as a process that challenges the dominant discourses that can impinge on practice.

Before beginning this PhD, I frequently heard comments from student nurses that reflection was purely an academic exercise divorced from the realities of practice. This was the antithesis of what Schon (1983) was arguing. He posited the potential for learning from messy, complex clinical situations and valued practical knowledge arguing for an “inquiry into the epistemology of practice” (Schon, 1983 p.viii). By this he meant knowledge which is situated directly in practice and which he earlier described as “theories in use” (Arygris & Schon 1978).

Arygris and Schon (ibid) found that “theories in use” were often different from the stories of practice told by practitioners, which they called “espoused theories”. In other words, we do not always do what we say we do, and theory does not always prepare us for the reality of practice. So for Schon it was important to learn directly from practice itself in the mess,
complexity and uncertainty of the action. He believed that theories did not always provide all the answers; they had to be shaped by the practitioner in the practice setting through processes of reflecting and knowing-in-action. He argued for double loop learning whereby action and reflection highlighted the contradictions and assumptions embedded in practice so that practitioners could learn to challenge these and thus develop their practice. For as Freire (1970 p.68) argued in sacrificing action the story of the experience would become just verbalism, while the sacrifice of reflection could result in purely activism. Paying attention to both action and reflection produced the politically informed praxis. For me, this form of practical knowledge in the midst of action, or as Schon (1983) called it reflection-in-action, was not an academic exercise as shown with John in the last chapter; it could be a matter of life and death. So I became fascinated by the mismatch between how some students regarded reflection in the nursing curriculum and how I saw its purpose as developing and challenging practice. This intrigued me so much that it became another spark for this inquiry.

What does the Nursing Literature say about Reflection-in-action?

The emphasis in the reflective practice literature tends to focus on written forms of reflecting\(^5\) while being somewhat vague about the actual processes that constitute reflection-in-action. Likewise there is little emphasis on the political nature of reflective practice with some notable exceptions\(^6\).

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Clarke et al (1996) suggested reflection-in-action is a deliberate thinking process allowing practitioners to reshape, reformulate and make accessible their knowledge while practising. However, Clinton (1998) argued there are aspects of practice which cannot be represented in one’s consciousness so he saw reflection-in-action as an immediate awareness of actions. He saw reflection-in-action as a misnomer and questioned whether it was possible to achieve at all. For Rolfe (2001) reflection-in-action is more than just thinking about a problem; it is a form of on the spot experimenting which brings together thinking and doing (praxis) and implies an imaginative process.

According to the Oxford English Dictionary (OED, 2006 p.1208) reflection is: “to throw back, reconsideration, go back in thought, mediate or consult with oneself”. This is rather a simplistic view for professional practice as it gives little advice on how to reflect in a meaningful way. It implies only thinking about an experience and whilst this may be useful, it does not necessarily challenge or offer any new actions for practice. Two definitions are given below to show the range of possible interpretations about what it means to reflect on one's professional practice:

“Reflective learning is the process of internally examining and exploring an issue of concern, triggered by an experience which creates and clarifies meaning in terms of self, and which results in a changed conceptual perspectives” (Boyd & Fales 1983, p 100)

“A process of consciously examining what has occurred in terms of thoughts, feelings and actions against underlying beliefs, assumptions and knowledge as well as against the backdrop (i.e., the context or the stage) in which specific practice has occurred” (Kim 1999, p 1209)

Both these definitions recognise reflection as a process for improving practice through increased self-understanding and inquiry into the context and structures that support practice. Kim’s (1999) notion of ‘consciously examining’ practice (and this includes examining the context in which care is delivered) offers a depth missing from the earlier OED definition. Both
these definitions of reflection however, suggest a solitary pursuit and it is not clear whether the reflection happens in the midst of practice or whether this occurs later. Whilst personal reflection may be easier to carry out, I suggest it can limit the possibilities of maximising learning from reflection. For me, the social nature of reflecting with others is where a changed perspective often occurs. This is because I believe reflecting on one’s own can destabilise a nurse’s practice through too much self criticism or it can condone her practice through too little challenge. For me, reflective practice involves noticing, imagining, challenging, inquiring, reframing, acting and developing different ways of knowing ones’ practice in order to become a more effective practitioner. In other words, it means the nurse is aware enough to make choices from a range of possibilities in the midst of the action of practice, and I refer to throughout this thesis as reflecting-in-action.

Reflective practice has been criticised on the grounds of timing (affecting recall), interference from stress and emotions, particularly anxiety (Newell 1992, Mackintosh 1998, Ixer 1999), and because it lacks a universal definition (Mackintosh 1998). This last criticism assumes that a single definition is necessary for understanding such a complex phenomenon and that there is perhaps only one ‘right’ way of knowing it. But one purpose of reflective practice is to transform and widen one’s perspective (Mezirow 1981, Taylor 2006) as well as to appreciate and accommodate alternative perspectives. This makes it unsurprising that numerous definitions exist and for me means practitioners can shape and use reflection in meaningful ways that develop their understanding of their own practice.

Whilst there have been a large number of papers relating to reflective practice that supports its worth⁷, surprisingly, there have been relatively few empirical studies in nursing. Of the empirical studies, both quantitative

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and qualitative approaches have been adopted and two inquiries used action research (Taylor 2001, Kim 1999). When I started this inquiry in March 2003 I found a gap in the literature relating to reflecting at the point of care delivery. Indeed, only one small scale observational study by Powell (1989) focused on reflection-in-action in a nursing ward. It used a non participant observation strategy and analysed data based on Mezirow’s levels of reflection. Essentially this was a reductionist approach, in keeping with the scientific paradigm prevalent at that time, applied to a highly elusive and complex phenomenon. During the inquiry years I became aware of several studies relating to either practising nurses’ reflections or reflecting in a clinical environment (Brookes 2001, Taylor 2001, Mantzoukas & Jasper, 2004, Stockhausen, 2006). I chose not to read this literature until after I had analysed the on-going data from all the different strands of this inquiry i.e. March 2007. These studies will be presented in the findings chapters.

Schon recognised the possible difficulties of reflecting in organisations when he questioned:

“"What sets the limits of our ability to reflect-in-action? How do individual and institutional constraints interact with one another? And in what directions should we look to increase the scope and depth of reflection-in-action?"” (Schon 1983 p.74)

In the nursing literature for the most part the social construction of practice is not engaged with so that there is an assumption that reflecting-in-action takes place individually and in the head of the practitioner while this self regulatory process will influence the quality of care giving (Fejes 2008). But how do we know this? I now move on to present the design of the inquiry.
Designing a Collaborative Inquiry

Given my ontological roots; based on stories and action, I was drawn to the action research paradigm because it valued practical knowing. Yet at the start of the inquiry I did not really think too much about the significant methodological or ontological differences between co-operative, collaborative, participatory action research and critical pedagogy which I found in the literature. If I saw them at all at this stage, I just recognised them as part of the participatory action research paradigm. I was far more concerned with getting straight into the inquiry. I deliberated whether the approach fitted the research question and concentrated on getting through the interminable process of ethics approval. It was only later when actually involved with the co-inquiry group and following more reading (Reason & Bradbury 2001, Tripp 1998, Usher & Edwards 1994) that I started to wonder about the language used and to begin questioning the methodological approach I had chosen. This questioning has been influenced by reading about social constructivism, post-modernism and post-structuralism.

I chose to base the methodology on the work of Bray et al (2000) who define collaborative inquiry, as:

“[the] process of repeated episodes of reflection and action through which a group of peers strives to answer a question of importance to them” (2000 p.6).

Bray et al (2000) claim the inspiration for collaborative inquiry was co-operative inquiry originally proposed by Heron (1996). Heron coined the term ‘co-operative inquiry’ in the early 1970s as an alternative paradigm to traditional scientific and social research which he believed excluded subjects from the research process. He argued research participants were

alienated from the thinking and decision making that generates, designs, manages and draws conclusions from the research (Reason 1994, Heron 1996, 1985). He suggested the researcher could be “subject and experimenter combined”, to produce an “inquiring agent” (Heron 1996, p.3) arguing that autonomy and co-operation were mutually enhancing values (ibid). Thus the research he proposed was experiential, involving equal relationships where the role of the researcher was facilitative and shared amongst those involved in the research. Bray et al (2000) and Heron (1996) refer to this process as cycles of reflection and action and argue knowledge creation emerges and is refined overtime.

Participants, Heron (ibid) claimed, were both co-researcher and co-subjects so that the research is ‘with’ and ‘by’ co-inquirers, as they are frequently referred to in the action research literature (Reason & Bradbury 2001, Bray et al 2000, Heron 1996). The assumption is that, co-inquirers involved in mutual and collaborative working are able to change their practice and organisation for the better, based on the new ideas generated, the joint sense they have made of these ideas which are then incorporated and tested by the group in the practice setting. Weil (1998) found this approach could be limited because it failed to take into account the system in which the practitioner is a part, and which has the potential to both enable and disable practitioners’ practice thus affecting their ability to influence and transform their organisations. This is especially noticeable in the NHS where change is difficult to influence and sustain.

Consequently, Weil (ibid) argued for a process she called critically reflexive action research. Through a group inquiry process where practice is brought into consciousness, reflected upon and challenged, key questions for systemic inquiry and critical reflection are realised. She argued the group process, through inquiry, dialogue, and challenge could tease out tacit organisational systemic knowledge at all levels in an organisation. Most co-inquiry action research literature assumes that improvements in professional practice, organisational outcomes or social
democracy and justice will occur (Yorks & Sharoff 2001, Bray et al 2000, Heron 1996). Weil (ibid) argued this is too simplistic and individualistic, denying the complexity of relationships, power dynamics and the enabling and disabling systemic practices and patterns developed over time that happen in all organisations.

I was drawn to collaborative inquiry because arguably this type of research is holistic, valuing creativity because human flourishing is seen as important. Consequently, there is not just an emphasis on the practical outcomes of the research and action is not separated from knowledge; both are intertwined (Reason & Bradbury 2001). As Reason (1994 p.333) suggested “knowledge arises in and for action” and therefore practical knowing is valued and made explicit (Reason & Bradbury 2001, Bray et al 2000, Heron 1996). Practice generates theory and in this paradigm practical knowledge is given more precedence than propositional knowledge (Brydon-Miller et al 2003). Learning is seen as a continuous and important part of the process, generating valid knowledge construction (Reason & Bradbury, 2006). For as Bray et al argue:

“effective collaborative inquiry demystifies research and treats it as a form of learning that should be accessible by everyone interested in gaining a better understanding of his or her world” (2000 p.3).

I was attracted to the epistemological argument that the research is inseparable from the learning of those taking part. There is an implication here, albeit not explicit, that learning from mistakes can also generate valuable knowledge. This resonated with a core belief of mine about the purpose of reflective practice. However, I found in the classroom many students were using reflective practice as a justification of their practice rather than for challenging it. Consequently, I wanted to ensure that this inquiry would make a difference to co-inquirers’ practice. Thus, developing accessible practical knowledge generated from practice and for practice was attractive and led to the design of this collaborative inquiry.
In collaborative inquiry ‘critical subjectivity’ and not objectivity is embraced because it is situated in a specific context, encouraging a deepening of the understanding and complexity of the phenomenon being inquired into. In choosing this methodology, I felt collaborative inquiry was compatible with many of the values I brought to my teaching practice that had been shaped by my experiences as a nurse.

One of the important distinctions in this paradigm, which differs markedly from positivist scientific research, is the belief that human nature and thus knowledge is socially constructed, historically constituted and therefore sense making hinges on pluralistic interpretations (Reason & Bradbury 2001, Freire 1998a, b, 1970). In other words, there are many interpretations of a particular phenomenon made possible by the researcher’s and co-researchers’ worldviews and values, the timing of the research and the relationships to and with the phenomenon under examination. Ontologically my world view is influenced by post-structuralism, in that I assume all knowledge is partial and contextual; being a product of our being in the world now and the historical, cultural, socio-economic and political influences which I/we may or may not be consciously aware of (Butler 1999, Freire 1998a, b, Hodge 1995, Usher & Edwards 1994, Bourdieu 1993a, Lather 1991, Gadamer 1975). As humans we are inconsistent beings full of contradictory practises and this requires recognition as part of the research process.

Three Levels of Reflexive Inquiry

appropriate practices or degenerative and inappropriate practices. Therefore she argued researchers should be sensitive to noticing, reflecting and adjusting their practice through the pursuit of “inner and outer arcs of attention” (Marshall 2001). The inner arc of attention seeks:

“to notice myself perceiving, making meaning, framing issues, choosing how to speak out and so on. I pay attention to assumptions I use, repetitions, patterns, themes, dilemmas, key phrases which are charged with energy or that seem to hold multiple meanings to be puzzled about, and more. I work with a multi-dimensional frame of knowing; acknowledging and connecting between intellectual, emotional, practical, intuitive, sensory, imaginal and more knowledge” (Marshall 2001 p.433)

The outer arc of attention refers to outside the self being linked to collaborative and relational working. Thus researchers do not bracket off their own experience and influences but openly accept that they are part of the inquiry process. Consequently, they stay alert to questioning, raising assumptions, noticing choices, questioning the sense making, and testing potential ideas with others in repeated cycles of reflection and action. This places diary keeping centrally as part of first person inquiry and dialogue at the heart of second person inquiry (Nolan 2005).

Torbert (2001 p.253) defined second person inquiry as “speaking-and listening-with-others [as] …the quintessential second person research/practice”. In other words, it means a relational process involving more than one person. He suggested “public testing of our interpretations” occurs in dialogue with others (ibid p.255). As Weil (1998) noted, the wisdom of organisations is held by those working in them so that through conversation and reflexivity, the interpersonal and social learning tacitly embedded can be valued and made explicit as practical knowing. Finally, third person inquiry takes place at an organisational level where “research/practice, focuses primarily on the exercise of mutual power to co-construct the future” (Torbert 2001 p.257). Weil (1999, 1998) suggests this level of reflexivity involves systemic inquiry to highlight disabling and
enabling organisational patterns over time. Torbert (ibid) saw this as organisation learning or research dissemination.

Early in the inquiry in 2003, I chose these three levels as part of the research design because I found there was a concentration in the nursing literature relating to the individualisation of reflective practice. While there were some studies about group reflection the emphasis focused on individual learning within a group process and not the process of dialogue, that is, a two way dialectic exchange. There was very little if anything about how organisational, political and systemic change could be arrived at through reflective practice. By considering reflective inquiry on these three levels I was beginning to shift my thinking so that I was noticing the complexity and consequences for individuals changing their practice and influencing their organisations. Before learning about systemic inquiry and Bourdieu’s work, I had a humanistic standpoint inspired by authors such as Rogers’ (1980) “A Way of Being”, Heron’s (2001) “Helping the Client” and Egan’s (1994) “The Skilled Helper” which focused on self actualisation and individual change processes. I had not meaningfully considered the implications of the systemic influences on the person. Rather, I tended to assume change would happen as a consequence of a practitioner raising practice issues. I began wondering about the age old sociological debate concerning the relationship between agency and structure and its potential relevance for understanding nurses’ experiences of reflecting. To what extent did reflection happen in nursing teams? Was there any second person inquiry happening in practice? And what might be the significance of the structure agency dialectic for understanding nurses’ reflecting while giving care?

In the nursing literature I found only one study (Jenkins, 2007) using the three levels of inquiry cited above which was not available at the beginning of this research. However, there are some studies based on Heron’s work

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(1996) adopting co-operative inquiries\(^{10}\) and others using collaborative inquiries.\(^{11}\) Some participatory action research studies have been carried out in nursing especially in relation to community development.\(^{12}\) Nevertheless, these studies do not differentiate or suggest levels of inquiry.

At the start of this inquiry my research was aimed at inquiring into the tensions and possibilities of reflecting during care giving from the three positions of first, second and third person inquiry. I wanted to design an inquiry that included my own first person reflective processes and research, that included a collaborative inquiry with a group of experienced reflective practice practitioners and one that could inquired into the organisational structures and processes that might encourage or impinge on reflecting while giving care in a hospital ward setting.

As the research progressed I found the language of first, second and third person inquiry cumbersome and not accessible to the practising nurses I was working with. Now I prefer to call these three levels of inquiry: personal reflection, where the nurse reflects on her own, relational reflection which involves an interpersonal relationship either where the nurse reflects in a one to one relationship or group process, and organisational reflection which involves systemic and organisational learning (Hopkinson, 2009). Thus the organisation learns and changes its practices as a consequence of the reflection so that the historical disabling patterns in organisations are challenged and changed. Hence systemic changes in working practices that make a difference to nurses’ working lives become embedded in the organisation as a consequence of reflective inquiry. I now consider how I intend to ensure this research has quality, preferring this term to those of rigour, validity and reliability. I link these

\(^{11}\) See for example Pound 2003, Konzal 2001, Krishnasamy & Plant 1998
\(^{12}\) See for example, Koch & Kralik 2006, de Kronig & Martin 1996
ideas with Bourdieu’s concepts which have helped shape the design and analysis of this inquiry.

**Establishing Quality in Collaborative Inquiry**

It is clear from the ontological, philosophical and epistemological positioning of this research that it is unlikely to produce ‘generalisable’ findings. Quality however, may be judged in relation to practical purpose and the impact of this action inquiry. I have interpreted this as the co-inquirers’ learning, multiple ways of knowing, the dialectic relations of those involved including the level of participation at all stages of the process, the emergent process reflecting the desires and consensus of the co-inquirers, the ethical nature of the inquiry, the level of democracy, and the nature of the critical reflexivity present within all aspects of the inquiry (Chui 2006, Reason & Bradbury 2001, Marshall 2001, Weil 1998, Heron 1996). An ideal to work towards is emancipation and social transformation but since collaborative inquiry is pragmatic, being situated in the real world of practice, it is not always possible to attain such laudable results. Particularly important for me is adopting a representation which is firmly rooted in self critique and critical reflexivity.

Therefore, I needed to understand the complexity of what reflexivity might mean for this inquiry and through literature searching and reading have expanded my understanding of it from the feminist, social science and action research fields. For Lather (1991 p.10) emancipatory praxis means the researcher uncovers hegemonic practices and her “complicity in what one critiques”. For Bleakley (2000a, 1999) reflexivity implies holistic, aesthetic and ethical practice and is based on how we act and position the inquiry. While Woolgar’s notion of reflexivity:

“is a willingness to probe beyond the straightforward interpretation …as the impetus for exploring different ways of asking questions about knowledge practices” (1988 p.16-17).
Woolgar suggests there is a continuum of reflexivity from benign introspection to “radical constitutive reflexivity”. Radical constitutive reflexivity in research processes is achieved by intentionally looking for similarities between our actions and the actions of those in the field. In the next chapter I develop this notion alongside my understanding of transference and counter-transference in a process called ‘the parallel process’. Radical constitutive reflexivity recognises there is a difference in the way an experience is represented and what actually occurred.
Consequently, Woolgar argued that representations or reflective stories may be different for the actors involved in the same experience.
In considering the stories of practice presented in this research as representations of life they become a form of reality in their own right. This seems obvious now but is a definite shift in my thinking since beginning the inquiry. There is a presupposition here that the story I will tell of this research will be different from the stories told by the co-inquirers because we have different world views. And as the coordinator of the different strands of this research my voice will dominate. I hope I have laid bare my key values, positioning and interests that will affect how I have attempted to make sense of the experiences contained in this work, in relation to my research question and emerging questions. As Usher and Edwards note:

“Reflexivity is not just a matter of being aware of one’s prejudices and standpoints but of recognising that through language, discourse, and text, worlds are created and re-created in ways of which we are rarely aware. We cannot always recognise that we are subjects within language and within particular historical, cultural and social frameworks. The key questions then become how we both constitute and are constituted by language and where lies the power to interpret and control meaning?” (1994 p.16)

Bourdieu (1993b) refers to this process as objectification of the objective. Before commencing this inquiry I was not familiar with Bourdieu’s work. I was drawn to it because it encapsulates conscious and unconscious relational processes and this linked with my interest in the parallel
process\textsuperscript{13} which has been central to my facilitation of reflective practice for more than ten years. In fact Bourdieu rejected binary thinking that placed dualities such as “body and mind, subject and object, understanding and sensibility” in opposition (Bourdieu & Wacquant 1992, p.20). He believed reality was imprecise, woolly or fuzzy and that academics had a tendency to collapse practical logic into theoretical logic which did not do full justice to the practical experience (ibid 1992). His concepts encourage uncovering “the social at the heart of the individual” (ibid p.44).

Bourdieu (1993b) argued that the relationship between structure and agency was not a dichotomy; it was complex and could not be simply reduced to a typography or hierarchical schema. Likewise he was against the conscious and unconscious split arguing it was not noticed during the logic of practice (Bourdieu & Wacquant 1992). His central tenet proposed an inter-play between the agent and structures in any field with both subtly influencing each other. He described the concept of field as dynamic and a social formation with its own functioning laws. These may be consciously and unconsciously embodied by those in the field, a term he called habitus. He argued that habitus and field were interrelated and were inextricably linked to power.

Bourdieu (1993b) noticed the tendency for the social order to remain static and suggested what is valued in a field is often perpetuated remaining unchallenged as a consequence of a wider field of power. In certain fields of practice distinct characteristics are learnt, played out and adopted unquestioningly as ‘the norm’. This allows for the absorption of the dominant cultural processes by individuals and keeps the social orders for example, gender and class distinctions, intact. Therefore, a field is socially constructed and inter-dependant with other fields. It has historical, political, symbolic and/or cultural influences. Bourdieu argued the field of a given practice and its wider field of power were based on a number of types of

\textsuperscript{13} The parallel process is an unconscious process that includes concepts such as transference and counter-transference. It will be discussed more fully in chapter 3.
capital which he called cultural, social, economic, political, legitimate and symbolic. A field is more than just a contextualisation of the research. Bourdieu’s notion of reflexivity involves questioning the predispositions of a particular cultural field to include the historical structures of the field itself and analysis of its multiple components as well as the relationship of the field to the external fields of power.

Bourdieu’s concepts of habitus - “a set of dispositions which generates practices and perceptions” (1993b p.5) so that it influences subtly our way of being in the world with others and therefore we come to embody these dispositions; and doxa – assumptions so taken for granted as to be invisible – are important concepts to work with as part of the reflexivity of this research. Bourdieu (1993a) argued that the power of language to classify was fundamental to all cultural production and questioned hegemony associated with such classification. The social field or context in which this classification takes place is also dependant on authorisation, i.e. power, and again is embodied unconsciously in the habitus and field. I used Bourdieu’s concepts as part of my reflexivity throughout this inquiry and particularly to question and understand my practice observations in Strand 2\(^\text{14}\) enabling me to analyse some of the data.

Through writing this thesis, it has become apparent just how complex the concepts of reflexivity and reflecting-in-action actually are. And whilst they may appear the same, or to overlap because they both refer to practical knowledge and inquiry into one’s practice, I now see them as operating at different levels of reflection. For me, reflexivity holds the multiple layers demonstrating the complexity of an experience in a way that reflecting-in-action does not overtly address (Etherington, 2004). The boundary between reflecting-in-action and reflection-on-action for me is now blurred because by reflecting after an experience there is also a process of reflecting-in-action. I now prefer the language of reflexivity which

\(^{14}\) This is the second part of the inquiry in which I returned to practice to observe my own and nurses’ reflecting in the ward
encompasses Bourdieu’s complex concepts of *habitus* and *fields of practice* with their social, cultural and historical undertones and recognition of power differentials. However, this insight came through the writing phase of this co-inquiry and so I show in the following chapters the journey that charts how this shift in my understanding occurred. I particularly address this in chapter 7.

In applying my own quality criteria in this inquiry, I have attempted to co-construct meaning with all the participants, but recognise that ultimately it is my interpretation that will dominate and therefore I must stay reflexive to my own embodied dispositions (*habitus*) and *field of practice*. I have tried to show the complexity of reflecting in the ward. I hope to show the contradictions and paradoxes that challenged my tacit assumptions in practice, in the classroom, and as a researcher, by noticing issues of power and asking ineffable questions. Previously, while I recognised the importance of questioning I also assumed that questions needed to be answered. Paradoxically, I valued the process of learning but also expected students to answer their practice questions with ‘the right answer’! This approach has power implications for me now.

**A Multi-Stranded Approach**

I designed a multi-stranded collaborative inquiry containing three strands. A strand was the term I used for each of the three separate collaborative inquiry groups to be recruited. Each strand represented a different phase of the research.

In Strand 1, I decided to recruit a co-inquiry group, from practitioners having a variety of clinical backgrounds, who had studied a post-qualifying course in reflection. I felt this would enhance the exploration of reflecting-in-action helping to identify best practice that could be taken into the next
two strands. My aim was to allow for comparisons between reflecting away from the bedside and those by the bedside as part of the inquiry. I envisaged the main form of data collection would be through storytelling of practice experiences.

In Strand 2, I wanted to work with a nursing team, and utilise my own reflective accounts including participant observation, by returning as a practising nurse. Once in the ward, I would recruit a co-inquiry group from the nursing team to inquire into the possibilities and tensions of reflecting during care giving. In Strand 3, I hoped to work with another nursing team to see if the environment or ward culture affected reflecting-in-action. In keeping with the emerging nature of this paradigm, Strand 3 changed to interviews with key people in practice development and risk assessment roles, and involved an action learning set with modern matrons. Finally, a Trust reflective model was designed with a group of modern matrons from a different Trust.

A theme continuing throughout all the strands was my own first person inquiry. I have kept a personal diary as part of my teaching practice for a number of years and it became an integral part of the research process. The intention was to chart the questions that emerged as I shifted attention to reflecting in the context of the ward from that as a teacher. My purposes were to notice my reflections as I participated in care giving after an absence of 10 years, to reflect on my practice as a teacher facilitating reflection in others, to reflect as a PhD researcher engaging with new literature and as a SOLAR 3 participant. However, most importantly, was to develop as a co-inquirer and co-subject in relation to reflecting-in-action both in and out of the ward.

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15 I was a PhD student in the SOLAR 3 cohort. We met 6 times a year for intensive workshops based on Weil’s (1998) critically reflexive action research process where I developed my co-inquiry action research skills through a critically reflexive group process in a cross disciplinary group.
Gaining Ethical Approval: A Story of Hidden Power

As I have argued, in some empirical and social science research detached propositional knowing and ‘objective’ positioning is highly regarded with subjective and action orientated inquiry seen as less worthy (Brydon-Miller et al 2003, Heron 1996). In the NHS this is evident because action research does not appear in the hierarchy of research evidence while randomised controlled trials are at the top of the taxonomy. I experienced this bias against subjective research directly through the Trust ethics research committee, which insisted I could not include students I was currently teaching and assessing. In the participatory action research paradigm, the presupposition is, that the specific and situated nature of the research is what makes a real difference to those engaged with the process and interpretations obtained through a detached observer are less likely to provide the richness and validity of those arrived at through inquiry with others.

Nevertheless, although I articulated the underpinning philosophy of the collaborative inquiry to the committee where I emphasised the shared experiences through storytelling, challenge, dialogue and relational practice, this was not appreciated by the ethics committee members. The dominant discourse in healthcare values the notion of objectivity rather than experience led research whereas I value the social nature of the research in which the relationships matter and are questioned in terms of power dynamics. I believe this adds to the quality of the process. In some positivistic approaches relationships exist but are often denied as relevant or as not influencing the process at all. Bourdieu (1993a) would argue that a doxa exists; that is, an assumption so taken for granted that it is not noticed or questioned. So the first ontological clash I experienced was around the assumption that I should not know any of the participants of the inquiry. Indeed, it took a lot of effort on my part to get the research off the ground at all.
I began the process of completing the ethics form in December 2003 and was finally granted ethical approval in September 2004. As a consequence of the forms changing and the new research governance framework, a lengthy and complicated application ensued. The completed form was 57 pages long and exemplified the weight of bureaucracy in the NHS that is now confronting all researchers and which has been an aspect of clinical practice for some time. I likened the process of seeking approval to that of chewing gum which is stuck to your shoe! The more you try to take it off the more it spreads everywhere!

I attended the ethics committee meeting in April 2004; attendance was optional, however, it was suggested being available to answer queries could speed up the process of approval. This proved not to be the case. The meeting started at 12.30 and could last until 17.00. This was the first meeting using the new COREC (Central Office for Research Ethics Committee) form. No time slots had been allocated to the studies being reviewed and it was possible that the committee would not call the researcher at all. This could have meant waiting for the whole afternoon not knowing if the committee had any issues with the study, only to find it had been passed through without comment. What a symbolic show of the committee’s power; a form of symbolic, cultural and political capital.

A further problem centred on the information sheets (see appendix 1) which at the time did not follow the committee’s suggested guidelines. The committee insisted I provide all the information sheets irrespective of the emergent design of the inquiry. This meant predicting what I would use in three years time and would not allow for learning from the earlier co-inquiries; a main purpose of the design. This felt unethical to me.

I was heavily criticised for not giving a definition of reflection in the information sheets, even though I had explained at the meeting that understanding how practitioners saw reflection was one of the initial aims of the inquiry. I argued providing a definition could interfere with the
process. Nevertheless, the committee insisted this was required and I later wondered how much this influenced the first co-inquiry group. It could potentially have set me up as more powerful and important than the other members and influenced their responses. However, they reassuringly told me that because the information sheet (now 6 pages) was so long, they didn’t bother to read it! This again felt unethical. To me, this is an example where hierarchical structures and positional power can potentially corrupt a valuable process and impinge on the research purpose and design. How ethical is this?

I have no way of knowing, but imagine the ethics committee members would be surprised to read this account and my challenge of their world view as powerful and undermining of research which does not seek to find ‘the truth’. I imagine they would see this research as lacking validity and not contributing significant insight nor adding to the body of knowledge. This aspect of the *habitus* and *field* goes unnoticed and is played out unconsciously through conformity with form design, provision of research term definitions and processes designed to encourage ‘objectivity’ and not participant - researcher relationship building.

My encounters with the ethics approval process seemed to highlight how unquestioning the scientific discourse is of their ontological positioning. As Bourdieu and Wacquant (1992) and Foucault (1980) argue those who determine the value of knowledge hold the power. In the following poem, I tried to capture the anger I experienced as I conceived the committee had overridden my positioning of this research. The poem notices the production of conformity and not creativity as a consequence of pleasing the committee. On reflection perhaps I did not argue my case forcefully enough but I was one person arguing against a group of 16 and at the time I noticed how powerless I felt against such an unyielding and unresponsive process; how flattening of energy this was. In the end I do not believe the forms influenced the co-inquirers’ understanding of reflecting-in-action yet
it might have reduced the number of practitioners responding to the research reducing the numbers available for the first co-inquiry group.

**The Fire Inside**
Watching the coals turn red
Feeling the heart well up inside
Noticing the volcanic wave of dread
The swell and flow of wounded pride

The loud blasphemous words from hell
That bask and grow in all that heat
Unleashed in a fury that shock and tell
That show how quickly one is beat

So dreams die down with the cooling embers
Of surfing waves ridden with ease
Creativity lost with bruising tempers
And passions buried by the engulfing please

Clare Hopkinson 17/05/04

**Strand 1: The Co-inquiry Group**

**Recruitment and Co-Inquiry Group Formation**

I gained ethics approval in September 2004 and began recruiting the first co-inquiry group. Students, who had previously attended a post qualifying reflective practice module, were invited to an introductory meeting on 25/11/04. If they agreed to take part they completed a consent form (see appendix 2). Those who self-selected became the first co-inquiry group which I called Strand 1. We discussed at the introductory meeting how taking part would be a large commitment as we planned to meet monthly for at least six months. I explained that co-inquirers could withdraw from the inquiry at any time without explanation and justification.

Initially a group of eight practitioners formed the first co-inquiry group meeting monthly for an afternoon per month for eight months. In all ten practitioners took part with varying levels of participation. Attendance varied with a minimum of two to a maximum of seven attending at any one
time. Two practitioners joined the group part way through and three group members withdrew; one because of time constraints and two because I was to ‘blindly’ assess a piece of work for their part-time studies. The ethics approval required me to exclude students whose work I would assess, even though it would have been beneficial for the inquiry.

The co-inquirers worked in a number of different Trusts and some had met before on a Reflective Practitioner Module. I was the only person who knew everyone. There were several nurses and midwives, a speech therapist and clinical psychologist working in a variety of healthcare specialities. Co-inquirers chose their own pseudonyms to aid confidentiality and anonymity:

Alex, F grade staff nurse working in general medicine
Alice, a clinical psychologist working in the learning disability field
Amy, a midwifery sister with a part-time remit for practice development
Jane, a sister in a minor injuries department
Jon, a modern matron working in elderly care
Jordon, a modern matron working in elderly care
Liz, working in a theatre practice development role
Lois, a speech therapist
Maria, a midwifery sister with a remit for practice development
Tracey, an assistant general manager working for a PCT (primary care trust)

Lois and Alice, the non nurses, acted as critical friends by challenging our taken for granted assumptions or blind spots as we called them. I felt this would aid the quality of the inquiry because as nurses we needed help in recognising our cultural assumptions. They also contributed their wisdom of working in the NHS helping us to connect to possible systemic patterns.
Eventually 3 co-inquirers withdrew (Liz, Amy and Maria). Maria suggested I interview her at the end of the inquiry. This prompted me to interview all of the co-inquirers separately to establish if the inquiry had made a difference to their practice and to check out my tentative sense making from Strand 2. However, Liz did not take part in this process resulting in 9 1-1½ hour co-inquirers’ interviews.

Our co-inquiry meetings lasted for 2½ hours. All were tape recorded with key quotes transcribed. Full transcripts were not produced although tapes were available for the co-inquirers. Originally, 6 sessions were organised but the group wanted to carry on meeting. Jon suggested that the co-inquiry should run concurrently with my return to practice so that I could continue to inquire with them during Strand 2 of the inquiry. The overlap was for 4 months. Nevertheless, attendance was always an issue and gradually the toll became too much for the co-inquirers consequently meetings ended with the summer break in 2005.

As the design changed in regard to Strand 3, I contacted the Director of research for the Hospital Trust and the Director of Nursing, my research sponsor, to see if I needed to re-apply for ethical approval. It was agreed that the action learning sets were covered by the ethics committee approval and so I would be able to use any data produced. I decided however, to ask for verbal permission to use each story as data.

Data Generation and Analysis through Cycles of Action and Reflective Inquiry

I did not want to add to the co-inquirers’ workload by suggesting they kept a diary during the research. This did not seem ethical because they did not normally do this. I wanted the inquiry to reflect the reality of practice as much as possible. As stated already, our main method of knowledge
generation was through sharing practice stories; we shared our ideas, our questions, our doubts and concerns. We used poetry, photographs as metaphors and through a collage constructed a visual storyboard which captured the themes of our storytelling and became our way of charting our sense-making.

We set ourselves actions between meetings to observe our practice or try out new practice ideas and actions arising from our group conversations as cycles of action and reflective inquiry. At the start of the next meeting we reviewed our observations and reflections of our actions. Consequently, some key themes emerged as we began developing our own theories of practice through this process of inquiring together. Some themes like whinging, anger and time to reflect resurfaced again and again.

As a group we looked for similarities and differences, contradictions, patterns and connections in the stories told, in order to develop our own meaning about reflecting-in-action during practice. This collective process produced a combined understanding and shared sense making of the data which is crystallised in our making of the storyboard. This was not envisaged at the start of the inquiry. I did not take part in selecting the images for the storyboard nor did I direct the actions to undertake in the month between our meetings, these were agreed by everyone in the group. I deliberately chose not to do this in case I was dominating the inquiry and abusing my power which I felt would not have been ethical.

**Storyboard Representation of Our Cycles of Action and Inquiry**

The image overleaf represents our data; what we called a storyboard of our sense making. It represents the collective wisdom from the group. In the storyboard we refer to our cycles of action and inquiry as week 1 to 7 but in fact these took place over eight months. The images represent the
different activities and questions and sense making of this strand of the inquiry.

In the first month (20/1/05) we chose two photographs that showed the tensions we faced in our own practice. The image on the storyboard representing this activity was chosen by Amy and became our first cycle of reflection and action representing the issue of “time to reflect”. For a month we noticed when we reflected during practice and when we found the time to reflect. Amy suggested our first question: “What are we busy doing in relation to reflecting?” which guided our observations and reflections in practice for the next month before we met.

The focus of the second meeting became whinging; when Jordon related a story of her frustration that staff would whinge rather than reflect. So our next cycle looked at when we whinged and when we reflected and noticed when others whinged in our workplace (see appendix 3 for an example that Jon brought to the next meeting). At the end of the third month we agreed to keep a dream diary because Lois noticed dreaming was a way she reflected. In the fourth meeting I shared some of my poetry and stories
from returning to practice and the image of the snowdrop was drawn by Alice. In the fifth meeting the common theme from our stories and reflections was anger and unexpressed emotions in the ward. We noticed when we became angry and how we overcame our anger and strong feelings at work.

By this stage attendance was tailing off and gaining consistency with the same co-inquirers was problematic. The storyboard allowed for a reflective process to take place and the co-inquirers who had not been at the last meeting an opportunity to contribute their interpretation of the image as well. In the sixth meeting we talked about the contradiction that we could be highly critical of ourselves while reflection sometimes made us feel strong and powerful. Whinging again became a focus; how do you change whinging into reflecting? In the seventh meeting Alice proposed a change in our inquiry question from the tensions and possibilities of reflecting in the ward to “If I don’t like this, what can I do to change it?” In the last meeting we focused on “putting your head above the parapet” and wondered as Jane suggested if this was linked to being “an approval slave”.

Alice described our story of the emerging eight cycles of action and inquiry as:

1. Time or lack of it overshadowing the group;

2. Whinging as being very predominant in NHS settings, where people ’moan’ but are unwilling to take proactive action;

3. The use of dreams in developing creative solutions to issues in care practice;

4. Vulnerability being seen as a strength rather than a weakness and the need to empathise with patients. The need to focus on being alongside patients as well as doing interventions to them;
5. The potential to gain deeper, wider and more holistic understandings of work situations, including a spiritual component;

6. The anger that was felt by staff in care settings which remained unexpressed

7. The sense of being slaves to the need for approval and difficulties in challenging others particularly those in authority;

8. The idea of being able to be more proactive; i.e. ‘If you are concerned about something – what are you going to do about it?’ “ (Written extract from draft paper July 06)

These ideas will be presented more fully and integrated with reflections, observations and data from Strands 2 and 3 in chapters 3-7.

**Interviews with Co-inquirers**

I conducted exit interviews with the co-inquirers from Strand 1, as Maria suggested, which was not part of the initial inquiry design. Again, this involved checking with the Director of Research for the Trust and the Director of Nursing, my research sponsor, to see if I needed to re-apply for ethics approval. It was agreed that these interviews were already covered in the terms stated by the committee through their approval of the rather vague term ‘key stakeholder interviews’.

The interviews took place in a variety of settings; in co-inquirer’s homes, workplace offices or the work canteen. My aim was to establish whether the co-inquiry had made a difference to their practice. The open interview schedule (see appendix 4) provided a loose framework but was not adhered to in a formulaic way. The interviews lasted between 1-1½ hours and were conducted in a co-inquiring way. By this, I mean that I inquired with the co-inquirers about the ideas arising in the group, the images from the storyboard and checked out some of my observations from practice; thereby continuing to cycle and recycle the reflections and actions through
conversation in order to deepen our understanding of the data. This was a multi-layered approach to the sense making process encouraging further insights and reflections (Weil 1998). I hoped this process would challenge my thinking and help to raise awareness of any possible distortions or defensive aspects of my understanding of reflecting-in-action during practice. So I found myself talking rather more than in previous qualitative research interviews I have undertaken.

The interviews were fully transcribed and analysed for themes and connections between data in all of the Strands i.e. the storyboard, co-inquiry meetings, practice field notes, reflective diary notes, stakeholder interviews and my teaching practice. Finally, I sent draft chapters to the co-inquirers for their comments. I wanted them to be happy with the way I had re-presented their stories and ideas and this resulted in some additions and the removal of one sensitive story.

What is an interview, if not a conversation? What makes an interview valid or more accepted by ethics committees and regarded as real research where co-inquiry or action research, generally, is mistrusted? The reality is that the conversation is recorded, is transcribed, is analysed out of context. Yet it is regarded as “more reliable”. Reach a saturation point through lots of interviews! Clearly, memory can distort notes made of conversations and conversations also fade but my experience is that sometimes the most important data are talked about after the recorder is switched off. How often is this still included in the research? And how do we know if it is? So it can be regarded as a weakness of my inquiry that much of the work is not formally recorded and relies heavily on my field and diary notes of personal jottings, my memory and interpretation, therefore potentially distorting the intended meanings of others. In my favour, I am responsive which helps to elicit stories of practice that can hopefully be meaningful for others. The check and balance for me has always been to question how self indulgent is this? What is its purpose in illuminating the
phenomenon for others? I learnt through conversation and play. Why as an adult are reading and analysing a text valued more highly? Yes we played in constructing the storyboard but we also allowed our unconscious processes to work which I believe made it a richer and therefore worthy experience open to multiple interpretations.

Diary Extract 18th Jan 07 following immersion in the transcribed data from the Strand 1 co-inquiry which included co-inquiry meetings and interviews

**Strand 2: Co-Inquiry in the Ward**

At Easter 2005 Strand 2 of the inquiry began. I went to work on ward 1 as a D grade staff nurse (the grade of a newly qualified staff nurse) to see how I could reflect on my own practice whilst also giving care. I kept field notes of all the shifts I worked in my reflective diary. I was interested in how easy it was to maintain such a process. By observing and participating, I wanted to see if reflection happened in the nursing team. I assumed stories would be passed between the nurses and I would collect informal and formal stories during care giving. I expected to use staff meetings to facilitate a reflective space and hoped eventually to pass on the facilitation to the staff. If I'm honest I expected the nurses to find the facilitation so helpful for their practice that they would incorporate it willingly into their monthly meetings. Now in writing this, 3 years later, I can see a tacit contradiction present here. On the one hand, I was expecting reflection to be passed on informally through the sharing of stories of practice while on the other as a consequence of my experience as a patient, I was not sure reflection would be happening at all.

Finally, I was interested in establishing a collaborative inquiry with team members to explore aspects of reflecting in the workplace. In particular I envisaged the focus would be on the key research question: What are the
possibilities and tensions of reflecting while care giving? And possible questions shaping Strand 2 might be:
What are the constraints that stop reflection happening in practice?
What encourages reflection to happen during practice?
What stories/experiences are shared either formally or informally?
How do I reflect during care giving?

Muddy Footprints: Connections with Ward 1

In order to maintain confidentiality and anonymity I have changed the ward name along with all staff names to protect their identity. It was a busy surgical ward for 28 patients with an emergency out of hours service functioning on a rota basis. I had been a link lecturer on ward 1 from 2000 until 2002 when the role was discontinued, at least 3 years before the inquiry began. This link role helped staff support the student nurse learning experience. I had not practised as a nurse in that area; in fact I hadn’t worked as a nurse anywhere for about 10 years.

As a link lecturer I visited the ward but there was no regularity to the visits. I tended to go when there were problems and when my teaching load would permit it. Part of the role involved auditing the ward for its learning environment and appropriateness for student nurse placements. The ward manager, Sheila, had been in post many years and we built a supportive reciprocal working relationship. I would listen to her working problems and offer advice or just be there for her to off-load some of her frustrations; she would listen to some of my work frustrations about the university. We seemed to have similar values about patient care and it helped that I had been a ward sister before. I also dealt directly with the staff nurses and students when there were concerns about the progress of students. I had taught some of the staff nurses at the university, but I did not manage to establish a relationship with all staff members.
Gaining Access

Returning as a staff nurse required considerable planning, negotiation, relating, explaining and liaison taking over a year to organise. I required an honorary contract with the Trust with on-going sponsorship from the Assistant Director of Nursing and permission from the Director of Nursing, ethics approval, uniforms, and an identity badge. I attended induction, mandatory updates such as basic life support, manual handling and IV courses in order to work fully as a qualified nurse. Liaison included several meetings with the Assistant Director of Nursing, the Research Director and the Ward Manager about the purpose of the inquiry before agreeing a mutual time to start. The ward sister seemed very enthusiastic about the research and appeared keen for me to work on the ward. The plan was to work a fortnight over Easter 2005 to become more familiar with the layout and staff and then work a day a week thereafter for at least six months but hopefully longer.

The Process of Strand 2 Co-Inquiry

“I observe myself and so I come to know others” Lao-Tze

I worked a total of 35 shifts as a staff nurse taking patients and caring for them over a six month period. After each shift I spent anything from a half an hour to a full hour reflecting on the experience. I used free fall writing, that is, a continuous stream of writing, which focused on my own reflection-in-actions if I could remember them. Sometimes I would use a model gained from Houston (1995) “I notice, I feel, I imagine, I want” to guide my reflections. Sometimes I used the starting questions for Strand 2 but mostly I did not remember to do this immediately after working the shift. Sometimes, I would escape to the toilet in the ward to write down what I had noticed in the moment. This ethically felt wrong and like I was spying. I shifted the focus onto myself concentrating on any mistakes I had made during the shift, any ethical dilemmas of care I was experiencing,
and gaps in my knowledge so that my diary entries became almost a TO
DO list. I wrote down my own stories and those from staff who had given
verbal permission for me to use them. Sometimes the overarching
research question guided the reflections but most often it did not.

I would change from my nursing uniform in the “staff cupboard” and then
go to a café after an early shift which finished about 3.30p.m or a pub after
a late shift which finished about 10p.m. I wanted to capture events as
close to the experience as I could. If I went home I was always interrupted
by domestic tasks or conversations. Interruptions became a theme from
this strand which I will explore in more detail in chapter 4. I noticed that if I
chatted through the days events with a critical friend (Taylor 2006, Tit
chen 2001) I lost some of the experience, that is, I realised I had talked it away.
I came away from that conversation with useful ideas and actions to focus
on but was unable to capture the detail in my diary and so that data were
lost.

I had a small black book in my pocket during each shift and a mini disc for
recording whilst working. I sought permission to record some
conversations or write notes down in my book. Almost all of these were
turned down by the staff. They were happy to talk to me but did not want to
be recorded more formally. In my bag I had official consent forms and
information about the research. I put a copy of these on the notice board
but very quickly they were covered over by other notices. I offered
information sheets and consent forms to the staff but no-one seemed
interested in reading them. So I learnt to explain the research and ask
verbally for permission to use any conversation with staff during a shift of
care giving.

I did not produce a formalised checklist for my observations but tended to
have a somewhat serendipitous process to my field note taking as
described above. Clandinin and Connelly (2000 p.103) suggest field notes
already contain an interpretative aspect and may have a “puzzling quality”
that tries to make sense of the experience rather than just giving an account of that experience. Certainly, I found my diary entries varied enormously with some very detailed experiences; some were vague and descriptive while others puzzled over the recurring themes that seemed to span the different strands of the inquiry.

Changing From Link Lecturer to Action Researcher

I realise now that I was quite naïve in not really considering the change in role from Link Lecturer to Action Researcher and its possible impact on the inquiry, especially my relationships with the nurses on the ward. Perhaps this was why I had an overriding sense that Strand 2 ‘failed’ insofar as I was unable to recruit a second co-inquiry group. I had assumed I would be able to tap into the ward staff meetings which proved erroneous because they rarely had any. Also, I was never fully comfortable with Strand 2 being only a first person or personal inquiry and am not sure why I felt this way. At the time I was having reflective conversations with staff and was in reality engaged in a co-inquiry, but in my head I couldn’t always see this as it felt nebulous. I found it difficult to work as a staff nurse because I was viewing the ward from a manager’s perspective even though this was not my last clinical role.

Reinharz (1997) recognised in her feminist ethnographic research the complexity of self in the research field. She suggested ‘self’ acts as a “fieldwork tool” and is changeable and proposed the following three aspects of self as: “research-based selves”, “brought selves”, and “situationally-created selves”. She argued it is impossible to know before entering the field which attributes of self will become meaningful but staying reflexive about ones impact is essential. She proposed:

“unless the researcher (and subsequent reader) knows what the researcher’s attributes mean to people being studied, the
researcher (and reader) cannot understand the phenomenon being studied.” (Reinharz 1997 p.4)

Consequently, I now realise there was a backdrop of mistrust while I was in the ward which I also contributed to. I explained to ward staff that I wanted to work with them to encourage changes that would make a difference to their working lives but my role and inquiry had only been agreed by the ward manager. They were not really expecting me nor had any sense why I was there. I sometimes felt I was seen as a spy in the camp, an outsider but I felt this myself, and so no wonder staff weren’t keen to be interviewed. However, some nurses did give permission for me to write down our conversations. I felt I was constantly explaining what I was there for and noticed I tried to seek validation from them to be accepted as part of the team. I had to get my hands dirty and prove myself before I could engage in the research. I found myself waiting for the research to start though in reality it had already begun! I focused on building relationships with staff and doing as many nursing tasks directed my way.

I had complex relationships with some of the staff. For example, I had been Richard’s personal tutor 3 years ago. Richard seemed to relish supervising me as a senior staff nurse; I was currently a dissertation supervisor for a third year student nurse, Paula, and had taught 3 other staff nurses as part of their degrees. Initially, I felt this would be an advantage to the action research but in the moment of working on the ward I became less sure. Now I think the complexity of the relationships confused me because I sometimes lost sight of the research and this may have caused staff to be confused about why I was there. On the other hand I already had a relationship of sorts with some staff so that I found they were willing to talk to me informally when there was time. Part of the difficulty I embodied was that I was schooled to believe that relationships in research needed some distance but was finding that actually it was the reverse; the closer the relationship, the deeper the conversation became.
Some of my hesitancy resulted from feeling that I wasn’t a ‘real’ action researcher. How would I know if this research would make a difference? It was too complex, too ambitious, and too nebulous! There were several nursing shifts where I found myself more interested in caring for the student’s needs and what I saw as maximising my time when it seemed “nothing was happening” in the research! On one occasion I fell back into my teaching role when the ward was quiet and I carried out dissertation supervision. Was this to avoid the action research which I didn’t feel was going well? It certainly seemed easier! Another day I stayed late after an early shift to meet with Paula about an essay. She had moved to another ward and surprisingly this seemed to have a breakthrough effect with one of the senior staff nurses, Jean. Jean described herself as cynical about reflective practice and she kindly brought me a coffee agreeing to a taped conversation about reflective practice. I tried to interview her three times but each time she cancelled just before, so the interview never materialised. This also happened with Sheila, the ward manager, three arranged meetings never to occur. I found these experiences devaluing and de-motivating in terms of the inquiry but can see now were probably issues of trust and vulnerability not necessarily personalised to me. I represented an outsider, a potential judge, critic, and an academic.

These ideas and their implications will be developed in the later findings chapters. Perhaps the staff were more comfortable with my role as an educator as this was expected? I am wondering now if this was a “situationally-created” role as well as a “brought self”. I was feeling uncomfortable because the research was not developing in the way I had anticipated. My “brought self”, didn’t feel fully clear about what my role was as an action researcher. Was it enough just to focus on my own first person inquiry, was this real research?
Strand 2: Emerging Processes

As part of Strand 2, I wanted to focus on how the organisation responded to aspects of reflecting during care giving. The original design of the inquiry had anticipated interviewing key stakeholders. This vague phrase was used in the research proposal because at the time I was not sure who would have Trust roles involving organisational structures or processes that related to reflection. While in practice I identified staff employed in practice development and risk assessment roles which I felt were relevant for organisational learning as a consequence of reflections from the ward. I conducted six interviews with staff in these roles. Information sheets and participant consent forms as designed for Strand 1 were completed. Interviews took place in the participant’s offices. All lasted for at least an hour.

Finally, I collected non participant data; again this was not initially planned but emerged as a consequence of Strand 1. Jordon, a member of the co-inquiry group and modern matron, suggested I spend time on a ward from her unit to observe some inter-professional care meetings to see if reflection happened in this team. I observed the team on two occasions for two hours each time.

Strand 3: Action Learning Sets with Modern Matrons

Strand 3 of the inquiry was designed to explore the effects of the ward culture on nurses’ ability to reflect during care giving. Initially I intended to work on a different ward and form a co-inquiry group as proposed in Strand 2. However, because this had proved impossible to achieve and in keeping with the emergent nature of action research, Strand 3 evolved into action learning sets with modern matrons and attendance at the Trust’s Facilitation Network (a senior staff group with a remit for facilitating change
in teams in the organisation). This change in focus happened accidently following an interview with the Assistant Director of Nursing (Gail) responsible for practice development in the Trust. In conversation I suggested the inquiry showed the need to develop the organising, challenging and supportive skills of the ward leaders; later this was to be picked up in The Productive Ward: Releasing Time to Care (2007) Initiative. Gail, however, felt development of reflection was needed at the middle manager level because the modern matron role was new and ill defined. Consequently, she asked me to facilitate an action learning set for modern matrons, thereby creating a reflective space to discuss key stories in relation to their practice and encouraging same level networking opportunities. I also hoped to feedback into the organisation my learning from the earlier two Strands and support the modern matrons in developing their new roles at a time of re-organisation.

These meetings began in October 2006 and finished in June 2007. Meetings were scheduled for two hours and took place monthly. However, as before with the first co-inquiry group, continuity and attendance was an issue. The dynamic nature of the wards meant the modern matrons could not always attend. An evaluation of this action learning set was conducted independently by Gail.\textsuperscript{16}

\textit{Reflections on the Inquiry Design}

As noted above I had difficulty in keeping focused on my research role in Strand 2. I experienced a huge tension in searching the literature as a consequence of an emergent action orientated research design. Where do you draw the line in terms of searching the literature? If I had let it,

\textsuperscript{16} Gail was the Assistant Director of Nursing. See appendix 5 for her independent evaluation.
searching and reading published literature could have completely
distracted me from the actions of the inquiry itself. Through searching the
literature in relation to the emerging themes, it has confirmed to me the
validity of partial, socially constructed and contextualised knowledge.

It proved challenging to analyse the variety of data and to present a story
that has coherence. In turning the data into themes I am artificially
separating the experiences and in danger of moving away from the stories
of experience so that I have struggled with how to present the complexity
of this inquiry in a meaningful and narrative form. How do I incorporate the
voices of those who contributed and co-inquired with me? How do I value
the time and commitment and friendships which enabled the research to
take shape and form? I cannot possibly cover everything but need to
present some practical knowledge gained which may resonate with other
nurses.

Reflecting on the complexity of this inquiry design, I was attempting to
draw upon diverse data not as a triangulation process but to gain
understanding about the complex process of reflecting-in-action in a ward
setting from a variety of angles. This has generated a large volume of
data: there are stories, poems, pictures and a plethora of ideas in the
following chapters. In organising the chapters into themes I do not intend a
mechanistic and artificial separation but a way of bringing to life the
experiences of this inquiry. It is not my intention to present the themes
sequentially or chronologically but to move between the data from the
different strands to make sense of the tensions and possibilities of
reflecting in a ward. My aim is to bring the reader along with me in the
struggles, tensions and possibilities of reflecting during care giving.
Conclusion

This chapter has focused on the ontological, epistemological, methodology and methods of this inquiry. I have positioned this research as post-structural and as an epistemology of practice that values multiple ways of knowing with pluralistic interpretations that are historically, socially, politically and culturally constructed. This work is context specific and does not claim to provide the truth, but one which is partial and value laden. I have designed a complex multi-stranded approach which has tried to be as collaborative as possible although I recognise this has not always been effective. I have learnt that relationships with co-inquirers in all strands are essential in developing sense-making and learning from the stories of practice. Therefore research is inherently social (Usher 1997) and relational. At the heart of collaborative inquiry is the need to demystify research and reduce power differentials so that meaningful learning can take place for all those involved. The following chapter focuses on the emergence of poetry as part of this reflexive collaborative inquiry.
Chapter 3: A Poetic Inquiry

Every poem breaks a silence that had to be overcome (Rich 1995 p.84)

This chapter presents the emergent reflexive poetic inquiry which became a defining aspect of this research. I used the poetry hesitantly at first as a small part of the inquiry, gradually it became integral and significant for my own and others learning as it evolved into a relational and collaborative process. The poems encouraged reflection on practice while also inviting co-inquirers to gain new insights in relation to their own work. I show in this chapter the different ways poetry was used leading to an appreciable change in my practice highlighting new cultural understandings of nursing practice. I suggest some of the poems hold the complexity of my experiences. They are not a rational account; or an individualistic and privileged process but can give voice, as the Rich (1995) quote above suggests, to potentially the ineffable, contradictions, paradoxes and difficult questions relating to nursing practice. Poetry values and connects others to experiences encouraging embodied knowing. Consequently, some of the better crafted poems are open to multi-layered interpretation and have the potential to highlight the tensions and possibilities of reflecting in the ward that I was grappling with during this inquiry.

Firstly, I chart my journey using poetry which I now see as a powerful and valid research process. Initially, some of the poems were used as data; some as a form of analysis and then as re-presentation of several interviews which were played back with the co-inquirers (Richardson 2003). Other poems arose out of my observations and interpretations during the inquiry Strands while some came from students’ stories shared during my facilitation of their work-based learning sessions in the classroom.

The poetry was fundamental in my shift from seeing reflection as an individualised process to one that is also historical, social, systemic,
nuanced and complex. Mirroring this change, my experience moved from using poetry as an individual process to a collaborative inquiry process. Therefore the poetry was central to my analysis of some of the cultural and political tensions of reflecting in the ward. In a way the poetry seemed to foreshadow a deeper understanding of reflecting in the ward that I was unaware of at the time of writing. More than just an intuitive process or a way of justifying my own analysis of this research, the poems were a way of making sense of my recent and past nursing experiences. I came to see them as ontological and as an epistemology of nursing practice through ethnographic insight. This Bourdieu (1990) would suggest, is a way of understanding my own habitus and position-taking as well as questioning some of the embedded doxa and field of nursing practice.

I argue the poems are ontological and an aspect of my habitus since my values are embedded both consciously and unconsciously in them. I suggest because poetry spans both unconscious and conscious experience it may enable a “felt experience” in the receiver of the poem, encouraging an immediacy and resonance with the feeling expressed. Therefore, I later used the poems as a deliberate felt experience encouraging a reflexive co-inquiry process with nurses in the classroom, in the ward and in senior positions within the Trust which I present below. Later in this chapter I show how noticing parallel processes became important data for this inquiry and start to trace some of the characteristics of the nursing field through my poetry. Later findings chapters will build on and incorporate these concepts more fully.

This chapter begins with a selective literature review enabling me to recognise the power of poetry, metaphor and imagery as valid research processes (Grisoni 2008). Originally I thought I was a ‘bit off the wall’ in even considering sharing the poems. I later question whether the aesthetic, craft or ‘art’ of the poem through the performance, rhythm, rhyme, imagery, metaphor and form of the poem is important.
What Does the Healthcare Literature Say about Poetry?

In 1969, at the age of 9, I won a national prize for poetry but only wrote poems at school. So I was very surprised in September 2003, at least 25 years since writing a poem, that they started to appear in my diary in my first person inquiry. Poems had never featured before in my reflective diary about my teaching practice. At first I did not value them dismissing them as not “real poems”. They mostly rhymed and had some alliteration but certainly weren’t art! I had no training in poetry reading or writing nor studied English beyond school years so my knowledge about crafting a poem was limited.

At the beginning of the PhD in a SOLAR 3 workshop (May 2003) we were facilitated by a poet, Carol Burnes, to explore and challenge our reflection and writing styles through engaging with different forms of research writing. Consequently, I learnt about the power of language and how imagery and metaphor could show the complexity and depth of experience. I learnt that writing was a form of inquiry in its own right, that a poem takes a stance, which can be crafted over time. A poem is enhanced by considering all the bodily senses such as taste, touch, smell etc to evoke and capture an experience. I learnt an effective poem shows and evokes rather than tells the reader. So that as Grisoni (2008 p.109) writes poetry can “access deeper insight into the emotional texture of social interactions”.

Since September 2003, the poems have been persistent yet erratic entries in my diary proving to be a powerful form of reflection. I eventually recognised a pattern that I would write a poem a few days after a specific event such as a PhD workshop, a meeting of the co-inquiry group, a research interview, a conference, or a nursing shift. There seemed a strong emotional connection prior to a poem appearing. I was inspired to
read literature about creative writing and further my understanding about the craft of poetry.

Wordsworth noted poetry could be a spontaneous outpouring of emotion while Robert Frost proposed poetry was the shortest emotional path between people (Hunt and Sampson 1998). In ancient times, Aristotle argued poets maximized their own emotional and spiritual resources through writing poetry and noted the liberating power associated with this (Furman 2003). Aristotle suggested:

“that poetry provides a safe outlet for the release of intense emotions. And he claimed that poetry models the valuable experience of passing from ignorance to knowledge”

(Culler, 1997 p. 69-70).

Arguably, poetry could be seen as a form of knowledge in its own right. The word ‘Poetry’ is derived from Greek and “means to compose, to pull things together, to shape, to create” (Harthill 1998 p.47). How different is this from the crafting of a thesis or report? The crafting of the words provides the meaning but for the author there is a process of discovering what you want to say during the writing itself that creates coherency and a distillation of an experience. As E.M Forster wrote “how do I know what I think until I see what I say.” I was wondering if poetry could be a legitimate epistemology of practice. Could it contain the practice wisdom or praxis obtained through Bourdieu’s (1993b) notions of habitus and field?

The poetry literature is limited in the nursing field but there is more available if linked to the wider term of healthcare, including allied health professions and medicine. Poetry has been used in a variety of clinical settings mostly with clients rather than staff, for example in: learning disabilities (Logan 2002), psychiatry (Olson 2002, Sluder 1990), palliative care (Robinson 2004, Roy 1999), midwifery and parent education (Davies 2008) elderly home care (Rice 1999) and poetry in the waiting room (Philipp 1999, Philipp & Robertson 1996).
There are several themes emerging from the poetry literature: firstly, poetry as a spiritual, an educative or healing process, secondly poetry as a process for ‘personal insight’ or empowerment, thirdly as a process for developing empathy and connection with others and finally poetry as an emotional, embodied, imaginative and artistic way of knowing practice.

Furman (2003) used his own poetry as personal therapy and it has been used in psychotherapeutic practice and counselling for some time (Furman 2003, Shapiro & Rucker 2003, Jones 1997). Furman (ibid) argued poetry has a healing and curative nature enabling people to come to terms with the reality of their existence. Indeed poetry as a therapy is available now in the UK (Chavis 2007) being established longer in America (Hedberg 1997). Killick (2004) and Hayes (2006) have worked with dementia patients for many years translating their language which is rich in metaphor and imagery into poems. There have been several poetry projects in hospital settings encouraging the general well-being of patients (Macduff & West 2002, Harthill et al 2004) while in medicine it has been used to overcome stress, pain or as a mood elevator (Philipp & Robertson 1996). There are further claims that nurses can use poetry as a potent therapeutic process with their clients (Jones 1997, Macduff & West 2002) and with elderly clients as part of reminiscence therapy (Taft 1990).

Poetry has been used in professional education forming part of a humanities course for medical students (Shapiro & Rucker 2003, Wellbery 1999) and featured in a limited way in nursing and midwifery education17. Shapiro and Rucker’s (2003 p.954) objectives in using poetry with medical students was to “develop imagination and curiosity about patients’ experiences”, “enhance empathy”, “encourage relationship building and emotional connections with patients”, “emphasise a whole person understanding of patients” and “promote reflection on experience and its meaning”. Similarly, Olson (2002) argued a poetry writing assignment

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forming part of a psychiatric nursing course, promoted a holistic approach to care and deepened insights from working with patients with mental health distress. Hurlock (2003) proposed a “poetic pedagogy” arguing the “surprise” from poetry “reminds us there are multiple meanings in nursing” (p.7). This resonated with my values of seeing patients holistically, my increasing understanding of the philosophy of post-structuralism and my interest in the emotional aspects of nursing work.

In nursing education reading and writing poetry has encouraged nurses to gain deeper and meaningful insights about their nursing experiences and has promoted greater understanding and empathy with their clients (Bolton, 2005, Olson, 2002, Hunter, 2002, Anthony, 1998, Holmes & Gregory, 1998). Hurlock (2003) thought poetry helped students remember why they wanted to nurse. Clearly, these authors highlight the importance of personal insight gained through poetry indicating its therapeutic potential to enable nurses to cope with the challenging experiences of their work which I found could get lost during the performance of nursing in a ward.

A further theme has suggested poetry develops and appreciates the “art” or aesthetic knowledge of nursing (Hunter 2002, Olson 2002). Holmes and Gregory (1998) argued poetry has rich symbolic and metaphorical language and therefore through poetic examination nurses could develop their nursing knowledge. While Macduff (1998) proposed poetry could convey the spiritual dimension of nursing care and Gadow (2000) argued it was an imaginative narrative encouraging nurses’ emancipation.

Alternatively Peck (1993) used poetry to synthesize and evaluate learning. I have used it, along with rap for many years with student nurses, as an evaluation of their course. This was designed as a fun, creative and collaborative group process. I hoped to encourage a more meaningful evaluation and reflection on their progress and transition to staff nurses rather than using the tick-box forms with the standard sanitised replies.
Having searched the poetry literature, I was developing my understanding of its potential power as a process for reflecting on professional practice both personally and collaboratively. I could see the use of imagery and metaphor could evoke emotions, empathy while contextualizing experience and inviting multiple interpretations of that experience. However, I was still not ready to share my own poetry until 2004, more than a year into this inquiry. Now looking back and wondering why I was so reluctant and wary of sharing the poems, I can see that I was prejudiced against poetry which I saw as an elitist intellectual pursuit. I didn’t read poems particularly, I didn’t understand them; poems were for ‘clever’ people. In Bourdieu’s (1993a) terms poetry had cultural, academic and symbolic capital.

**Can Poetry be used as a Deliberate Reflective Process?**

practice, reflective practice was viewed by nurses as a cathartic process (Clarke & Hopkinson 2000).

There is very little nursing poetry literature that suggests poetry can be used as a deliberate collaborative reflexive process inquiring into nursing practice. For example, Taylor (2006) and Johns (2006) recognise the creative value of poetry but seem to regard it as an individual and private pursuit and do not acknowledge openly that poetry can connect others to the emotional aspects of nursing. However, Taylor (2006) recognised that creative expression can assist reflections over time to deepen self understanding. Nevertheless, it was in 2007 after I had been using poetry in the ward and classroom for three years, when I came across Foureur et al’s (2007) and later Searle and Sheehan’s (2008) work facilitating group reflective processes through poetry reading and writing. They argued poetry can help nurses “express the complexity of human care practice” (ibid p. 203) thereby appreciating the reality and impact of nursing on nurses’ own lives.

However, Foureur et al (2007) and later Davies (2008) described poetry as a “tool” for reflective practice. In noticing the language of ‘tool’ I see this as in danger of becoming a potentially instrumental and mechanistic process which is at odds with my own discovery that poetry enables a powerful emotional and relational connection with others that is complex and nuanced. Somehow the language of “tool” seems to reduce the potential from the process. ‘Tool’ appears in the reflective practice literature in nursing more often associated with models or when describing reflective practice as a function that can enhance practice\(^\text{18}\). I see this as a doxa that subtly reduces the relational and systemic aspects of reflecting by encouraging an instrumental and mechanistic approach to reflection.

Through language, the field is culturally produced (Bourdieu 1993a) and I now see that cultural and symbolic capital resides with the values of

\(^{18}\) See for example Duffy 2007, Gustafsson et al 2007, Tate 2004
objectivity and functionality through terms such as ‘tool’. Tools can be used as creative processes but the instrumental and managerialism of the NHS tends to appropriate creative strategies and produce ‘tool-kits’ and guidelines to be followed\(^\text{19}\). This seems to me to be at odds with the underpinning philosophy of reflexivity; consequently, there implicitly appears to be less cultural and symbolic capital attached to personal, embodied and emotional knowing that can be encouraged through using poetry as a reflexive process. Similarly, using poetry as a way of looking into the cultural interpretations of nursing has been ignored by the writers reviewed here.

Bourdieu noted for art in general, there is a tendency to suggest a “cultural product exists by itself, i.e. outside the relations of interdependence which link it to other products” (1993a p.32-3). He argued this negated the social and political nature of art production. Not only that, as Rich cited in Yorke (1997 p.12) suggested, writing poetry is “an instrument for embodied experience” and so arguably, poetry could provide rich ethnographic insight into the cultural capital of the field, the doxa and habitus of practice. She suggested capturing the unconscious can be useful for the writer’s own insight noting:

“Writing poetry above all involves a willingness to let the unconscious speak – a willingness to listen within for the whispers that tell of what we know, even though what we know may be unacceptable to us and sometimes, because we may not want to hear, the whispers may be virtually inaudible. But to write poetry is to listen and watch for significant images, to make audible the inner whisperings, to reach deeper inward for those subtle intuitions, sensings, images, which can be released from the unconscious mind through the creativity of writing. In this way a writer may come to know her deeper self, below the surface of the words.”


Could this be enhanced through performance and sharing the poems with others? By using poems throughout this thesis I believe their multilayered

meaning adds to the reflexivity of the text. I now see the poems as potentially working at the three levels of co-inquiry suggested in the last chapter, i.e. at the personal, relational and organisational levels. The poems offer practical and embodied knowledge relating to the inquiry. As Freire (1998a p.20) writes “I am a totality and not a dichotomy…I know with my entire body, with feelings, with passion, and also with reason”. Yet in research it is usually rational thought placed in a text which is valued while the body, feelings and passion are edited out. Reflecting in the moment as I will show in the later chapters is dependant on all these aspects of knowing.

**Can Poetry be used Legitimately in Research?**

I have proposed poetry can be used as a deliberate reflective process but can it legitimately form part of a research process? Bourdieu argues that what is seen as legitimate is a product of the *habitus* and *field* and relates to power, authority and reputation which are dependant on the different capitals such as symbolic, cultural etc. (Bourdieu 1993b).

Etherington (2004) described poetry as a means of communication and inquiry in reflexive research suggesting “It allows us to *feel* our thoughts and images, and to *imagine* and *think* our core issues” (ibid p.152). She showed its use in auto-ethnography and heuristic research but it was unclear if the poems were shared during the inquiry process to gain wider cultural insight and resonance. The reflexive impact was described for the writer but I gained the impression the poetry was used mostly as data representation rather than as a deliberate inquiry process.

In the nursing literature to date, I have not found poetry used in the research process either as a methodology or epistemology of research practice. In the social science field Richardson (1994, 2003) has written about the value of poetry in research and poems are appearing in the
Qualitative Inquiry journal in their own right (e.g. Prendergast 2006, Royle 2004). In medicine, key writers include Philipp (1999,1997) who argued for operational ways of evaluating the effects of poetry and Shapiro (2004) and Furman et al (2008) who suggested poetry could be valid research data. In organisational research Grisoni (2008 p. 125) proposes poetry as “a practical and accessible way of approaching the heart of people’s experiences and feelings within social systems” and warns it is important not to judge the standard of the poetry produced. Rather, it is the insights gained that are worth attention. She used poetry as a collaborative process but of course this book was published after I began using the poetry with nurses. Thus, where poetry has featured in the research process, it has mostly been as representation and interpretation of research data while Prendergast (2006) used poems creatively as a literature review.

Bourdieu argued that social science research for all its positivist claims of replication is however, similar to that of the “writer or novelist” (Bourdieu & Wacquant 1992 p.205). And Usher (1997) suggested:

“We think of story-telling as “unserious”, as fictional, whereas our image of research is that it is about truth and is therefore an altogether more serious business. Equally, it’s not easy to accept that an account of research is an example of telling a story. To attempt to explicate the “nature” of research through a story does not somehow seem appropriate.” (p.27)

In thinking of research as a story then it does not seem preposterous to propose researching through alternative literary devices such as poetry especially in an action research paradigm that values multiple ways of knowing. My growing understanding of the power of poetry helped me to see poetry in a different way; as highlighting the complexity of human life in a distilled format. I was now recognising that like stories, poems have the possibility to travel across both oral and written traditions and could reflect the emotions, values, history and intentions of the culture from which they derive. Arguably, this has made poems ideal for portraying
social events as data (Furman et al 2008, Etherington 2004) while at the same time creating an interactive interpretive process (Grisoni 2008, Richardson 2003). Richardson (2003) with a sociology background spent 15 years exploring alternative forms of representing research texts. She positioned her work as post-structural creating poems from her interview data which she gave back to her participants. She argued:

“because the poetic form plays with connotative structures and literary devices to convey meaning, poetic representations have a greater likelihood of engaging readers in reflexive analyses of their own interpretive labor, as well as the researcher’s interpretive labor in relation to the speaker’s interpretive labor. The construction of the text is thus positioned as joint, prismatic, open and partial”

(Richardson 2003 p.189)

The imagery found in poetry invites the reader to make their own interpretations encouraging multiple meanings. Thus Richardson (ibid) implies a co-construction process whereby understanding and meaning-making is the result of a further reflexive process allowing the reader to become more involved and engaged with the text. In her earlier work, Richardson (1994) suggested writing is:

“a way of knowing - a method of discovery and analysis. By writing in different ways we discover new aspects of our topic and our relationship to it”. (p.516)

Thus she argued all writing is a method of inquiry. Metaphors, are central to poetry, and have been used in research to arguably reveal paradox, contradictions and to deconstruct experience (Gabriel 2008, Froggart 1998). Froggart (1998) showed root metaphors of emotion were used by nurses to describe their work experiences while Barker (2001) argued metaphors have a healing potential. Metaphors have the potential to travel across traditional professional disciplines and therefore poetry is congruent with the post-modern values of post-disciplinary classification. Nevertheless, as Paley (2004) counters:

“Poetry is not always transcendent and emancipatory. Science is not always literal and oppressive. Poetry does not necessarily
“defamiliarize”; science frequently does. Poetry does not invariably challenge conventional ways of thinking: it may instead confirm them, and be more inclined to resist cultural and political change than to promote it.…….They have both represented the voice of oppression. They have both represented the voice of emancipation.” (p.117-118)

Paley (ibid) warns about the limiting effect of taking up binary-based thinking i.e. polarisations, even when professing to be positioning ones work in a post-modern paradigm. He argued that metaphor belongs to both science and poetry and citing Lakoff and Johnson (1980 p.4) noted “most of our ordinary conceptual system is metaphorical in nature”. Therefore as a consequence of this multi-disciplinary reading, I felt encouraged to use poetry as a legitimate research process to add to the understanding of reflecting during care giving. Yet, I also recognised the need to stay reflexive about the poems because poetry is not a panacea for reflexive processes. I am claiming only that it has helped me make sense of my nursing experiences and allowed me to process the emotional and embodied aspects of my knowledge and practice as a nurse and teacher. The poems have articulated emotions and political tensions in care giving helping me to question the field and habitus of nursing practice. Later, I will show how some of the poems resonated with other nurses’ experience.

In presenting this literature, I have shown the potential for using my poems as an epistemology of practice, as data re-presentation, and as interpretation. In the following section I discuss how I used the poems as a collaborative inquiry process. I show the hesitant, accidental and gradual journey becoming a purposeful collaborative inquiry.
At the start of the co-inquiry (March 2003), I fell through the floor of my kitchen. A washer hadn’t been fitted properly to the cold water supply at the back of the washing machine causing a very slow leak that travelled underneath the floor vinyl and rotted the floorboards. I was taken aback that a small problem could cause a major disruption to my household. I wrote the poem above about this experience and was surprised to find I had unconsciously linked the emotional cost of caring. I was not aware of this while crafting the poem. The poem questions the impact of caring, for me as a nurse and teacher, and asks: what is the emotional labour of caring (Smith 1991)? Hochschild (1983) originally proposed this term and suggested in interpersonal relationships at work, people engage in the management of their emotions, which she referred to as “emotional work”. She carried out an empirical study on air-stewardesses and showed they had to suppress feelings to sustain an outward appearance of conviviality which she argued was an active and gendered process.

Later, I recognised the pattern of emotional labour in other poems I had written (this insight came through re-reading and reflecting on the different poems). On 3 further occasions during the inquiry years, I had problems with flooding and started to wonder if these episodes were a metaphor so
that I puzzled over what the powerful imagery of water leakage might hold for this research.

During March 2003, I read Mary Midgley’s work (1996) that used the analogy of plumbing with philosophy. Through this resonance, I began to value the use of analogy, image and metaphor for my practice and more radically in reflexive research. Midgley (1996) suggested when philosophy is effective it is usually taken for granted and goes unnoticed; likewise plumbing because both are complex systems. However, when there is something wrong with the philosophy like plumbing, it can emanate bad smells, be hard to repair and the problem can be difficult to identify. This resonated with my washing machine leak. In linking her ideas to nursing, I realised that when nursing is effective some of the ‘soft’ social skills used may go unnoticed becoming invisible to others; sometimes even to the nurse herself. When this aspect of the service is lacking, nursing can have potentially damaging effect on patients and their significant family and friends which may later be hard to repair.

But intuitively, reflecting on the poem again I wondered if the image was more than just the cost of caring, or of either ignoring ones emotions and/or suppressing them. As Bond (1986) suggested, emotions could explode like a champagne cork if they were under sufficient pressure. So perhaps the more important question was actually: what happens if emotions leak out at work?

The word ‘leak’ here could be seen as pejorative but this is not my intention. Instead I use the term to question the softer aspects of caring such as talking and listening to patients and to question: how do we cope with the emotions generated where we face daily, others’ pain and suffering and perhaps our own as well? I will illustrate this with a story of a patient I shall call Mary whom I nursed in Strand 2. She had neck cancer originating in the thyroid gland requiring major neck surgery, the formation of a tracheostomy and extensive stomach pull up. During my diary writing I
spontaneously and unconsciously wrote a poem about her, attempting it in her voice. As the entry indicates I forgot to give her medication at 20.00 which was discovered by Richard the staff nurse, who “told me off”. I gave the drug eventually, an hour late.

What are my further reflections on yesterday, my ethical dilemma with Mary? She is terminal and can only communicate by lip movements, no sound. I get frustrated because I can’t always understand her needs; she gets frustrated because I don’t get it and so keep getting her requests wrong. That makes me feel guilty that I am not caring for her as well as I ‘should’ be. Another dilemma and tension was around her wish to be left alone and knowing she is depressed so this probably wasn’t the best course of action to take, and my need to show I’m not a lazy nurse by making sure I got the nasogastric feed into her. I know if she doesn’t get the calories she will die quicker and I want her to be fit enough to go home, to be with her family. Then there was her anxiety. I did not connect the missing propranolol with this until nearly the end of the shift. I should have given the drug at 20.00 but because this wasn’t the usual time for drugs I forgot about it. I should have filled in a clinical incident form but didn’t, which is interesting. What was that about? I must use this incident with students when I next facilitate risk assessment or work-based learning at the university. How can I instil hope in this situation? Am I linking going home with instilling some sense of hope?

Neck Cancer

I can no longer freely talk
I no longer use a knife and fork
The hole in my neck has changed it all
I feel frustrated, depressed and small

Using the writing board is such a faff
I no longer feel like having a laugh
Was all the surgery worth it, I ask myself?
I’ve learnt the most precious gift is health
I wish I could take this in my stride  
But, oh the effort and broken pride  
If only I could look the same  
I wouldn’t want to hide in shame  

It’s an effort to hold my head up high  
Protecting my family through the awkward lie  
Perhaps the nurse hears my silent sigh?  
Helping me home, where I want to die  

Clare Hopkinson 17.6.05

Is reflecting-in-action about more than just empathy? As Lois said in our co-inquiry “What is the relationship with empathy and doing a good job?” We were unable to answer this. And she also asked “do we need to get some distance to be able to empathise?” I think my poetry writing enables some of this distance.

Diary Extract 17/6/05

I discovered I was not the only nurse to feel frustrated and inadequate when looking after Mary. One evening on the handover with the ward staff, I talked about my frustration and how I felt I was picking up the emotions that Mary was experiencing. I thought I might be experiencing a parallel process where I was experiencing the same emotion she was.

The notion of a parallel process is a common concept in counselling (Clarkson 1995) although it is not usually associated with nursing but I believe exists in some relationships with patients. I have used the concept of the parallel process during my facilitation of reflective practice stories since 1998 when I came across the concept during my master’s research. The parallel process is also known as the transference/counter-transference relationship occurring in interpersonal relationships. As Jones noted (2004):
“the main features of both transference and counter-transference are the intensity of feelings experienced by a person toward a notable other, feelings that are unfitting to the current situation” (p.15)

Transference is an unconscious process (Jones 2004) and Hawkins and Shohet (2000 p.209) describe it as: “seeing a present situation / relationship through the emotional lens of a past situation/relationship”. While they describe counter-transference as: “the responses of the counsellor or psychotherapist to their patient/client, both conscious and unconscious” (ibid p.206).

In my Masters’ research I had proposed transference/counter-transference happened between a nurse and patient in some close relationships where strong emotions, such as anxiety and anger were present. Clearly, there is an emotional aspect to nursing. Nurses often find themselves in difficult situations where patients and significant loved ones experience extreme emotional responses as a consequence of their illnesses. I asked the nurses looking after Mary whether they ever noticed if they experienced the same emotions as their patients might be feeling because I felt this was happening to me. No-one answered this question. So I went back to talk about Mary, how did they feel when they looked after her? The staff nurses said Mary was “difficult to look after” and they felt cross and frustrated because she wouldn’t wash or make any effort for her husband. Yet the leap to consider why that might be was missing. It was as though they took the diagnosis of depression away from the context of her cancer and terminal illness. Was there a body and mind split here? There did not seem to be a holistic view of Mary. This brought alive the role of empathy in reflecting-in-action for me, that is, getting at the unexpressed feelings in the moment. If I could empathise with Mary then this understanding of her could be translated into decisions and choices about caring for her needs in a more appropriate way. But did my own needs and especially my emotions get in the way of being able to imagine what she might be feeling?
A few days later there was a discussion about Mary again at the evening handover with two staff nurses expressing disquiet about her impending discharge. How were Mary and her husband going to get on at home? How would they cope? One nurse said she thought Mary would come back to the ward. We talked about hospice care and how difficult it was to get this and that it was only available just before a patient would die, usually about three days before. This meant it was mostly too late for the patient and family to really benefit from the hospice environment. By this time I had written the poem Neck Cancer and hesitantly shared the poem just before the late shift handover to three staff nurses and an auxiliary nurse. I felt very nervous and told the staff they would probably think I was a bit ‘off the wall’ for writing poetry. But to my surprise, the quality of the conversation changed and opened up some powerful reflections in the team. I found sharing the poem and my own emotional state allowed a conversation about how best to care for Mary. We talked about the ethical dilemma we faced about creating some boundaries such as a daily wash while respecting her decision to refuse the nasogastric feed.

Sharing stories of care rarely happened in the team; because, usually we nurses ‘just got on with it’ that is, giving care, not reflecting on that care. Of course this could have been because I was an outsider to the normal team (Coghlan & Brannick 2001). Therefore the trust and safety elements required to show uncertainty about caring for others was missing. On this occasion we were able to acknowledge and empathise with each other because we recognised there were no easy, quick fix solutions for Mary. I noticed the difficulties in providing physical care appeared to be discussed more openly at handover perhaps because these are more easily addressed with concrete actions or decisions. It felt like there was a reluctance to debate or acknowledge the more tricky aspects of nursing such as psychological care or differences in our value systems. But the poetry seemed to facilitate a deeper type of conversation about our values and intentions helping us to see we wanted the best for her and providing a team connection. This was unusual because intentions and values
underpinning care were not usually articulated in the ward, at least when I was present.

Mary was a relatively young woman whose daughter had just had a baby and she was deprived of the joy of entering fully into this experience. The sadness could have been overwhelming for her and I found myself also feeling noticeably sad and weary after I had looked after her. On one shift while working with her I told her how I was feeling sad and frustrated and wondered if she was feeling the same. She burst into tears and held my hand tightly. Later in the afternoon in the teaching room, when I stopped for a coffee break, I burst inexplicably into tears. This made me realise how powerful the parallel process could be. When I talked about this experience with my partner Gordon (who had a mental health and counselling background), he helped me see that I might be experiencing projective identification. I was unfamiliar with this concept and discovered it is a complex form of transference where the emotion may be passed onto the person involved in a relationship thereby fully experiencing the power of that emotion (Clarkson 1995). In this case, I was experiencing Mary’s sadness as if it was fully my own.

Now reflecting on this story I wonder was I also paralleling how students and staff might feel when faced with strong emotions in a ward? Normally emotions were not expressed openly which is not to say that they did not exist. How did I cope with this in the past when I was a ward sister? I wasn’t always bursting into tears then. I remember taking myself off into the store cupboard and focusing on mundane tasks like emptying the stores as a way of grounding or getting some distance, or was it really a way of avoiding the emotions altogether?
I wrote ‘Ageism’ above and ‘The Wounded Nurse’ below, in response to the emotional intensity of two separate sessions with two different work-based learning groups at the university. Two students told stories of their ward experience which had a powerful effect on me and would not leave my thoughts until I reprocessed them as poems. At the next session, a fortnight later, I gave the two students a copy of the poems, and was asked to read them to the rest of the group. This was the first time I had ever shared any poetry with anyone not even my family members. So sharing the poems happened accidentally. Both students had voiced their frustrations, anger and tears during their work-based learning session. After I had read the poems the students talked about the conflict of giving time to patients even when they suspected the patient may need to talk. Further stories were told about the challenging nature of nursing work. I could see a shift during this session which I believe had come about through sharing the poems. The students were not justifying their practice but were starting to raise powerful questions about it and the values
underpinning it. On subsequent sessions where I shared the poems the quality of the conversation always changed like this.

The Ageism poem includes my own experience many years ago when my mother was hospitalised and subsequently died. It again highlights the emotional labour of nursing and the politics and language of elderly care. I suddenly realised that although the poems came from others’ stories there was usually a resonance with my own past experience. Therefore, the poems are both my personal experience and the experience of the student nurse; they represent first (personal) and second person (relational) inquiry. Later I realised they may contain aspects of the *habitus* and *field* of nursing. I noticed I felt very vulnerable when sharing my poems and eventually saw this as an example of using my *vulnerability as strength*²⁰, a finding of this inquiry relating to reflecting-in-action. I noticed sharing how I felt in the moment with the students was another important part of the process.

*The Wounded Nurse*

He pulls a knife  
And the nurse is scared  
She was trying to help him  
Feeling now unprepared  
For this attack  
Which leaves her speechless  
Let down by the system  
Alone, coping with the mess

Managers and medics come to watch  
Security guards and police pin him down  
Feeling sorry for him in all this mayhem  
Though anger escapes through the perplexed frown  
What now it’s all over?  
Back to work with a merry smile  
Keep busy, busy, there’s lots to do  
Not noticing the stomach still full of bile

Clare Hopkinson 10/7/04

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²⁰ This finding will be discussed more fully in chapter 7
‘The Wounded Nurse’ created a debate about the effect some nursing incidents have on the nurse. To what extent would she be able to make strong connections with her patients in future? Surely, some self protective mechanism would lead to a detached approach to caring for other “difficult” patients (Menzies-Lyth1970, Stockwell, 1972). Bile also means anger and in our fifth co-inquiry group (9/6/05) we started to question the presence of anger while caring for others and what effect this might have. Could this be displaced in defensive or difficult behaviour towards others?

On reflection, I am still surprised about the powerful effect the poems had in opening up a reflective conversation or dialogue. I sometimes see something new in a poem which was not intended or I was not aware of at the time of writing. For example, I seem to express the assumptions of the dominant discourse or field unwittingly in the Ageism poem by referring to the doctor as a man but of course she could just as easily be a woman! This is not an easy observation to make when I consider myself a feminist!

**Co-Inquiring into Practice: Using Poetry Deliberately**

I described in a SOLAR 3 workshop (April 2005) how I had been unable to engage the ward staff in setting up a co-inquiry group to meet regularly to look at the tensions and possibilities of reflecting during care giving. This was two weeks into the Strand 2; I was impatient, wanting to get ‘started’ on the research ‘proper’. I felt I had failed miserably in engaging any interest and felt the inquiry was going badly at this stage. By now I had begun sharing some of my poems in class and with my SOLAR PhD colleagues. Liz from the PhD group suggested using the poems in the ward and seeing what happened. So I put some of them on the notice
board in the ward teaching room\textsuperscript{21}. I asked the following two questions and for any other comments:

- “What do you think of these poems? Any comments please”
- “What place do you think poetry may have in nursing?”

In the fourth co-inquiry meeting (12/5/05), I shared my reflections of this process with the co-inquiry group. The poems had been covered over by other notices. No-one wrote on the comments sheet and I thought this could mean no-one was interested in them. However, I have learnt not to jump to conclusions becoming aware of some of my assumptions during this inquiry and thus learning to be more patient with others’ responses. Consequently, I asked staff on the ward what they thought about the poems which resulted in a number of conversations about the emotions experienced at work. I half expected the nurses to consider me as ‘new age’ and a ‘bit bonkers’ for introducing poetry but many of them felt the poems resonated with their own experiences. Again the poems encouraged the telling of several similar personal experiences. The Ageism and The Wounded Nurse poems sparked most response from the staff on the ward while the PhD of Gossip appealed because of the humour. About a year after I had worked on the ward I bumped into a staff nurse who asked me where the Ageism poem had been published. She had forgotten I wrote it and thought it was a published piece. She told me she could still remember how it questioned bed blocking and made her feel differently about the process.

During the conversations with ward staff I was told the poems had provoked feelings of frustration and anger because of the tension in never having enough time to talk and listen to patients. Two nurses said the poems had made them realise how much they felt “dumped on”, how they were always the last person in the chain; that they didn’t have time to go

\textsuperscript{21} The poems included: The PhD of Gossip, Ageism, The Wounded Nurse, The Washing Machine Leak and Moaning Minnie. (I had not written the Neck Cancer poem by this stage).
off for mandatory training sessions because there was nobody to replace them. “They felt hard done by”. Elizabeth described feeling resentful about everything she had to do while Pat felt sad that she had to keep doing tasks like answering the phone rather than getting to know the patient. This was similar to Alex’s (from our co-inquiry group) observations. Elizabeth recognised when she had a connection with her patients she felt she had more job satisfaction. Perhaps Lois’s linking of empathy with the satisfaction of doing a good job was an important noticing.

Back in the fourth co-inquiry meeting (12/5/05) while sharing and reflecting on the process of using the poetry in practice I again noticed the quality of the meeting seemed different. We talked about our own personal suffering in relation to experiencing the death of family members. We inquired together about how this encouraged empathy with others and we realised that sharing our own experiences with patients and staff meant sometimes sharing our sense of our own vulnerability. We came to realise that this could be seen as a strength and was not the same as the whining: ‘poor me’ whereby we might feel victimised.

A Poetic Co-Inquiry with Senior Nurses from the Trust

In the final stages of the inquiry (1/2/06) I used my poetry at a meeting of senior staff who met every two months as the Facilitation Network. This group formed in 2003 to support creativity and change as a consequence of the NHS Plan (DH 2000a) and Agenda for Change (DH 2004). I joined this group as a deliberate attempt at third person (organisational) inquiry as I wanted to offer back my learning to the organisation that had sponsored my practice experience. I had already attended several meetings which happened concurrently with my time in practice. There were 12 senior people present including a member of the Executive team.

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22 This will be further explored in chapter 7
23 These findings will be discussed in chapter 4 and 5
and a visitor from the Department of Health. I asked them to select a poem and work in pairs and consider the following questions:

- “What strikes you from the poem?”
- What if anything does it trigger for you?

I used the following poems: Ageism, The Wounded Nurse, Moaning Minnie, Caught in the Headlights, In the Classroom, and A Manual Handling Incident24.

**Moaning Minnie?**

you don’t get chance to catch your breath before another change is on its way I could tell them how to sort it out but they wouldn’t listen to what I had to say

Directives, policies, standards and protocols Implement them somehow, do your best I could tell ‘em it ‘d never work too much change, just give us a rest

They tell us off when we do things wrong Just implement them dear, now run a long never any advice on how to do it though only advice to say it’s too slow

when do they stop and check what’s been achieved? or listen to staff who feel aggrieved Onto the next change, it’s for the best oh no not again, another behest

I’m still gonna do it, in my own sweet way as I’ve always done it, come what may

Clare Hopkinson 12/3/04

I wrote ‘Moaning Minnie?’ after facilitating a session on change management with a group of third year student nurses using an experiential exercise causing loud laughter and debate. Unfortunately, it prompted another lecturer to march into the room and demand that we keep the noise down. On at least three occasions when using this

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24 See list of poems to access page numbers
experiential exercise, a lecturer would storm into the room complaining about the laughter and be abruptly surprised that I, a lecturer, was in the room. This seemed like a parallel process that might be happening in practice and exemplifies the inclination of the field to remain static. In the poem I tried to capture the imposition of another’s will on staff that felt exhausted in a culture driven by constant change. After writing it I noticed that the stanza had changed from 4 lines to 2 lines at the end of the poem. Unconsciously I had represented visibly the resistance to the enforced change. I began sharing this poem with other student groups who recognised the experience described in the poem. They picked up on the ‘Us’ and ‘Them’ in the poem and felt this was part of the nursing culture.²⁵

Feedback on the poems from the Senior Nurses’ Facilitators’ Network included: the poems seemed “real”; they could recognise the experiences but found the passivity in the poems disturbing and questioned how much this actually reflected the nurses’ views by the bedside. This caused quite a discussion and disagreement and provoked a conversation about individual responsibility and eventually leadership. The senior staff felt the experiences in the poems were from other Trusts and were really surprised to find that 3 of them were actually from their own Trust. The emotions triggered by the poems were: “a sense of shame”, “desperation”, “sadness and anger” and questions were raised about how to maintain a positive and optimistic attitude. The conversation focused on the effects of caring for others, the financial constraints and whether staff only heard this aspect when dealing with the managers. They recognised that change in the NHS was now a way of life and it was easy to “get bogged down in it”. We discussed how change is inevitable but the tension was how to get this into the psyche of the bedside nurses so that there wasn’t so much negativity and despair in the wards. It was felt that recognising frustration could help with resistance to changes. The senior staff acknowledged the

²⁵ This finding will be developed more fully in chapter 6.
balance between the corporate needs and clinical needs was a significant challenge for them as the individual could be lost in the process. In facilitating this part of the meeting I kept bringing their discussions back to their own Trust Document: Treating People Well Communication Strategy and what this might mean for their practice.

Later, when the notes of the meeting came out, it was the Ageism poem which was included. I gained some helpful feedback on the use of the poems. The group felt it was a “challenging” process but “felt a very safe way to get emotions out because it gave some distance on the experiences”, “useful for exploring situations”, “makes you think about how your behaviour is perceived” and “how we need to support people and do we ask for support when we need it?” 26

**Reflexivity on the Field of Nursing**

I wrote the following poem about three months after finishing my shifts on ward 1. It focuses on the increased use of gloves in the ward which was a response to increased hospital acquired infections. I found myself questioning the tension of caring through direct touch and the caring act of not introducing infection. After I had written this poem I began to realise that poetry was a form of ethnographic insight as well as being a process that could question the cultural practices of nursing. I called it “Just a pair of hands” because this is a common nursing phrase usually said by students when they feel used and abused in the ward as a consequence of carrying out the physical care for patients. The issue of who carries out hygiene and direct physical care will be addressed again through the paradox of the busy syndrome27 which became an important cultural tension inhibiting learning and thereby discouraging reflecting in the ward.

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26 See appendix 6 for notes of the meeting
27 See chapter 4 for a fuller account of this key finding
Just a Pair of Hands

I get my hands dirty
Shit, piss and bloody exudate
Removed by these hands.
Inverted gloves
Deposited safely in the sluice

I wash my hands
Till they sting
Red, raw, redeemed
Finger nails short
Scrapped, scrubbed and alcohol rubbed

I touch people
With caring hands
Careful not to contaminate
Warm and sweaty
Behind these latex gloves

Clare Hopkinson 1/4/06

I was gaining more confidence using the poems with other groups of students at the university and sharing them more widely through workshops at conferences of nursing academics. I felt the poetry articulated my practice experiences in a way that was “alive” and was embodied. I began noticing students could identify with the obvious poems cited in practice but those with metaphors or images like The Washing Machine Leak that seemed less obviously linked to nursing, were less popular. It felt to me that the students were hesitant where there was more than one possible answer. They liked the concrete nature of the poems purely based in practice such as the PhD of Gossip, Ageism, A Manual Handling Incident, Neck Cancer, Just a pair of Hands and the Wounded Nurse\(^{28}\) as they were literal and explicit about nursing and perhaps were more likely to resonate with their own experiences. However, I am mindful that the resonance could have occurred because those poems were better crafted and less clumsy. Thus I now question, contrary to the literature previously presented, whether the art or craft of the poetry and the

\(^{28}\) See list of poems to access these poems
performance of the poem does in fact matter. Perhaps it’s not just the process of co-inquiring with poetry that is important?

**But is it Art?**


Because of writing poetry, I joined a multi-professional organisation called LAPIDUS (Literary Arts for Professional and Personal Development). Through this organisation I mixed with ‘real poets and artists’ or rather people who attempted to make a living out of poetry and other creative art forms. I gained a lot of supportive interest in how I was using poetry with nurses. John Killick, a well established poet asked to review some of them and gave advice on making them more effective. I tended to name the emotion in the poem and he encouraged me to remove this allowing the reader to experience the emotion directly. For example, I changed the penultimate line of ‘Neck Cancer’ from “Perhaps the nurse hears my silent weary sigh” to “perhaps the nurse hears my silent sigh” which makes the ending of the poem more effective. As Goldberg (1986 p.68) recognised “Don’t tell, but show” is part of the craft of creative writing. Holmes and Hunter suggested writing poetry involves 3 phases:

- a) creating an image of experience
- b) fully articulating the image and
- c) sharing a clear new meaning of the image” (1998 p.1192).

Evidently, some of my poems don’t do this very well, consequently, they are unlikely to engage and resonate with others. Fenton proposes (2003 p.22) “the handling of rhythm and form is instinctive rather than codified”. Similarly I found I was not consciously aware of how I was crafting the poem or its embedded meaning which came later, mostly through its performance. I found a tension in writing poetry which seems to mirror a tension in reflective writing. In imposing a specific form on a poem this
potentially stifles the spontaneity of the piece and yet the structure or form of the poem can also deepen the insight and add to the aesthetic of the poem. This is similar to the tension of using reflective models for writing reflective stories of practice which often codify the experience and yet through the questions can prompt deeper insights. This seems to me a paradox.

Nevertheless some poems are better crafted than others. I learnt mixing metaphors can add to the confusion and it is difficult to evoke the bodily senses. As Culler (1997) suggested:

“The meaning of a work is not what the writer had in mind at some moment during composition of the work, or what the writer thinks the work means after it is finished, but, rather, what he or she succeeded in embodying in the work.” (p.66)

I am still learning the art of ‘embodying’ in poems. I am learning this through the language, rhythm, rhyme, image, metaphor, and the form of poetry. I have realised it is how the experience is represented, shaped and named that allows others to be challenged, or to resonate and connect with it. Now I see the performance of the poem can provide new insights but have not found any literature in healthcare addressing the importance of the performance. Instead the emphasis is on the power of the process rather than the craft and performance of the poem (Davies 2008, Searle & Sheehan 2008).

How does the performance enhance the poem? Fenton (2003) suggests some poems are written for the page while others are better suited to performance. Pelias (1999p.ix) suggests “performance is a way of knowing” which relies on the body being in control of the mind. Fenton contends “poetry carries history within it” (ibid p.22) and this includes its oral transmission. He suggests when poetry is performed the audience must grasp its meaning in the first instance as there is usually no second chance for performing. Therefore, the loudness, timing, rhythm,
pronunciation, emphasis and speed become important. Whyte (2001p.146) likened performing poetry as “coming out of hiding” and recognised “the self revealing nature” (ibid p.147) of performing it. I found by exhibiting this vulnerability, an unintended consequence became a power reduction between the students and myself. I role modelled courage and creativity which I suggest is an important aspect of reflexive learning.

I wonder in denying the aesthetic quality of the poem whether this might diminish its effectiveness? Russ (1983 p.29) in her review of women’s literature suggested there were two ways women’s work was trivialised: by accusing it of “not being art” and labelling it as “shameful and too personal”. She argued women’s writing was seen as “confessional” while this was not usually levelled at men citing Rousseau, St. Augustine and John Donne as examples where their autobiographical work was not dismissed in this way. Could this also be a tension for reflective stories of practice as well as for my own poems in the ward? Was this an example of habitus, field and symbolic capital afforded to men and not women?

Reflecting on my use of poetry, I think the art does matter but in considering the poems as art this can destroy the ability to write them. It has only been through sharing the poems that I have come to appreciate their reflexive, embodied, emotional, cultural and political quality. The relational aspect of sharing has been an essential part of my learning process and has deepened my reflexive insight.

Conclusion

This chapter presented poetry as an epistemology of practice and has detailed how it can be used as data re-presentation, as data analysis and a form of reflexive inquiry. I have shown in this chapter how poetry contains the complexity of practice because it has the potential to be multi-
layered and provide new insights over time. Therefore a poem is of “it’s time” and has the capacity to capture the cultural and political discourse of that time. I have begun highlighting through my poems some cultural aspects of the Field of Nursing which will be further developed in the next findings chapters (4-7). I have argued poetry is a way of producing valuable ethnographic insight so that the field and habitus of nursing can be illuminated and questioned thus creating a reflexive inquiry at the personal, relational and organisational level. Poetry may encourage the expression of values underpinning practice and emotions generated through working with others. It exposes the writer’s dispositions and so values can be made explicit therefore showing my ontological disposition and habitus. Poetry embodies both conscious and unconscious experience and uses a different way of knowing that is embodied. The felt experience provided by a poem can be helpful in deepening a conversation about the tensions and possibilities of nursing others. The interactive nature of poetry, as an individual and social process, can encourage a reflexive conversation and thus collaborative inquiry because it can embody practice wisdom. Therefore I have used poetry as a valid post-modern collaborative reflexive inquiry process that illuminates personal, relational and organisational levels of reflexivity.

The next chapter focuses on the tension of being busy and its relationship with reflecting-in-action. It will develop and question the class differentials and historically embodied habitus that I argue are still present in the ward and may contribute to the possibilities and tensions of reflecting in the ward.
Chapter 4: The Paradox of the Busy Syndrome and its Historical Roots

Time is an illusion, lunchtime doubly so (Douglas Adams, The Hitchhiker’s Guide to the Galaxy)

The last chapter bridged epistemology, ontology, methodology and began the process of presenting some of the inquiry findings by representing my journey using poetry. This chapter is the first of four dedicated findings chapters that explore the tensions and possibilities of reflecting in the ward by practising nurses in which I begin unpicking the process of what it actually means to reflect during care giving. I present here and in the following chapters the social nature of reflecting and through Bourdieu’s concepts of *habitus* and *field* along with relevant literature, show how the ward culture, systems and political tensions can enable and inhibit reflecting. Furthermore, Bourdieu’s work encouraged me to historically examine the context of ward nursing to consider and question doxic assumptions that might impinge on today’s nurses and their ability to reflect in the ward. A great deal of the following chapters address the ward nursing culture. This I suggest has a direct bearing on nurses' willingness and opportunity to reflect and learn in the ward. At times it may seem as though I have drifted away from reflecting-in-action but the connections will become more apparent as you move through the findings chapters.

Amy, a co-inquirer, chose the picture overleaf to represent the tension of being “too busy to reflect” and questioned if this could be used as an excuse to discourage reflecting in the ward. Amy felt the picture represented the paradox of time: “*Is the man stopping time or oppressed by time?*” and she linked this with reflecting; did reflecting increase the workload or save time? I later realised this mirrored the issue of whether nurses are able to exert their influence, that is, use their agency, over the structures and systems which potentially control their work. And how might this enable or inhibit reflecting? Amy asked: “*What are we really busy doing in relation to reflecting?*” which became our first action inquiry cycle.
Surprisingly I did not anticipate at the beginning of the inquiry, that time would feature so prominently and yet there is an implicit linkage of time in the language of ‘reflecting-in-action’; that is, reflecting, doing and time are inseparably intertwined. Bourdieu (1990) saw time and space as central to the logic of practice through action and argued time is relational. Indeed while working on the ward, time would sometimes ‘race’ away so fast that at the end of the shift my diary entries would repeatedly state that I was “too tired to think”. Alternatively, it would drag so slowly that I would think: “I wish I wasn’t here because I am so busy in my teaching role that I could be finishing my marking!” This demonstrates the subjective nature and social construction of time that is never value free. For Bourdieu any analysis of practice should explore temporality (Jenkins 2002) but this is not so straight forward because the concept of time is difficult to pin down. It has preoccupied both scientists and philosophers throughout the ages. Newton constructed time as linear and absolute because he saw it as mathematically equal parts whereas Einstein viewed time as complex, being easily distorted; it was the speed of light that was constant not time itself. Ricoeur, however argued, “We are not capable of producing a concept of time that is at once cosmological, biological, historical and individual”29. Consequently, time is easily taken for granted, full of assumptions, not always noticed and its impact is difficult to articulate.

29 www.wikiquote.org/time
In this chapter I present experiences which connect to an overarching theme of time and particularly two tensions identified as inhibiting reflection in this inquiry namely, interruptions during work and the work-home balance. I argue nurses are not naturally drawn to writing reflections, preferring oral ways of reflecting, and this will form the focus of the next chapter. Practising nurses participating in this inquiry associated reflecting with written reflection, seeing it as time consuming and a waste of time.

For Bourdieu (1990) a problem with social and scientific theory is that it tends to destroy the reality of practice, by ignoring the temporal dimension becoming unrecognisable to those involved in practice. For example, he cited theoretical schema constructed after an event that lose the temporal reality as a consequence of their construction.

“Practice unfolds in time and it has all the correlative properties, such as irreversibility, that synchronization destroys. Its temporal structure, that is, its rhythm, its tempo and above all its directionality, is constitutive of its meaning”. (Bourdieu, 1990 p.81)

In other words many deconstructions and constructions of practice may lose their sense of time through the analytical process effacing the reality and meanings generated from practice. I have found this to be the case in some written reflections which can lose the ‘presence’ of the experience by neglecting much of the context including the time element. In constructing this thesis into chapters and structuring themes from poems and stories I have attempted to incorporate the time dimension by moving backwards and forwards and not presenting the data in a chronological order; rather presenting experiences ‘out of sequence’. Several poems have appeared to anticipate later themes which have emerged in the data. By including these and portraying time in a non linear way I have tried to demonstrate the way poems, stories, reflective and narrative inquiry are often non linear. More usually they are elicited over time, being recycled, partly emerging and later disclosed more fully (Frank 1997, 2007, Clandinin & Connelly 2000). I suggest time is embodied, relational, contextualised and changeable so that it is time’s linearity which is
illusionary as the Douglas Adams quote above suggests. Consequently, a linear portrayal of time may potentially deny the historical influences available to us in the present and our future anticipations that Bourdieu argued were embodied in the fields and habitus of practice (Bourdieu 1990, 1993a,b, Bourdieu & Wacquant 1992). In this way reflecting-in-action would have both an anticipatory purpose (van Manen, 1977) and an historical influence.

I begin the chapter by considering the contradiction that nurses in this inquiry said they were too busy to reflect while also stating they reflected all the time. I explore, by referring to some historical interpretations, how the ward culture or field of practice of ‘being busy’ may have become embodied and thus may still impact on the image and status of the nurse today affecting nurses’ ability to reflect in the ward. Moreover, education can be a product of economic, social, cultural, political and symbolic capital and thus a byword for class distinctions (Bourdieu 1993b). Consequently, I propose there is an historical tension related to class in nursing which is caught up in the idealised Victorian feminine image of ‘a good nurse’ and which may still influence the social and cultural capital afforded to some aspects of nursing work today.

As part of the field and habitus of practice nurses embody the need to keep busy; many nurses walk fast, talk fast and interrupt others, talk over others as though time is of the essence and may be running out. Amy said: “if you don’t crunch your 30 seconds in, someone else will take your space”. I suggest ‘appearing busy’ is a cultural process taken for granted, i.e. a doxa, one which erroneously equates speed with efficiency in caring for others. I argue keeping busy or ‘doing’ is more acceptable than ‘being’ for some nurses, serving to keep the nurse from thinking, feeling and noticing the emotional impact of the job. Now I see keeping busy as both a real process (often wards are understaffed) and also a learnt and embodied habitus of the field which may serve as an avoidance coping
strategy, discouraging learning and, in particular, reflecting; hence the paradox.

Too Busy To Reflect But We Do It All the Time

One of the original aims for this inquiry was to see whether nurses used reflective writing to support their practice. Written reflection, a common theme in the nursing literature as a way of reflecting-on-action, is strewn with confusing language. There are learning logs, journals, portfolios, structured accounts, reflective models, reflective reviews and personal diaries. Some reflective writing is public (e.g. a portfolio or an assignment) while other writing is private (e.g. a diary). Through writing nurses are encouraged to reflect on their experience. These stories are usually prompted by surprise, inexperience or emotional or ethical discomfort (Bolton 2005, Burns & Bulman 2000, Crathern 1998, Ghaye & Lillyman, 2006, Glaze 2002, Gould & Baldwin 2004, Johns 2006, Moon 2004, Taylor 2006).

It seems hardly surprising that this confusion might translate into practice where I found diary keeping or written reflections were not valued. Writing was not linked to inquiry as Richardson (1994) had suggested so that I found there was reflection inaction in relation to this process. There was almost a stubborn resistance: reflection was “a waste of time” and “too time consuming”. I now see this as part of the field and habitus that does not use or value reflective writing. The following poem tries to capture the issues in keeping a diary, one way of reflecting-on-action.
Reflecting through Diary Writing
To be or not to be that is the question?
Asked by greater minds than me
Still, a sense of what I am and why
Of what I also want to be

Dasein, of this time and shaping time too
Of multiple me’s that conflict and grow
Which one’s do I dismiss, discount, distrust?
Which ones do I willingly want to show?

I write this diary with no idea of shape or form
Poems arrive effortlessly on the page
Time and context often forgotten somehow
Twixt metaphors of sadness and rage

To do or not to do that is the question?
When life is so full why do I need you?
Too tired to think I often write
Yet re-visioning the prism, find gems a new

Do I pretend to you my friend?
Perhaps there is a flinching eye towards the day
When all these secrets held so tightly
Will break free of the page to have their say

Clare Hopkinson 19/5/04

Maria, a co-inquirer, anticipated my findings from the ward, when she said:

I would say I write very little and that purely is time. I know we talk about time, and we are busy, but actually I have no time, really. I mean we are doing our courses, we work full-time, work extra shifts, got two children, you know, I have no time. Well, we’re both the same, [her job share partner]. We haven’t the time to spend to sit down writing. It is non-existent. Actually, we do almost 90% of our reflection talking to each other. (2nd Co-inquiry meeting 3/3/05)

I questioned nurses on the ward to see if they kept a reflective diary and no-one did although Elizabeth, a newly qualified staff nurse who had previously completed a counselling course, had for a while. She stopped when she found “it took up too much time” and she wasn’t sure what benefit she gained from it. One day there were four of us in the office taking a break when Polly, a healthcare assistant said she had never
heard of reflective practice. Deborah, a senior staff nurse told me she liked reflective practice though never wrote anything down. She told me she talked in the pub as her way of reflecting and liked to have breaks together with the staff so they could talk about the work because they rarely had team meetings. Polly then asked if Deborah meant the debrief sessions they sometimes had after a particularly difficult experience, like an arrest. Deborah said yes that was an example and reflecting was also about “offloading” and “not taking work home with you”.

Pat, a bank staff nurse, said reflection had been important for her but found models restricting, she liked the natural way of asking herself, what she could do better/differently. She used an analogy with driving which was weird because that was what Teresa (another staff nurse) had also used earlier. Pat told me when you approach a junction and you know you’ve approached it wrong you think I’m not going to do that next time! So it is for nursing. She linked reflection to her upbringing, the influence of her father who had always got her to think and take responsibility about the consequences of her actions. He had told her don’t expect to be appreciated at work, get your appreciation at home.

Diary Extract 26th May 05

Pat’s description of reflection is similar to findings from Glaze’s (2001) study where 14 students following a Masters’ programme developing reflective skills were interviewed. Glaze found the nurses were “more aware of how their personal biographies shaped their actions” (p.643).

For the qualified staff, reflecting was seen as extra to work not integral to it. It was paradoxically seen as natural; reflection was “something we do all the time” as “commonsense”. Similarly, Brookes’ (2001) and Smith and Jack’s (2005) studies, found nurses saw reflection as a natural process. Brookes (2001) in a hermeneutic phenomenological study investigated how practising nurses in a mental health long stay elderly care home reflected. She described nurses' experience of reflection as spontaneous,
comfortable, positive and relaxed. Reflecting was not restricted to practice but was also part of their personal lives. She suggested:

“Reflection enables them to know themselves, better themselves, improve themselves and grow personally. (ibid p105) and “Reflection, as described by these nurses, while not purposeful, has huge purpose.” (Ibid p.106)

Brookes proposed reflection ‘came to the nurses’ rather than being a deliberate process and found nurses reflected-in-action to make sense of their experience and to manage feelings. This theme of managing emotions through reflection featured prominently in the literature. Brookes saw reflecting-in-action as: “thinking-in-action and acting knowledge (which) provides an alternative view to reflection in the midst of action” (ibid p108). Deidre, a specialist nurse interviewed in this inquiry described reflection as “just something that you do informally” in order to “let off steam”. She felt nurses reflected through chatting. Perhaps staff did do it all the time as Schon (1983, 1987) had discovered in the indeterminate zones of practice when practice went wrong or was unexpected. Was I expecting something more than this in relation to reflecting-in-action?

Students told me they only wrote reflections when they had to, for example for an assignment, not out of choice. Teekman (2000) found nurses had great difficulty in identifying propositional knowledge and found little evidence of critical inquiry in the critical incidents he analysed. However, authors such as Jasper (1999), Smith (1998) and Durgahee (1996) found nurses valued self learning through writing diaries/journals. They suggested emotions generated by work were released through the process of writing leading arguably to more resilience to workplace adversity (Jackson et al 2007). Nevertheless, Jasper (1999) found the nurses saw writing reflections as difficult and unnatural and while it developed self awareness, learning, analytical and critical thinking it was also regarded as risky. What happens if the emotional experiences are usually blocked out as a way of coping with work? Or were sometimes too overwhelming to deal with? From my experiences of marking reflective
written assignments, the writing process does not guarantee nurses will actually write about their feelings generated by their practice. I started to wonder if the articulation and recognition of feelings through reflecting was actually counter-cultural to that expected and learnt in the ward.

The co-inquiry group, who were all really committed to the benefits of reflecting, preferred to reflect in their heads in the moment or talk it through with someone else. Time was cited as the main reason for not reflecting in a written way. It was not compatible with family life. The co-inquirers said reflecting was central to their practice and involved a questioning approach, a “standing back” in the moment or “mulling over” of the day’s issues. They used the following ways to reflect about work: walking the dog, swimming, chatting in the car, thinking while driving home, shared informal chat over lunch/coffee and in my case at the photocopy machine, sometimes in meetings a reflective conversation might happen, thinking in bed at the end of the day, listening to music, reading fiction, writing poetry and dreaming. Usually these reflective activities took place away from the workplace, in our own time and sometimes invaded the home work balance. Tracey said:

Because I have an hour and 10 minutes drive each way that time in the car on the way home, an awful lot runs through my brain. I think an awful lot about things then and in the morning I can go in I am fresh. I think right “How can I take things forward today”? “What am I going to do?” You know, “how am I going to deal with this particular issue?” Because it’s the difficult issues I have the problem with and they are the ones I have to think about the most (Final interview 28/6/06).

Yet as Jane, a co-inquirer, noticed her staff saw reflecting as a “stick to beat us with” (final interview 9/02/06). Clearly, there were mixed attitudes in practice towards reflecting. Why might there be such strong diverse opinions about reflective practice?
For Jordon, unless she had a performance issue with a member of staff that she felt was likely to backfire on her, she preferred to reflect by thinking.

**Clare:** one of the key things to come out of this [inquiry] is time. It takes a long time to reflect. I don’t know what your thoughts are on this?

**Jordon:** Yeah, I think if you’re gonna write it down it does. And I think if you’ve got the quick check-list in your head the whole: what happened? What went well? What didn’t go well? What would I do next time? What’s gonna be my actions coming out of this? It doesn’t take seconds really and especially if you’re reflecting-in-action while it’s going on. I don’t think it does but I think it’s the writing it down, that takes the time. (Final interview 20/4/06)

Both Tracey and Jordon have created their own reflective model similar to Gibbs (1988) that they run through automatically in their head suggesting both may have embodied a questioning approach to their practice. Lois had noticed one of her reflective processes happened through dreaming. She would sometimes go to sleep with a work problem and in the morning amazingly, would have a new idea or solution. This prompted our third reflective action cycle which involved keeping a dream diary for a month. Alex, Alice, Jordan, Jon and I found the dream diary hard to complete and by this stage, Liz, Maria and Amy had withdrawn from the meetings. I did manage to record a few dreams but I became more aware of dreaming when I worked a late/early shift pattern. There was obviously less time between the shifts and for sleeping perhaps encouraging my thoughts to race over the day’s work.

Before this inquiry, I never considered dreaming as a reflective process although as I write now, realise fiction writers and therapists have used dreams as an important part of storytelling and for highlighting subconscious issues and hidden emotions. I would not have connected dreaming with reflecting-in-action without the co-inquiry group. I wonder now how dreaming might alert me to my emotions including the suppressed ones or help stimulate my unconscious knowing. Dreaming
and its relationship with reflective practice and reflecting-in-action is worthy of further research inquiry as we only touched briefly on it in this cycle.

In the introductory meeting (25/11/04), I discovered most of the co-inquirers were drawn to this research because they had a practice development element to their role. Liz raised an important question that was later raised by others in our third inquiry meeting (April 2005). Liz asked:

Does reflection have a place in helping practitioners move on from practising it in the classroom, assimilating it and then how does this or might this affect their practice? (Introductory meeting 25/11/04)

We were to come back to this tension in various guises during this inquiry. Mostly the question was simplified to learning in practice. Did we learn in practice through reflection? Was learning synonymous with reflecting? Amy, Maria, Jordon and Lois returned to this issue. Alex, Alice, Jane, Jordon, Jon and Tracey were more certain that they had benefited from the classroom experience of reflective practice and had taken reflecting into their current practice. For Liz, Amy and Marie, all practice developers, there was a clear tension in translating learning from courses back into the clinical setting; there seemed to be a lack of will by certain staff to use their new training and this was later identified as a concern in Strand 3 by the modern matrons and by Laura, Rachel and Sharon, in practice development roles who were interviewed in Strand 2.

As the inquiry progressed I became aware of the contradiction that qualified and student nurses in the ward and classroom would tell me they were too busy to reflect while almost simultaneously saying they reflected all the time. At the second meeting (3/3/05) I asked: “is there genuinely, not enough time?” We questioned whether there was a cultural element which used being busy as an excuse to pick and choose the tasks being asked of the nurses which perhaps included reflecting. We decided nurses
used time in a contradictory way; sometimes as a way of avoiding practical actions that they did not want to do or perhaps felt incompetent to do and yet often there genuinely was not enough time to get through the expected workload. There was just “too much to do”. A midwife or nurse might be sent on a course but on her return to the clinical area could still feel incompetent. Sometimes there was a time lag before the skills could be practised which contributed to some staff’s reluctance to use their new learning.

Now I see this as related to confidence and fear. In not practising the skills straight away then fear can set in, and in a culture where the nurse is likely to be blamed for making a mistake then she is unlikely to want to expose her vulnerability through the possibility of not performing adequately. Avoidance could be a way of protecting herself from such exposure and discomfort. Therefore in the field of practice learning is subtly undervalued because a prominent habitus absorbed paradoxically is be perfect while the field promotes watching your back. This does not encourage learning from mistakes; a central tenet of reflecting. It is easy to see therefore how this aspect of the field of practice and embodied habitus can subtly undermine reflecting in the moment in the workplace. I gained the impression from practice that learning for learning’s sake was discouraged – we were too busy and staff were expected just to “get on with it”, that is, get on with the work and don’t ask questions.

Alex suggested a fear of litigation stopped staff from talking openly about mistakes whereas in Nigeria where she had trained, case meetings were held and attended by all of the multi-disciplinary team to discuss mistakes. For Alex these meetings were a learning process rather than a blaming process but patients were less involved and less knowledgeable about their care which she felt allowed staff to be more open with each other. Patients in the UK were more informed about their conditions because of internet access. Maria, as a practice developer, had worked hard to

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30 This key finding will be explored more fully in the next chapter.
encourage a learning environment that was open and conducive to learning from mistakes. She noticed some staff would avoid tasks by hiding behind comments such as:

💬 It’s not my job. I’ve been told to look after 4 patients. I’m looking after them. For me the more you do the more confident you become. (Final interview 27/1/06)

Maria raised an important aspect of the *habitus* and *field* of practice that valued being busy by linking doing to confidence. We wondered if “being busy” potentially inhibited reflection. In feeling indispensable and “busy” could this be a way nurses sought recognition and felt valued, equating speed with confidence, efficiency and thus competency? Did the culture of nursing value being “too busy” or was it actually a systemic problem due to a shortage of nurses available to provide the required quality care? Perhaps it was both and how might reflective practice sit with this tension?

For Alex the pace of work was often frantic with competing demands on her time. “Everyone wants you to do three things at once which you know is not possible” and this left her feeling angry or resentful. She rarely managed a lunch break or a coffee break which mostly she would take on “the run”. I asked her if staff shared their stories and experiences on her ward and Alex told me:

💬 No we don’t have time because of the stress of work. We are too short of staff that things just happen and nobody has time to even say “how was your weekend?” or take five minutes to talk about social events or your private life. We don’t have the time to share or relax in the common room over a drink because we don’t always get a break and when we do some staff will use their mobile phones to contact family or loved ones because that is the only time we get. We might get 10-15 minutes before we go off again so nurses hardly share. Once in a while we might and perhaps we should improve in our sharing of experiences but time for detail isn’t there. (Final interview 31/10/05)
Alex found being so busy was isolating and meant there was less team-working and time for relationship building. Earlier in the conversation however, she said

The possibilities of reflecting in the workplace are really huge because we reflect every minute when we are in the workplace  
(Final interview 31/10/05)

Alex typified the contradictory notions held about reflecting that staff were too busy to reflect and also did it all the time. I started to realise that perhaps it was an ‘expected reply’ by staff to say that ‘we reflect’. For Alex, being busy was a daily reality in her ward where there was a staff shortage. In fact we were interrupted in our final interview by a phone call asking her could she go into work on her day off as a member of staff had gone off sick. Interruptions featured in all aspects of this inquiry and I eventually came to realise was a parallel process mirroring the interruptions ever present in the ward. As Alex experienced, constantly being interrupted at work, had an emotional impact leaving her feeling she was not doing a good job. In the SOLAR 3 workshops I was frequently interrupted when I offered my experiences and opinions and I felt somewhat insecure and resentful as I will show in the writing piece: Whinging Wilma and Co-Inquiring Clare31. Interruptions distracted my train of thought and stopped me reflecting in the moment drawing my attention elsewhere. Action seemed to be lost sometimes through the interruption. Interruptions seemed to have an emotional impact creating a feeling of dissatisfaction with my work; of not finishing it properly. Could staff also be feeling this as a consequence of interruptions and feeling overworked?

**Interruptions**

I am interrupted and lose where I am

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31 See next chapter 5
The issue of time and the tension of being too busy to reflect were focused on several times. Amy said:

_Do you save time through reflecting or do you create more pressure on yourself because you have less time as a consequence of writing reflections? Is the man [in the picture] stopping time or oppressed by time? (1st Co-inquiry meeting 20/1/05)_

In our discussions Lois coined the phrase “the busy syndrome”. Later in our first meeting Amy said:

_Reflecting-in-action for me is the ability to “stand back” and think about what you have done and what you could have done. We all say it’s too busy and I couldn’t do x but it’s very superficial, isn’t it? People have to believe you are busy because you told them but busy doing what? It’s only when you try to unpick it, ok, tell me what you’re busy doing. Then you get “well erm, erm”. So that’s challenging because what you are really saying is I don’t believe you’re busy. I think as experienced practitioners we are less sympathetic to that busy syndrome because we have an expectation that they should still do more. That’s a tension. Are we expecting too much of people? (1st Co-inquiry meeting 20/1/05)_

Amy, a midwife and practice development sister, learnt to try and unpick the claims for busyness. Did nurses need to feel busy? I was beginning to realise this was part of the embodied _habitus_ and _field_ of practice. We talked in her interview again about the busy syndrome and she told me:

_Nights in deliveries are probably the worst place because they are very very busy. But because you are really, really busy you don’t get a chance to stand out of it and that’s one of the things reflecting-in-action is all about, standing out of it and saying why are we so busy? We get bleeped and they’ll say we need you to come and help. So you go there, and I’m a bit long in the tooth now, so I_
Amy implies that she is able to discriminate and assess the context of practice which was missing from some of her staff. Did nurses believe they were busy when sometimes they were not? Stephanie, a practice development manager with a responsibility for risk assessment, struggled with this contradiction. Deidre, a specialist nurse noticed:

*I don’t think you can always blame it on a shortage of staff because, you can go on to some ward areas, and you can see straight away, there’s three people hanging around the nursing station. Well, you go and do whatever you do but half an hour later you come out and they’re still there. What have they been doing?* (Interview 17/4/05)

West et al (2005 p.435) in a survey of all nurses including healthcare assistants and modern matrons, found 64% of a sample of 2,880 felt overworked and reported they did “not have enough time to perform essential nursing tasks, such as addressing patients anxieties, fears and concerns”. They found giving emotional support and physical treatment were the most likely areas to be neglected if the nurse was short of time. Similarly, Storfjell et al (2008) found less than 1% of the qualified nurses’ time was spent on providing psychosocial support. I wondered if providing emotional support to patients was best avoided because it generates too much discomfort. The co-inquirers however, felt reflecting-in-action allowed the nurse to “stand back” and take stock even in the busiest moments which helped reduce the discomfort and emotional impact of the job.
This suggests to me, that hygiene needs and emotional support are undervalued, having less social and cultural capital in the ward. My assumption is that both are central to effective nursing care. It is only recently that ‘basic nursing skills’ has been renamed ‘essential nursing skills’. This language could imply less symbolic capital than technical nursing skills forming part of extended nursing roles. Bourdieu suggested it is through linguistics that identity is formed. While in 1960 Menzies-Lyth proposed nurses used depersonalisation and fragmentary work processes to act as a function against the anxiety generated by the job. She suggested working with the suffering of patients and carrying out mundane and repetitive work created anxiety for nurses. Consequently, by not providing hygiene needs or emotional support nurses may be able to protect themselves from the patient’s suffering. I suggest in a close nurse-patient relationship as I found in nursing Mary\textsuperscript{32}, it is possible to experience strong raw emotions through a parallel process involving transference and counter transference. If there is less engagement, and a close relationship does not develop with the patient then the nurse is unlikely to experience transference, possibly reducing the emotional impact, especially discomfort. However, reflection is sometimes generated by discomfort so perhaps nurses were not engaging with reflecting because they wanted to avoid or were not ‘feeling’ while giving care.

In West et al’s (ibid) study, 65% of respondents said they had too much work to do while 33% felt they were understaffed resulting in less time for direct patient care. This led me to again question the lack of time in practice as a systemic staffing issue. Perhaps it is unrealistic to expect nurses to engage emotionally and practically with their patients especially if they are understaffed?

\textsuperscript{32} See previous chapter
Does a Busy Environment Affect Reflecting-in-action?

Before reading West et al’s findings (ibid), we identified a tension in our second co-inquiry meeting (3/3/05), that “nurses find it difficult to reflect in a busy environment”. Co-inquirers wanted to support themselves and colleagues to reflect in practice. They questioned: “how do you support or encourage reflection in others?” They felt their practice had benefited from reflecting while their colleagues were often cynical; seeing reflection as a “waste of time”. Paget (2001) devised and sent a questionnaire, based on two focus groups, to nurses following completion of a reflective practice course. He wanted to see if there were any resulting clinical outcomes. Although he had a small sample size with a response rate of 35% (n=72/200) reducing the generalisability of his findings, he found nurses regarded reflective practice highly and could identify significant long term changes in their practice. However, he did not identify what these were. Some respondents from the focus groups saw reflective practice as an academic exercise which may have accounted for such a low response rate. In the questionnaire, 38% of participants identified restrictions in implementing changes to their practice. Paget suggested this was due to an unsupportive culture or management “as well as the restrictions imposed by the nature of a busy environment” (p.210).

In Strand 3 Emily, a modern matron, explained how time worked against her. If she chose to work clinically, which was an expected part of her remit then she could not keep up with her emails and strategic work. So she would take her laptop and write while she sat in the car waiting for her son to finish playing football. But long term this approach was tiring and extended her working day. There was a tension for her in that, if she spent time with her staff, she would also pick up more problems to sort out, again reducing her time to work on the strategic issues. She felt she was reacting all the time to situations. There was never enough time to do things properly or to think through situations carefully. She just reacted in
the moment. The job was endless; it was a struggle for her to finish anything.

During my time on the ward I worked several very busy shifts where I heard on more than one occasion a nurse at handover say “I’ve not even had time to go to the loo today!” Jon, a co-inquirer, told me she worked a 60 hour week in her role as a modern matron; a lunch break for her too was an illusion as she worked through it. She had put her master’s degree on hold because the workplace was so busy but she found education was motivating and helped her with her job. Liz withdrew from the study after the introductory meeting because she did not have enough time to take part while co-inquirers sometimes could not attend meetings due to the pressure of work; having too much to do and not enough time to do it in. In Strand 3 the lack of attendance at the action learning sets was usually cited as “not enough time” or “pressure of work”.

The struggle with attendance in Strands 1 and 3 was echoed by Jane, an Emergency Practitioner and manager, in her interview. She had only managed to attend one co-inquiry meeting and commented on the difficulties of getting her own staff together for reflection on their work related issues and practice.

Jane: I’d like to set up a reflective practice group which I haven’t managed to do because of the constraints of money, staffing and everything else that the Trust is in at the moment. But we are getting hopefully, second year students from August and that may well be the leverage to try and go down that route again.

Clare: You’ve planned to have monthly meetings then?

Jane: We were going to try, we’ve tried monthly meetings and one or two people turn up and the other people are working and you end up….

Clare: I got exactly the same problem with the co-inquiry group and that’s really interesting, because I feel that it’s a mirror for something that’s happening in practice but I can’t quite put my finger on what that is.
Jane: Well staff won’t…once upon a time they would have come in for a staff meeting for half an hour or an hour in their own time, they won’t do it anymore.

Clare: Why do you think that is?

Jane: Because everyone’s pushed so much because there’s no leeway, we don’t have a hand-over period because of what we do. One person comes on and one person goes off so you’re at minimum staffing all the time so there’s absolutely no leeway. People feel that they’re not prepared to put that little bit extra that they would have done, because you could’ve let them go a little bit earlier another time when you had a slight lap over but you can’t do it anymore. (Final interview 9/02/06)

I experienced the pressure of work first hand. I was working on the ward on the early shift and due to go at 2 p.m. to a basic life support update. This was held in the education centre down the road. I began work at 7 am and was so involved and engrossed in looking after my patients that I lost track of time until it was too late to attend the session. Reflecting on this in my diary later that day, I began to realise that ward nursing was somewhat different from my day in the late 80s. What was different? My ward had certainly been busy a lot of the time. We had a high proportion of students compared to qualified staff and a few support staff called nursing auxiliaries whereas now, there were more health care assistants and fewer students. We also had patients with complex needs but now nearly everyone on the ward had complex needs. My patients had required considerable help that day but it felt like it was more than that. There was no computer and so as a sister I was not sat at a desk responding to Trust information requests although that did happen sometimes. Liz had complained about the information overload caused by emails and how this invaded her clinical time. There were fewer specialist roles creating liaison discussions. There were more forms to fill in which seemed to take away the nurse’s professional judgements. Everything had to be documented, for example, venflon checks, manual handling assessment, wound and pain assessment etc. The words of the porter came back to me, “morale was low, too much paperwork”. I started to notice that there was less helping each other out though not always due to less staff or overwork.
There were more specialist roles now such as palliative care sisters, risk assessment managers, practice developers or stroke co-ordinators. Was this deskillling the other qualified nurses? Were these ‘experts’ helping the permanent staff? Did this create more or less time for staff on the wards? Perhaps staff felt more inadequate by comparing themselves to these specialists and this resulted in an unwillingness to try new learning where they ‘might get it wrong’. Perhaps they felt incompetent in comparison.

One of the themes in my diary writing concerned comparing myself with others. Perhaps comparison was linked to appearing busy all the time? No-one was available to look after my patients even if I had made the effort to leave the ward. Had I subconsciously absorbed this and become less proactive about education in the clinical setting so I didn’t even bother to ask anyone for cover? Where was my own sense of agency, here? How could I have forgotten something as important as a basic life support update? Learning for oneself did not seem a priority in the ward; nurses’ learning seemed to have little social and cultural capital and therefore why would reflecting be any different.

Sheila, the ward manager, later told me in an informal conversation, that her staffing budget had been frozen due to financial constraints and she was three staff short. The Director of Nursing had changed the staffing and workload formula and was indicating that Sheila would have to cope with the shortage; after all there was a national shortage of nurses. She was criticised for booking extra bank nurses and instead expected to provide the same level of service with reduced staff. The unpredictability of the emergency treatment room and complexity of patient care meant it was difficult to know how many staff were needed on some shifts. Rachel, a risk assessment manager and practice developer commented, in her interview, on the staffing shortages and how the ratio between trained staff and untrained staffing was changing with more untrained nurses. She felt this had implications for the quality of the service. Could it also have implications for reflecting in the ward?
About a year later, in March 2006, I attended a senior staff meeting to talk about facilitating learning within the trust. This group comprised mostly senior nursing staff, being either modern matrons or division heads of nursing. They were concerned about the poor uptake of in-house training. I explained how difficult it was to be released from the bedside when giving care, as sometimes there was no-one spare to hand over the care to. If staffing is cut to the bone, how can managers expect nurses to have time for education? As Jane had said there was less leeway. In this meeting I gained the impression that the managers felt it was a lack of will on the part of the nurses; a simplistic and blaming analysis. However, I saw it as an aspect of the habitus and field of practice, an unconscious process that denied the need for education putting others needs first, and a staffing issue depending on the context. I suspected the way the managers were ‘blaming the staff’ was like the drama triangle game.

I have used Karpman’s (1968) theory of the drama triangle in facilitating reflective practice, following my Master’s degree in 1998, as a way of explaining how interactions between people often go wrong. In this process there is implicit rather than explicit communication. Karpman explains this unconscious game between people through a visual representation of an inverted triangle with the three roles, one at each corner (see above). These three roles namely Persecutor, Rescuer and Victim get played out during an interaction. Karpman suggested roles would be switched during the game; with one person moving in and out of at least two of the roles very suddenly. Sometimes it is possible to switch between all three roles so that the game is dynamic rather than static.
Stewart and Joines (1987) suggested this unconscious process was usually learnt in the family.

In the persecutor role acting as an attacker or in an aggressive way, they put others down or belittle them giving an implicit message that the other is out of order. The rescuer offers help and this is often done not from an equal positioning but from a one up position, seeing others as ‘not ok’. When the switch comes the rescuer feels hard done by; ‘I was only trying to help’. The victim invites others to help him/her using a ‘poor me’ invitation because this person feels that he/she is ‘not ok’. When the switch happens for example, the victim may feel the person helping them isn’t good enough i.e. switching to persecutor role, that person is then likely to verbally attack the rescuer. The original persecutor will then move into victim role feeling ‘poor me’, and ‘hard done by’.

Sometimes referred to as *racket feelings*, one of the purposes of this game is to block the honest expression of emotions by re-experiencing emotions that are familiar from the past so that intimacy, collaboration and shared meaning is not experienced (Bagshaw 2000). It is proposed that these feelings are safer as they are familiar and that this is an unconscious process (Berne 1975). I found this theory sometimes helped students on my reflective practice modules or work-based learning modules, gain a different insight into their practice. I noticed in nurses’ stories that, rather than caring for patients, they were sometimes inclined to rescue them, and would feel really bad about a situation i.e. feel hard done by as a victim or feel persecuted. The patient or colleague would present as a victim, unconsciously inviting the nurse to make everything better for them, i.e. rescue them. In the interactions of this game a person is always left feeling hard done by; ‘I was only trying to help’. Drawing attention to the effects of The Drama Triangle game seemed to support nurses by encouraging them to see that there is a fine line between caring for someone and rescuing them. Blaming someone as a way of avoiding ones own responsibility may potentially unconsciously invite the game to take place.
I started to wonder if the busy syndrome might be an inexplicit game in the ward inhibiting reflecting. But what purpose might it serve and what if nurses really were overworked? My new understanding of post-structuralism was helping me see that both situations were possible. Recently there has been an increasing interest in how nurses spend their time; driven in part by the need to make best use of their knowledge and skills through extended roles and in part by the spiralling cost of nurses’ salaries that form a high proportion of the total hospital budget (Storfjell et al 2008, Adams & Bond 2003, DH 1998). Adams and Bond (2003) found no link between higher staffing levels and higher standards of nursing practice. They argued however, the converse was not the case so that less nurses resulted in task orientated care normally associated with poorer levels of nursing care and hierarchical nursing attitudes.

A recent survey by the RCN (2008) of more than 1,700 nurses found that 88% believed non essential paperwork had increased over the last five years coupled with a lack of administration support, preventing nurses from spending time on direct patient care. Nurses received less than three hours clerical support per week with two-fifths having no clerical staff support. Subsequent to this inquiry an NHS Institute for Innovation and Improvement project (2007) called “Releasing Time to Care –The Productive Ward Programme” has been piloted. It suggested that savings of up to 40% of nurses’ time could be better used towards direct patient care by using its programme of 13 self directed learning modules. These are aimed at developing ‘a well organised ward’. Some time saving ideas include: focusing on effective ward processes by reducing the time the team spends on delivering meals therefore allowing more time to assist with feeding, reducing interruptions on drug rounds, removing the rush of admitting patients all at the same time by staggering admissions and discharges, reducing the time spent on handovers, ensuring the dignity of patients by providing safe, clean and responsive care, improving the patient experience by ensuring Trust standards are adhered to and improving ward rounds so they are quicker and more consistent.
This initiative promotes time efficiency processes and a "productive improvement agent". It is unclear what this actually means but is presumably a way of developing nurses' leadership skills. There are toolkits to assess how one's ward is 'doing' and improve ward based measures that help the team to make informed decisions on how to effectively re-organise the ward. This project is to be rolled out throughout the NHS. Whilst I have identified similar issues through this inquiry such as the lack of time spent with patients, the distracting aspect of interruptions which can lead to mistakes, and staff feeling unsupported by managers, it is yet to be seen if The Releasing Time to Care project will make a difference to the quality of the patient experience.

I found even when the ward was quiet at Easter (no operations were scheduled) there was still an air of being busy or needing to appear busy so that I came to see it as an aspect of the habitus and field of practice. I was reprimanded by a staff nurse for taking too long in carrying out the evening observations because I had been chatting with the patients as I went along. On other occasions it felt like there was an unsaid expectation that a nurse could not have a break until all her work was completed, as Amy had described earlier. This encouraged a culture of martyrdom, where it seemed nurses vied with each other to go the longest and in many cases doing without a break altogether. It felt like an unsaid assumption that the longer the time before a break was taken the better the nurse! 'I'm busier than you!' I could see the victimhood of the drama triangle game here. In immersing myself in the data, I started to wonder about one of our co-inquiry questions “Am I an approval slave?” and whether this might be connected to the need to be or seem to be busy? If there is an expectation that you are busy as part of the culture, what happens when you are not busy. Are your approval needs still met? Paradoxically, this could be seen as not doing a good job and will not necessarily encourage nurses to spend more time with patients, as the Releasing Time to Care project is suggesting. Equally, in standing back to reflect in the ward even for a moment, this could also appear incompetent.
My argument is, that if ‘being busy’ is part of the habitus and field of practice and serves to avoid engagement and emotional investment with patients, then political initiatives such as Releasing Time to Care will mostly fail as they do not take into account the cultural and emotional aspects that keeping busy affords. They certainly do not address the possibility that staffing levels may be inappropriate leading to less time spent with patients. Implicitly, the message is that if you organise yourself better then you will have more time with patients. However, as I have tried to show this will not necessarily occur. By implication it therefore becomes the nurses’ fault for not managing the process better and is likely to feed into the drama triangle game causing a resistance and passivity to the programme outcomes. Likewise Jane’s attempts at getting staff together will largely fail, as reflecting requires stopping for a moment to consider options and choices and could be interpreted as the antithesis of keeping busy. Nurses may not be organising their time well but in my opinion this is too simplistic an analysis and denies the unconscious processes embedded and embodied in the field of practice.

**Roots of “The Busy Syndrome”?**

How do nurses come to embody needing to keep busy? What might be the historical roots influencing this aspect of the nursing field and habitus? I felt returning to historical accounts might help me understand why reflection seemed counter - cultural in the ward and why many nurses regarded it as a waste of time. I have suggested this paradox may be related to a need for approval and a doxic assumption that busyness equates to efficiency and competency. In this section I examine selective historical influences that might have a bearing on this aspect of the ward culture. History was central to Bourdieu’s work since he defined habitus as a process that “embodies history, internalized as second nature and so is forgotten as history” (1990 p.56). By this he meant the doxic assumptions
can become embedded in the fields of practice which are carried in the body as habitus, as unconscious verbal and non-verbal behaviour, attitudes, dispositions, prejudices and games. Thus they become invisible, unnoticed, and unquestioned over time. And Bourdieu’s work suggests looking historically for explanations of how culture is produced since:

“The boundary of the field is a stake of struggles, and the social scientist’s task is not to draw a dividing line between the agents involved in it by imposing a so-called operational definition, which is most likely to be imposed on him by his own prejudices or presuppositions, but to describe a state (long lasting or temporary) of these struggles and therefore of the frontier delimiting the territory held by the competing agents.” (Bourdieu 1993 p.42-3)

This involves looking outside the field at the dominant wider fields of power for their influence on the habitus and field of practice. Bourdieu saw education inextricably linked to fields of power and class with ‘ignorance’ used as a byword to signify the working class (Lawler 2004). Bourdieu did not have a defined schema for class distinctions rather he linked it to a group’s social entitlement and capacity (i.e. habitus and field) through their economic, political and cultural capital. Thus some groups remained dominant (the gentry and middle classes) and others were dominated (the working classes). He argued “those in the know” are able to judge and disapprove of “those not in the know” keeping the distinctions operating (Lawler 2004 p.116). Waquant (2006) citing Bourdieu wrote:

“The representations that individuals and groups inevitably engage in their practices, is part and parcel of their social reality. A class is defined as much by its perceived being as by its being.”

(Wacquant 2006 p.11)

Perhaps this could have a bearing on whether nurses reflect or not? And could this be linked to nurses’ sense of their own identity? In this section I draw upon selective secondary literature from nursing historians and in particular focus on the historical roots of hospital nursing and education looking at class distinctions as a possible explanation as to why some

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33 I have already highlighted the Drama Triangle Game played out in practice that goes unnoticed.
aspects of nursing may hold more social, cultural and symbolic capital than others. I question the image and status of nursing in hospital ward settings that affect nurses today and possibly may still impact on the attitudes towards reflection in the ward.

The history of nursing is not a dominant discourse in the nursing field and in my organisation does not feature in the student nurse’s curriculum. Perhaps this mirrors a reluctance to learn from the past that is mirrored in the “paradox of the busy syndrome”. There is a parallel tension here with learning from reflective practice: how much of one’s past does one reveal? It is important to treat these historical accounts cautiously as they are likely to reflect the dominant discourse or political aspirations of the time as well as those recounting the past.

Versluysen (1980) argued it was during the 19th Century that medicine tried to establish itself as a profession. In so doing, women from all levels of society who prior to this time had practised healing, midwifery, physician and surgical work as part of their domestic craft became excluded from the early medical profession. These women included educated ladies and peasant rural women many of whom gained small payments for their services away from the family home. For most women, however, these skills were practised on family and neighbours as part of a community expectation, with no payments received. In many instances these women gained more experience and arguably were as skilled if not more so as their male counterparts who usually were poorly educated and practised from barbers shops; very few physicians at this time possessed a degree.

Versluysen (1980) argued it was a deliberate gendered and political act to create distinctions between ‘curing’ and ‘caring’ functions which until this time had not been separated. This served to increase the status of the male doctors when in 1858 they created their society of physicians and set about establishing a ‘profession’. Consequently the status and skill of the women who operated in the same field of practice was undermined and
excluded. Subsequently, women became associated with the more mundane and ‘passive role’ of providing hygiene management which Versluysen (ibid) argued was identified with caring and mothering; later to become nursing. This largely fell on working class women. Therefore she proposed the sex divisions evident in the family were transferred into the workplace and served to keep women subordinate to their male counterparts. She questioned:

“We should not forget that throughout the ages women have willingly cared for the helpless, infirm, and socially dependent, but that the reward for this has too often been indifference, scorn, or the status of a servant class. We do not know why this has happened with such consistency, nor why women’s caring has been so devalued in our society” (Versuysen 1980 p.197).

It is beyond the scope of this inquiry to answer why caring has been so devalued though I suggest it is in part due to gendered views on femininity, class distinctions, and professional vying for status and power. It can be seen that the medical staff prospered while the status and image of nursing struggled. I think this is still relevant to nursing today and impacts on how caring and nurses are currently viewed in society. I turn now to how hospitals emerged to see what light this may shed on the status and system of hospital nursing.

According to Abel-Smith (1960) it was around the turn of the 19th century that the poorer classes started to move out of the home and into a form of hospital based care. The choice at this time was either the workhouses or voluntary hospitals where the focus was on predominantly social rather than medical care. The workhouses were for ‘paupers’ and were seen as places to die; they were not designed for nursing the sick (Abel-Smith 1960). In the workhouses the nurses were untrained, unpaid and lived and worked on the wards in awful conditions. They usually had been patients themselves i.e. ‘paupers’, supposedly more ‘able bodied’ than those requiring ‘nursing’, nevertheless, their skills were limited (Abel-Smith 1960). Part of their rations included porter or gin in order to cope with the stench and putrid conditions (Maggs 1983, Abel-Smith 1960). Prostitution
was also prevalent and was a way the women could earn extra drink or rations (Abel-Smith 1960). This may have led to the prevailing image of the nurse through the fictitious character, Mrs Sarah Gamp by Charles Dickens, in Martin Chuzzlewit serialised in 1843-4 (see photograph overleaf). She was later utilised by the reformers in a portrayal of nurses as drunken sots, hardened by life and of a mature age being: brutal, gossiping, ignorant, and superstitious women; a rather one-sided view of nurses at that time (Williams 1980). The workhouse nurses are clearly portrayed in this characterisation removed from the context in which they were ‘caring’.

The voluntary hospitals were supported by charitable contributions or philanthropists and nurses were either from a Religious Order or had been domestic servants and again usually mature women, sometimes widowed, typically known as ward-maids (Abel-Smith 1960, Maggs 1983, Williams 1980). Abel-Smith (1960 p.4) described nursing at this time as “little more than a specialized form of charring” and it had little or no status in the institution; it certainly had no economic, social, political or symbolic capital. Evidently, in both ward contexts, nurses were from the lower social classes. This was not the case for all grades of nurse in the voluntary hospitals, where sisters were recruited from a higher social class usually from the middle class. While sometimes it was possible for a nurse to be promoted from nurse to sister this was rare (Williams 1980). The sister’s role was to oversee the ward nurses and they took orders directly from the physician (Abel-Smith1960, Williams1980). Sister’s duties focused on the enforcement of cleanliness and patients needs carried out by nurse maids through direct supervision (Williams 1980). Matrons, whose main duties were administrative, were not involved at all in ward work and were recruited from an even higher social class often higher than the physician (Abel-Smith 1960, Williams 1980). Thus the hierarchy in nursing was established, dependant on a class system, with doctors involved in the appointments of nurses, the “ordering” of nursing tasks and the position of sister was kept under their “close control” (Williams, 1980 p.59).
The move of the ‘poorer classes’ from the workhouse to the hospitals coincided with the development of medical practice occurring in the hospitals, the social reform of nursing and the increased demand for nurses (Abel-Smith 1960, Dean & Bolton 1980, Maggs 1980, Williams 1980). Williams (1980) argued the reform and portrayal of the image and status of nursing was based on the perceptions of the ‘leisured upper classes’ and medics of the day, which began equating the characteristics of a ‘good nurse’ with that of a ‘good woman’ (Williams 1980, Maggs 1983, Abel-Smith, 1960, 1980), a common gendered process (Lawler 2004). This may have been influenced by the famous quote from Florence Nightingale “it takes a good woman to be a good nurse” (Dean & Bolton 1980 p.94) but more likely reflected the societal Victorian values of femininity based on class distinctions. A hierarchy became established between the nurse and patient that had not been obvious in the workhouses through the introduction of a uniform as a signifier of power (Dean & Bolton 1980). While it was much later in the 20th century that the richer classes began using hospitals; they still preferred to employ private nurses in their homes (Williams 1980) and therefore clearly would have preferred a ‘good nurse’ with a ‘good character’.

Characteristics of a ‘good nurse’ were influenced by religious ideals, the army and perhaps the new public schools for girls, so that obedience, patience, gentleness, discipline, devotion, altruism and trustworthiness were valued (Abel-Smith 1960, Williams 1980, Dean & Bolton 1980). Maggs (1980, 1983) and Williams (1980) argued the portrayal of nurses in the late 19th century gave an idealised image which did not reflect the actual nurses of the time:

“they represented attempts, deliberate and non-deliberate, to erect a model of behaviour, expectations and performance to which all nurses could aspire and subscribe, but they also formed the basis of the criteria by which nurses and nursing could be judged” (Maggs 1980 p.20).
The propaganda from the reformists is evident in the photograph above in the portrayal of a younger, prettier, clean, well groomed and religious nurse as the face of improvement. The older nurse is depicted not with a cross in the background but with a gin bottle and umbrella associated with the fictitious character Mrs. Sarah Gamp and is clearly a lower working class woman from her dress which the reader would probably associate with ignorance.

Florence Nightingale historically is credited with establishing nurse hospital training and recruiting a better class of woman when in fact there had already been some effective training provided via the hospital system (Abel-Smith 1960, Maggs 1980, Williams 1980). Nevertheless, there was a shift in recruitment after the establishment of the hospital training schools which encouraged younger ‘lady probationers’ from the middle classes to enter the profession for a three year training (Abel-Smith 1960, Maggs
1983, 1980). Thus the balance in the hospitals began shifting between working class nurses to those from the middle classes. Nightingale recruited mature and respectable women used to hard work, i.e. working class women as well as the lady probationers. However, Abel-Smith (1960) argued she did not intend to restrict nursing to women of a higher class although she unwittingly popularised it as an occupation for ladies.

Williams (1980 p.72) contended Nightingale did not change “the set of practices" that was nursing rather she established a different “source of control” of those practices by creating a ward sister’s book which was the first written record of the nurse’s practical competence. Nightingale was also responsible for organising examinations external to the ward. Thus the split between the education of the nurse outside the ward and away from the complete control of the sister is a pattern that still continues today and has implications in relation to the habitus and field of practice creating two sets of fields for the practising nurse.

A number of medical tasks were devolved to the sister. According to some medical accounts there were concerns that nurse training was becoming ‘too theoretical’ with nurses encroaching on the medical students’ and junior doctors’ roles particularly in relation to their bedside knowledge and skills (Maggs 1980, Williams 1980). Hence it was politically important for doctors, while simultaneously increasing their power and status, if nurses occupied a role that could be seen as their ‘handmaidens’, one that subserviently followed orders (Maggs 1983). It is likely that nurses would have been expected obediently to follow orders so that they did not think for themselves or ask questions. Abel-Smith described the culture as:

“Faced with a crisis, the reaction of the nurse was to do and not think. It served also to protect her from self criticism if her efforts did not produce the required results. It was at least comforting to know that a recognised procedure had been perfectly performed even though it had been ineptly chosen" (1960 p.243).
Nightingale was a woman of action and may have been influential in creating a culture that valued keeping busy. She is famously quoted as saying:

“You ask me why I do not write something… I think one’s feelings waste themselves in words, they ought to be distilled into actions and into actions which bring results” (Nightingale 1851)

Could it be that the culture of ‘keeping busy’ became a way of ensuring the lady probationers were kept under control? I believe it is part of the habitus and field of ward nursing that still exists today. It helps to explain how learning is devalued and how nursing tasks such as providing physical hygiene and emotional support whilst not openly devalued do have less social and cultural capital in the ward itself. I suggest this also extends to reflecting in the ward.

Employed in the more senior positions, the lady nurses took over the profession, establishing a three year training, with state registration finally occurring in 1919 after some political struggle (Abel-Smith 1960). Nurse training is still three years which is surprising given the increase and considerable advancement in the complexity and technology of care. The reformists including Nightingale set in motion a potential struggle in the field of nursing between two distinct groups of nurses and two potential forms of habitus; ‘the lady’ nurses (middle and higher classes) with their emphasis on knowledge, a career and values of being a ‘good woman’ and the ‘older’ nurse (working class usually with children) where nursing was a job, an unquestioningly practical one that required limited training and following orders. Arguably, in this field of practice there remain struggles for power and recognition seemingly historically influenced, whereby the hygiene needs of patients are largely carried out by the less educated ‘working class’ nurses and the organisation of the ward by the more educated ‘elite’ classes. Therefore I suggest there is less symbolic, social and economic capital associated with direct patient care than the organisation and co-ordinating functions of nursing.
Arguably, this nursing split has transmuted over the years and I believe still exists. For example, this dichotomy could be seen in the registered and enrolled nurse roles and now in the qualified and healthcare assistant nursing roles or the specialist highly educated roles and the ward nurses. There were less male nurses historically in the general wards than in psychiatric care (Maggs 1983) which adds another potentially gendered struggle in the field with doctors and between female nurses. This struggle in the field has different underpinning values and ideals based on power, gender, historical embodiment and class distinctions which may contribute to sources of conflict and game playing in the ward today creating a culture where learning and thus reflecting is devalued.

How have these historical influences affected the image and status of nurses today? Fletcher (2007) suggested what is known about nurses’ image is from the perspective of others: the public, the media, and other healthcare professionals rather than determined by nurses themselves. The media portrayal of nurses has changed very little from the photograph above. Nurses are perceived as “female, single, childless, white and under 35 years of age” (Fletcher 2007 p.208). Citing a study by Kalisch and Kalisch in 1982 that examined how nurses were portrayed in novels, Fletcher noted nurses were always women and doctors were men while the nurses were seen as kinder, obedient, serene, conforming and flexible. It would seem that ‘the right personality’ or the ‘characteristics of a good woman’ is more important to the general public than the education of the nurse because she is still seen as carrying out the doctors’ orders. Interestingly, Fletcher also suggested, the strongest public image was that of “the overworked bedside nurse” (2007 p.214).

Stanley (2008) researched the portrayal of nurses in feature films from 1900-2007. He noted a shift in the depiction of nurses with earlier films showing nurses as “self-sacrificial heroines, sex objects and romantics” and more recent films increasingly portraying them “as strong and self confident professionals” (2008 p.84). Nevertheless the heroine, sex object
and romantic/feminine appeared most commonly and consistently across the decades suggesting how much nursing is caught up with idealised views of femininity and the middle class notions of ‘self-sacrifice’. Could this be why nurses put others needs first and tend not to value their own learning? Therefore, because reflective practice focuses on personal learning this would be problematic. Secondly, in a culture where thinking is discouraged and the Drama Triangle game is played out, I suggest the historical messages carried in nurses’ bodies as an aspect of the field and habitus, clearly is at odds with the sense of agency developed through reflection.

**Conclusion**

An analysis based on Bourdieu’s ideas suggests the historical context continues to play out in the field and habitus through the games, social relations, interactions and inactions where identity and agency is created in relation to the visible and invisible structures that influence the social action and inaction of the nurses. This chapter has highlighted the tension surrounding the inaction relating to written reflections which was seen largely as “a waste of time”. Perhaps writing or even documentation per se forms part of the habitus and field that I have called *watch your back* and which will be discussed more fully in the next chapter. The increase in paperwork currently experienced in the ward makes it unrealistic that nurses will reflect in their own time and has potential consequences for the home work balance. It might represent different class values whereby middle class women are more likely to take work home although I propose this very tentatively. Less contentiously I argue that reflective writing is not used or valued by most nurses as it is a form of unpaid work. In our co-inquiry group more creative ways of reflecting were found which focused on thinking or talking with others and will be explored in the next chapter.
Dreaming was also linked to a reflective process as an unconscious way of encouraging practical knowing but this needs further investigation.

This chapter has predominantly focused on the contradiction that nurses were too busy to reflect but reflected all the time. I have shown how fields of practice contain the struggles for the legitimacy of the different forms of capital held within this contradiction and these are often historically constituted. In explaining the complexity held within this contradiction I have proposed that firstly it may be a reality caused by a shortage of staff and work overload, and secondly, an historically embodied process based on class, gender and power influences. The busy syndrome may contribute to nurses feeling isolated resulting in less time for team-building and relationships thus keeping the hierarchical structures unthreatened while creating the possibility for more conflictual relationships through the Drama Triangle Game. Ward nurses possess less autonomy and are subjected to direction from those with more status and power which is historically influenced and contributes to embodied dispositions in particular a sense of powerlessness. I have proposed that through reflection nurses may stand back in the busiest moments to take stock and question their practice but this is counter-cultural when seen in the context of the busy syndrome.

Finally, I have suggested appearing busy may also be an embodied habitus, a coping strategy which serves to protect the nurse from engagement in relationships with patients thereby avoiding transference and counter-transference from such relationships. Thus it helps to protect the nurse from experiencing the parallel process of strong emotions. I tentatively propose that the struggle held within this contradiction could be seen as a product of the conflict of values held in practice based on class notions of a ‘good woman’ and a ‘good nurse’ as a way reflection and learning may be discouraged. Currently I suggest there is still a struggle between the reality of the nursing work and the idealised image based on the Victorian middle class ideals of femininity of a ‘good nurse’ and ‘good
woman’. I see this as a gender and class issue which I suggest contributes to the “watch your back” culture and the game playing of the drama triangle in the ward setting.

I have shown historically the psychosocial support and hygiene needs appear to have lower legitimacy in the ward so that caring functions seem to have little social and cultural capital. This could in part be related to historical class differences where working class women carried out such care and more educated middle class nurses administered and co-ordinated care. Whether it is acknowledged or not nursing is not one homogenous grouping; it is still hierarchical with grades of staff that go back to the earliest hospital structures and with class distinctions which tend to be overlooked. To describe the image and status of nursing as purely a struggle between the educated lady nurses and the working class women is clearly too simplistic and generalised an analysis because the field contains the complexity of all of the capitals (symbolic, economic, political etc), as well as the wider fields of power, yet it is in part influential. It may relate to the preference for nurses reflecting orally rather than in written form which forms the basis of the next chapter.
Chapter 5: Whinging and Gossiping in the Ward

In February 2004, I talked about this inquiry to a friend saying I was going to work as a ward nurse to see if nurses learnt through sharing stories during care giving. He laughed and said “so basically your PhD is about gossip!” Afterwards I wrote the following poem including stories from a work-based learning session facilitated earlier in the day. The poem focuses on ward relationships, politics and power which will be partially addressed in this chapter. The over-arching theme in this chapter is ‘Voice’; identified in this inquiry through whinging, gossiping, talking behind your back, reluctance to speak out and staying silent. Voice is a feminist concept relating to agency, relationships, subordination, domination and power. Bourdieu’s work addresses this concept through authorisation and legitimacy of the various capitals in the field and habitus alongside the wider field of power. Here I intend to focus predominately on collegial relationships and personal power (one’s sense of agency) and the associated aspects of the habitus and field that inhibit and enable voice.

**The PhD of Gossip**

Into the loos
In twos
Quick fag out of sight
Deep breathe with all your might

The kettle’s boiled
Milk and sugar?
Oh my God what a shift
What a bugger

Come quickly, we’re not quite sure
Do you think we could’ve done more?
Can you believe what that doctor said?
We tried our best and now she’s dead

Keep busy, busy and then don’t think
Perfume on the dress to stop the stink
Spontaneous informal talk through whinging and gossiping happened a lot in the ward, in the classroom, and in meetings. We questioned in our co-inquiry group, could different forms of talk be reflexive processes occurring during care giving? For example, when might gossiping become storytelling? Alternatively, when might it be appropriate to keep silent; what I have called reflecting inaction. Therefore this chapter questions whether gossiping, whinging and silence are forms of reflecting-in-action and asks what purpose these different discourses might have in the ward.

The chapter begins with a creative writing piece where I attempt to reflect-in-action as a personal inquiry to explore whinging. Next I highlight the
tension of self surveillance and self exposure through reflecting. I explore the purpose of whinging in the ward showing it is an emotional offloading process easily dismissed as lacking legitimacy. I apply whinging to the concept of emotional capital and tentatively propose emotions experienced through whinging could be racket feelings (Berne 1975, Stewart & Joines 1987). I suggest these feelings may be an embodied aspect of the habitus and field so that nurses’ experience ‘old familiar’ emotions such as resentment and powerlessness rather than experiencing the immediate raw emotions of sadness or anxiety generated through caring for others.

The chapter then addresses the agency of informal conversation and unpicks aspects of the habitus and field resulting in nurses’ unwillingness to reflect in the ward. I argue whinging is catching; spreading through the team and stimulating emotions in others which I call an “emotional orgy”. I propose there is an un-stated undercurrent a habitus and field of practice of “watch your back” as a consequence of “talking behind your back”. I explore its impact and contend this could be another possible explanation why many nurses in this inquiry did not overtly value reflection.

**Whinging and Reflecting-in-action: A Personal Inquiry**

Jordon, a co-inquirer and modern matron, raised the problem of whinging in our co-inquiry meetings as the first form of talk to be potentially non-reflexive. We talked a lot about whinging sparking several cycles of co-inquiry as personal (first person), relational (second person) and as an attempted organisational (third person) inquiry. Our second cycle of action and reflection noticed our own whinging patterns and those we worked with. We became interested in whether we could interrupt the whinging process. Jon summed up the co-inquiry group’s understanding of whinging when she said “whinging is not seeing any good in a situation.”
Whining Women?

Gossip, whinge, nag
Don’t they ever get tired of hearing their own voices?
Voices shouting into the hurricane
Brought back by the bouncing boomerang
So fragmented as to make no sense

Gossip, whinge, nag
And within such a censoring and tremulous voice
A voice inaudible above the cacophony and clatter
Wistfully wishing to be heard
But who is willing to listen?

Clare Hopkinson 8/3/05

In March 2005 I wrote the poem above during a SOLAR 3 workshop. I was in the midst of our whinging co-inquiry cycle at the time. I found I unconsciously linked being ‘unheard’ with gender and a feeling of powerlessness, which later became important ideas for this inquiry. The poem questions whether the ‘whinger’ might have a legitimate complaint that is ignored paradoxically because of the whinging process. Jon felt she could interrupt the whinging process saying:

"I always sound like a moaning, whinging person, but I actually consciously stop myself" (Final interview 22/6/06).

I found this difficult to achieve and explored my own whinging in the following creative autobiographical piece. It was written for another SOLAR 3 workshop and drew upon Moskowitz’s chapter (1998 p.37) “The Self as Source” for its inspiration. She suggested creative writing could be a reflective process to encourage looking at “disintegrated parts of ourselves and our experience” to provide personal insight and new ways of managing and viewing our experience.

In this piece I try to capture the thought processes in whinging and reflecting and attempt to portray my thoughts ‘out loud’. I use the device of ‘Breaking News’ to show the interruptions as they happen in everyday life.
taking this concept from the television news with its instant broadcasting. I hope to show an experience of reflecting-in-action which is both a real and imaginary experience by splitting myself into two characters: Co-inquiring Clare who is attempting to work collaboratively, and inquire through reflecting-in-action and Whinging Wilma, who prefers to complain and whinge. I began this piece during the eighth co-inquiry meeting when no-one arrived and then Alice came in the afternoon. I finished it at work the next day, before and after teaching, and have slightly re-worked it, shortening it, for use here.

**Worked Up Whinging Wilma and Calm Co-inquiring Clare**

**Written 24.11.05 - 25.11.05**

As Worked up Whinging Wilma my thoughts shout shrilly: *Don’t the participants recognise I’m a busy person too? Why haven’t they turned up? It’s so unfair! Now I’m really lumbered, I’ve still got a hundred and one things to do. How can they not turn up, this was what they asked for, what they were struggling to cope with in their places of work. I even set the dates to suit them and changed the times of the meetings because it was easier to get a whole day off than escape from the snares of work for an afternoon meeting. So much for involving others in the decision making process! Bloody typical! Hmmph! It’s just easier to do it all yourself! Next time, if there is a next time, I won’t be doing co-inquiry! I’ll go back to research that involves qualitative interviews. So much quicker and easier than this flaming social change! What’s the point? I knew changing the times wouldn’t work. I should’ve just ignored their wishes and done what I knew was best for them!*

Co-inquiring Clare thinks: *The co-inquirers are doing me a huge favour taking part in this research. They’re all travelling so far to get here, it’s a miracle we managed any meetings at all. And we’ve now had 7 so that’s pretty good really. I can still reflect on my part in this experience. Did I set it up right in the first place? Was I a bit negative on the phone when I rang people to check whether they were coming to the meeting and to prompt them to remember we were looking at whinging?*

*I’ll write into the experience noticing my own whinging and learning. First person inquiry will be good enough; the micro in the system can hold the wisdom of the macro. Didn’t Susan Weil say that in our SOLAR 3 workshops? I could try alternative ways to grow the group. Am I noticing myself telling me “I told you so” when I*
whinge? That’s interesting, it’s quite a critical process. Helps me feel bad about myself, keeps me in my place, feeling powerless to change anything.

So I’m wondering because I have seen it in the ward and in students, that whinging is catching. Do I catch the emotion of the whinger? I notice it travels like wild fire through a team. If I whinge then I gain comfort from someone agreeing with me. In fact do I seek to elicit this response in others? But do I have some legitimate complaint as part of the whinging which can get overlooked or devalued through the process?

**Breaking News: You need to stop writing; Alice has turned up for the afternoon session**
Whinging Wilma thinks: That’s so unfair. I was just getting into this writing, now I’ll have to break off and when am I going to find the time to finish it. I suppose I’ll end up writing tonight now and God knows when I’ll get the ironing done and the house is a real tip. I’ve got to cook dinner and empty the dishwasher and the washings piling up. My lazy kids never notice how bloody busy I am, you would’ve thought they’d help out but oh no, I’ll probably listen to them arguing because I want to use the computer tonight. All these demands on my time; it’s not right. There’s just too much to do. God I hate this place.

Co-inquiring Clare thinks: Is it still a co-inquiry if there are only 2 people present? Yes I think so and that has implications for my methodology. It’s great; Alice is showing so much interest. Am I feeling sorry for myself and a bit of a martyr when I whinge?

**Breaking News: Stop writing and welcome Alice**
**Breaking News: Start writing again after Alice has left**
Co-inquiring Clare thinks: An hour and a half conversation has proved to be very productive. We have looked at the value of whinging and its purpose and have agreed to write up some of the wisdom from the group meetings, as an article. We have made sense of whinging through the process of sharing our stories of whinging and identified feelings such as disappointment, loss of control, being overwhelmed, hopelessness, fear, resentment, anger and insecurity. We decided that earlier themes identified in our storyboard that mapped ideas such as the wailing wall, invisibility, not putting ones head above the parapet are linked to playing out a form of victimhood.

**Breaking News: You need to stop writing and make that important phone call and check your emails because 2 co-inquirers sent apologies**

34 See appendix 7 for a flipchart of this inquiry process.
Calm co-inquiring Clare thinks: *Praps I’m wrong maybe the group will carry on for a bit longer. It is still difficult getting the co-inquirers together. What is this telling me about my inquiry?*

Whinging Wilma thinks: *Only 2 had the decency to email me. What a cheek! Well it’s curtains to the group! I’m not making any more effort!*

**Breaking News: Start writing again about whinging and its possible relationship with reflecting**

Co-inquiring Clare thinks: *Alice and I went back to our image of the snowdrop in the pavement which symbolised empathy and the theme of using our vulnerability as a strength, as a possible way of showing an alternative to whinging. We have recognised one way to combat whinging might be through supportive challenge, appreciation and nurturing.*

**Breaking News: You need to stop writing so you can get stuck in traffic for an extra three quarters of an hour then argue with your son after tea that you absolutely need to have your turn on the computer!**

Worked up Whinging Wilma thinks: *He always argues with me who does he think he is! It’s not as if I want to do this bloody writing anyway. No-one will read it, what’s the point!*

**Breaking News: You need to stop writing and pick up your daughter from dancing**

Worked up Whinging Wilma: *Oh no, I’m 5 minutes late already. Why didn’t she tell me it was my turn to pick her up this morning? Selfish that’s what kids are. I’ll be in the dog house now. It just never stops. The bloody joys of single parenting!*

**Breaking News: You need to stop writing and pick up the phone**

Calm co-inquiring Clare says: “*Sorry love I’m just on my way*”. Worked up Whinging Wilma thinks: *Shit, hurry up computer I’m late. It’s all your fault I’m late!*

**Breaking News: You need to stop writing and actually go and pick up your daughter from dancing rather than thinking it**

Calm co-inquiring Clare placates her angry daughter through apology, empathy and humour. She thinks: *I forgot it was my turn to take Cathy’s friend home even though Cathy reminded me in the morning before school. How distracted I’ve become since working on the PhD! She resumes her place at the computer and thinks: Where were we in the bumpy journey? It’s another steep bump to get this writing finished and my car seems to have stalled. I can see this writing is helping me see that whinging is a way of letting off steam as Deidre suggested but do you get rid of the steam?*
BREAKING NEWS: You need to stop writing because son is shouting up the stairs “Mum Doc Martin’s on, you said you’d watch it with me”
Extremely worked up Whinging Wilma, thinks: “Shit, I’d better try and be a good parent. Harry will only throw it back in my face, when he’s older and tells me how un-motherly I was during his important years. How I was never there for him.” She sits in front of the television not listening and not paying attention to it, while running through her head is a list of all that she hasn’t completed and the TO DO list keeps growing.

Calm co-inquiring Clare thinks: If I get to work early tomorrow I can finish the writing piece off before I facilitate the work based learning. I’ll have reflected on the way in the car (useful to remember this strategy from the first co-inquiry meeting) and be able to polish it off in no time. Perhaps my unconscious thoughts will be stimulated by dreaming. Great, some quality time with my son! An opportunity to laugh off all this accumulated stress. I am feeling a bit fraught at the moment, glad I’m more prepared to look after myself now.

BREAKING NEWS: You need to stop writing and actually watch Doc Martin
BREAKING NEWS: Next day sitting at the computer at work
Calm co-inquiring Clare thinks: I wonder if whinging provides a vehicle for being listened to and so may serve some purpose. But it doesn’t seem to be linked to constructive action; it does seem to stop at a point which doesn’t empower the person. So I wonder what stops the action. Because there is comfort and fear in whinging perhaps it is understandable and unsafe for individuals to take action in an unwieldy bureaucratic environment, safer to be part of an invisible crowd?

BREAKING NEWS: You need to stop writing and thank a colleague for the lovely coffee she has kindly brought you
Calm Co-inquiring Clare searches the web: Interesting: “in reviewing what harm you feel was done to you, you solicit the sympathy of others and from their involvement you receive some comfort”. I know I feel hard done by when I whinge but do I solicit sympathy, play out “poor me”?

BREAKING NEWS: You need to stop writing because your colleague has noticed an email from the module leader about giving out letters and evaluation forms to the students today
Whinging Wilma says: “how inconsiderate of her, she’s always last minute. Doesn’t she realise I’m working on lots of sites. I’ve a good mind to ignore the dictate and not bother giving it out. I don’t know how to change the printer settings so I can print from here”. She thinks: I never get the time to go on these courses, always have to work it all out myself, on the run as usual, no support from
management about these things. Damn, It’s her fault I’m not going 
to have time to finish this writing.

Colleague says: “I’m fed up as well. We could definitely do with this 
information earlier. I know what you mean about her, she doesn’t 
consider the impact on the rest of us when she’s so late with 
everything.”

Not so calm Co-inquiring Clare notices she’s fallen into the trap of 
whinging and asks the secretary for help. She notices a parallel 
process in her own lateness with this piece for the SOLAR 3 
workshop and wonders about embodying aspects of the research. 
The secretary suggests forwarding the email to her so she can print 
it off for her.

Breaking News: You haven’t got time to write now as you are 
due in class, not even time for a trip to the toilet 
Calm co-inquiring Clare thinks: yes I do solicit sympathy, ouch! I must talk to the module leader about the impact on us when the 
information is so late. Perhaps she doesn’t realise what extra stress 
this causes us. She probably has as little time as the rest of us. Is 
this part of the field we are working in - “too busy”?

Breaking News: You need to stop writing because you still 
haven’t been to the toilet 
Calm Co-inquiring Clare’s mind pauses for a moment wandering off 
to think about the work based learning day she has just facilitated. 
She thinks: It was great having Nadia, a student from the group, 
facilitating meditation. Nadia said meditation “helps you get rid of 
bad thoughts, helps you think about the other person, and builds up 
your mind so you can control it. It helps relax you and calms you 
down”. This seems similar to what I think reflecting-in-action might be. No actually I think reflecting-in-action is more than just clearing 
the mind and controlling it because that seems to negate the 
emotions and promotes rational thought. There is something here 
that is similar to our co-inquiry group sense making which 
suggested pausing in the moment, no matter how busy you are. I 
think I’ll keep practising!”

Somewhere in that meditation process sat on the toilet, 
Whinging Wilma becomes absorbed back into Calm Co-
inquiring Clare. Relieved in more ways than one, Clare goes 
back to the dreaded email to discover more work for her to do! 
First she decides to send an email to the module leader asking 
to meet with her to chat about the module and how things 
could be improved. 
Whinging Wilma thinks: It probably won’t make any difference; the 
module leader won’t listen to me. We won’t be able to find the time 
to meet anyway. I’ll leave it for now and do it later when I get more 
time.
The story above highlights the loss of action through whinging. I blamed it on a lack of time but really it was a lack of will. I didn’t want to change anything; I had no energy to try because the work life balance had tipped the scales. I didn’t have a sense of my own agency. I realised whinging could be related to the culture of martyrdom through feelings of being overwhelmed, powerlessness and resentment. The writing piece also raised issues about self awareness and reflecting.

Before starting this PhD I had a reasonably fixed concept of ‘self awareness’ divorced from any context, seeing it as part of and developed through reflective practice. It was a journey and an ideal to strive for. I didn’t understand the post-structural notion of contradictory ‘multiple selves’. I tended to see concepts in a binary or polarised way, that is, I was either whinging or I was co-inquiring; I was either emotional or I was rational. This also related to research; it was either objective or subjective depending on which paradigm the work was situated. The idea that I could hold both contradictory positions simultaneously, related to a specific context and irrelevant to a context, seems obvious now but was not the case in 2003.

The dominant discourse in the nursing reflective practice literature emphasises development of self and self-awareness as transformative aspects of reflecting. It tends to imply a linear and ‘whole’ consistent sense of self devoid of a context. Consequently, it rarely focuses on how the NHS structures and professional ‘norms’ shape professional identity or how this might relate to nurses’ ability to reflect (Platzer et al 2000a). The assumption is that self awareness is a positive process and in learning more about herself, the nurse will improve her practice, but is this the case? I turn now to the tension of exposing oneself through reflecting.

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The Tension of the Reflective Confession: a Form of Cultural Capital?

You might be asking yourself what is the point of the creative writing piece above? How can it be valid research? It’s just a subjective story that isn’t seriously adding to the academic body of knowledge. It’s light-hearted, clearly self indulgent and explicitly personal. Bourdieu was opposed to the concept of ‘self’, arguing it was a bourgeois fabrication of the middle classes used to legitimate their cultural and social capital. Therefore in adopting a reflective stance that is self revealing, as a white middle class well educated woman, I might be using a confessional style of reflecting to legitimate my values, prejudices and research positioning. Consequently, Skeggs (2004) argued ‘self’ was a process that concealed class distinctions through its emphasis on a particular set of values at the expense of others. However, the personal is political (Richardson 1997) and so is identity (Butler 1999). Personal experience does not necessarily strive for truth. It is time related, sometimes time dependant and is arguably socially, culturally, politically and emotionally constructed. So that in this creative writing, I tried to portray emotions while also capturing the political and cultural tensions we discussed during our co-inquiry meetings, especially the impact of interruptions, reflecting in our own time and the work-home balance. Mantzoukas and Jasper (2004) found ward nurses were expected to reflect on practice in their own time and space. They concluded from their interpretive ethnographic research that:

“The concept of reflection appears to be invalidated by the organisational hierarchy of the wards on the basis of a power struggle game. The ward structure portrays reflection as an abnormal method of practice and knowledge development.”
(Mantzoukas & Jasper 2004 p. 925)

They found nurses gave validity to knowledge based on “hard scientific knowledge that doctors possessed” while ignoring the multifarious knowledge used by nurses (ibid p.928-31). This was similar to my
experience with the ethics committee where scientific knowledge was valued and taken for granted. Consequently, the creative writing piece could be dismissed as lacking validity. Mantzoukas and Jasper (ibid) found there were power struggles between different professional staff especially between doctors and nurses, and nurses and managers which inhibited reflection in the ward. This could be because scientific knowledge has more historical legitimacy since it has more cultural, economic and political capital while doctors and managers have more symbolic, economic, social and political capital through their roles. Hardly surprising then, that a focus on the self would be seen as invalid knowledge for practice and is perhaps testimony to a continuing patriarchal outlook.

Furthermore, I deliberately portrayed a confessional and provocative style of reflection in the creative writing piece. There is an identified tension in the confessional approach to reflecting in the literature (Bleakley 2000b, Rolfe & Gardner 2006, Swan 2008) with accusations that it is ‘too personal’ and self indulgent (Russ 1983, Gilbert 2001) or class and power related, being a product of the middle class ability to legitimise their cultural capital (Skeggs 2004, Swan 2008). Fejes (2008 p.247) found in his investigation of reflective practice, that nurses came to “solve rather than run away from” their problems leading to increased responsibility for their actions. He contended there was no need to ‘confess’ mistakes because through reflective practice nurses become “confessors to themselves” creating a political regulatory process.

However, Nolan (2005) argued that showing human imperfections and contradictions is a way of being ‘authentic’ in the reflective inquiry process. Nevertheless, how much of yourself do you reveal? What happens to that information? Is that information used against you later, indirectly through a wider field of power; a form of symbolic violence and domination by those with more cultural, political and symbolic capital (Bourdieu 1993a, 2001)?

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36 See chapter 2
Bourdieu’s work has led me to tentatively question if a tension of reflecting-in-action might be partially related to class distinctions between middle class nurse values of ‘self improvement and self sacrifice’ and working class nurse values of ‘doing the job and obeying orders’. As I have already argued, nurses’ historically embodied dispositions may not necessarily have the same cultural, political, academic, social and symbolic capital creating differing cultural capital and power struggles in the field. Perhaps this contributes to the attitude that reflection is a “waste of time”.

In my story about John\textsuperscript{37} where I made a fatal error, I wonder if this happened now would it lead to litigation or removal from the nursing register. Clearly, this tension is likely to inhibit reflecting and is linked to issues of power. Later I will show, as the nurses largely felt unsupported by managers, it can be ‘too risky’ and exposing to own up to making mistakes.

Surveillance through reflecting has pre-occupied some of the nursing discourse on reflective practice\textsuperscript{38} but is not a dominant discourse. Gilbert (2001) noticed a hidden unspoken discourse relating to surveillance and reflecting. He argued that through reflection nurses’ practice is visible, accountable therefore it can be judged whether it is safe or not. This could lead to a self managed process potentially absolving those in hierarchical positions from taking responsibilities or could be an intrusion from those with power affecting the identity and autonomy of the nurse in subtle ways. Similarly, Cotton (2001) contends that political regulation can occur through normalising judgements. She asked:

“Which individuals and groups within nursing are given voice and privileged in the discourse of reflection and which are silenced and devalued? (2001 p.517)

\textsuperscript{37} See chapter 1
This made me wonder about the complexity of whinging as both a legitimate way of complaining about the dissatisfaction of work and a way of silencing staff. I wondered whether the managers in Strand 3 might dismiss the concerns of their staff by socially constructing their complaints as whinging and negative, ‘bitching’ and ‘women’s talk’; a rather simplistic analysis. Do staff dismiss themselves, and their valid complaints through whinging by talking away a desire for action, as I had done in the story above? It became apparent that whinging was multifaceted.

**What Purpose Does Whinging Serve?**

According to the Oxford English dictionary (2004) “To whinge” means to “whine, grumble peevishly”. Further, they define “to whine” as making “a long drawn out complaining, cry as a child or dog; (utter) querulous talk or petty complaint.” Not finding any healthcare literature about whinging I checked the web. On a website blog, Heiser (2003) wrote whinging was the “practice of complaining without doing anything about it.” This would imply that to shift whinging into reflection, action is required. Another anonymous site proposed whinging is a British cultural attitude; Australians apparently don’t whinge! Perhaps whinging is not just an aspect of the habitus and field of nurses but a wider systemic issue? The author wrote: “if someone feels powerless or otherwise unwilling to challenge authority, complaint to a third party provides the illusion of control.” As many ward nurses have very little control over their work perhaps this illusion served a purpose?

I propose there is a connection between whinging and the complex emotions experienced by nurses while caring for others. To examine this connection I draw on the concept of *emotional capital*, not originally identified by Bourdieu, but developed by feminist writers such as Nowotny
Reay (2004) described emotional capital as:

“about investment in others rather than self- the one capital that is used up in interactions with others and is for the benefit of those others” (p.71)

Unlike the other forms of capital, emotional capital tends to be associated with women and arguably centres on private rather than public fields of practice. There are claims that reflective practice promotes emotional competence and resilience (Jackson et al 2007, Horton-Deutsch & Sherwood, 2008). Furthermore there is currently a plethora of interest in emotions in organisations, usually associated with emotional intelligence. However, this is too crude a measure and simplifies the complexity and relationship of emotion with its social, political and moral constructions (Fineman 2000). Nurses invest in others through care giving in the public domain. I have argued this involves developing relations with others which by implication involves an emotional investment. Relationship building is a complex process entailing amongst other qualities: trust, compassion, effective interaction through active listening, empathy and an understanding of unconscious processes. Thus arguably it can be viewed as a form of emotional capital. Nevertheless, as shown in the last chapter, there are tensions in providing such care.

While working in the ward I was conscious of observing my own whinging and any whinging in the nursing team. Jon, a co-inquirer, found a mixed reaction amongst her work colleagues about whinging39. Her team suggested whinging could be turned into reflecting and thus learning. Whinging happened because of organisational changes which created stress, a fear of the unknown and organisational pressures. In Strand 2, I interviewed Deidre, a specialist ‘sister’ with a remit for practice development that involved her visiting many wards. She linked whinging to advice-giving and informal chatting noticing that it was a passive process.

39 See appendix 3
She thought it helped nurses relieve the emotional aspects of the job. Deidre said:

Nurses chat, they chat informally and they've always done that. Sometimes it’s the way they let off steam. So you say to somebody, I’m really not sure about this. It will be somebody that’s probably on the same level as you, not necessarily somebody more senior, and you will talk through things. I mean, it will be an advice giving session and maybe, okay, it’s not as formal as reflection like in an action group, where you're actually formally trying to get them to look at the problems and come up with their own solution. But the problem is that sometimes that goes into whinging, doesn’t it? That doesn’t always lead people on to forming their own conclusions, does it? That’s what I’ve noticed. It becomes a whinge and then you’re not actually learning from it, are you? And you end up harbouring a lot of resentment, too, don’t you, and that’s the problem with it. You can’t get rid of all those emotions…. It’s not constructive all the time at all. (Interview 17/4/05)

Deidre raised an important contradiction: whinging could both encourage advice-seeking and thus learning and also encourage emotions to build up through holding onto resentments which stopped learning. She implies the build up of resentment is a difficult emotion to get rid off and doesn’t encourage solutions to work problems. In re-reading my personal diaries and my attempts to notice and feel my Whinging Wilma, I recognised resentment and noticed disappointment, hurt, and a lack of recognition also featured when Wilma was in the foreground. I realised through writing in Wilma’s Voice that I whinge or complain when I feel ‘put upon’ and when I feel I am giving so much to others that I deny my own needs. I began considering the tension for nurses caring and giving to others while sublimating their own needs; for example, not taking a lunch or toilet break. I saw a resonance with Reay’s (2004) description of emotional capital; focusing on the needs of others rather than oneself. I noticed I felt powerless and comforted when I found someone agreeing with me. It was easy to deflect responsibility for my own disappointment onto someone else as though it was someone else’s fault. It was comforting to deflect the responsibility for my actions onto someone else, in a way ‘blaming others’ as a way of protecting myself. In the ward whinging seemed to happen
spontaneously when the nurses felt ‘put upon’ by other colleagues as the following diary entry observed.

Two healthcare assistants were complaining that they were helping everyone else out and still had their own work to do. The staff nurse told them to be assertive and say no. I wonder if they will or if it’s the complaining which is more important. Are their complaints legitimate and would anyone be interested in listening to them?

Diary Extract 4/4/05

Jon, like Deidre, saw whinging as asking for advice but thought whinging was partially a reflective process whilst the other co-inquiry group members felt it wasn’t. Jon questioned: could advice gained through whinging enable the nursing team to constructively develop their practice? She felt reflection needed facilitating in the ward noticing it was a social activity rather than a solitary pursuit. She said in our third co-inquiry meeting:

Whinging can be the trigger to seek assistance through reflection

Clare: But you need to know when to ask for help and I’m not sure from my experience that everyone has that skill

Tracey: Definitely not, some people need help to think what they are doing don’t they?

Jordon: Yeh, when I am teaching or training, you ask people what have they done, why have they chosen to do it, all that sort of stuff, I would say, how do you think this morning has gone? What do you think went well? What did you think didn’t go well? And looking back at it now is there something you would have done differently? So I tend to use a more reflective approach to help people understand where they are in their own development than I probably would have done before – I think.

(3rd Co-inquiry meeting 14/4/05)
I realised through the creative writing piece that whinging could re-stimulate emotions from an experience and wondered if a strong feeling associated with an experience was necessary to encourage action. Jon suggested there might be some emotional labour attached to facilitating someone to stop whinging. She suggested “there might be a tipping point for seeming to cope, whinging and asking for support”. Jordon and I noticed emotions were “offloaded” onto others through whinging spreading through the nursing team and creating an atmosphere of negativity. Similarly, Heiser (2003) wrote whinging was ‘unproductive’ and suggested it was catching, bringing down the morale of the team because it focused on negativity and not solutions. In our fourth co-inquiry meeting Jordon said:


the only reason I’m asking this is because I think we have an issue with some people who are off-loading their concerns and then other people are winding them up. Instead of using reflection appropriately, and trying to work a way round it, what we are finding is that they are off-loading to people of a similar level.

Jon: they’ve got everybody off-loading on to them, haven’t they?

Jordon: Well, not off-loading on to them, but the issue is that they are winding each other up and then there’s all this me, me, me, type thing about. Rather than dealing with the issues and reflecting and thinking, okay, like we’re doing now. We’re sitting here saying, it’s busy but what are we busy doing and so on. Actually, they’re going the other way and instead of doing that. it’s like your situation with this patient they don’t want to look after, they kind of say, well, we shouldn’t have to do it and we don’t need to do it and we shouldn’t have to put up with this and instead of reflecting, they’re actually …

Lois: Belligerent in a way?

Jordon: Well, yes, that’s what it is. It is negative. I wonder whether some of that is because of a lack of reflective skills. (4th Co-inquiry meeting 12/5/05)

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40 This point will be developed in chapter 7 in the section on anger.
Jordon felt whining was self-absorbed behaviour that didn’t recognise the needs of others whereas I wanted my needs met through whinging. Jordon also noticed whining happened between staff at the same level in the organisation and contributed to low morale and reduced job satisfaction. It became apparent as the inquiry moved through Strands 1, 2 and 3 that whining, feeling unsupported and low staff morale were concerns for all the participants and suggested a systemic NHS problem. The feeling of being ‘put upon’ is evident in the phrase “We shouldn’t have to do this” and it seems to have a resignation associated with powerlessness. In the co-inquiry we thought reflecting during care giving could reduce the negativity associated with whining through effective facilitation by asking reflective questions, direct communication and developing systemic agency.

However, in our cycle of trying to interrupt whining, we learnt how difficult it was to shift the conversation to a reflective process in a team. We saw reflection as constructive because it contained the elements of challenge and support whereas whining contained justification and agreement. We realized whining expressed emotions and dissatisfactions in an indirect way that kept the status quo intact. We wondered if the ‘whinger’ felt there was no point trying to change the system or work processes, accepting the stress and demonstrating a lack of agency or sense of personal power. Perhaps the nurse wouldn’t necessarily know how or where to take the changes she would love to happen or perhaps she might be anticipating a backlash for trying.

Concurrently, I was reading Augusto Boal’s (1979) Theatre of the Oppressed who suggested many productions in the theatre served to ‘wind the audience up’ into an “emotional orgy” of inappropriately evoked emotions. He argued this was a subtle form of power and control over the audience. I observed this happening in nursing teams when one member started to whinge there would be an emotional response that seemed to be heightened through the group process. As Bion (1968) suggested

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41 This will be further explored in chapters 6 and 7.
emotions can become exaggerated in groups. Freire (1970, 1998b) on the other hand, proposed that oppressed groups would attack each other verbally or violently, a process he called “horizontal violence”. He argued this was a symptom of feeling powerless.

Taylor (2001) carried out a collaborative action research project with 12 experienced registered nurses working in a large rural Australian Hospital developing reflective practice skills. They met for 1 hour a week for 16 weeks sharing their stories of experience. The group chose to focus on dysfunctional nurse-nurse relationships which emerged as a theme from their stories. Taylor (ibid) argued that bullying or horizontal violence was a result of oppressed behaviour where colleagues turned against each other as an adaptive attempt at gaining power in a helpless situation. It was a multifaceted problem not easily solved. Her group suggested young and inexperienced nurses were often targets of the victimisation. The messages learnt involved: “not to complain”, “fearful obedience” while also needing to “feel invincible and perfect” (ibid p.410). Through the cycles of action and reflection the nurses recognised that power came from knowledge and they needed to respect colleagues’ knowledge. Taylor suggested, professional jealousy, low self esteem, feelings of responsibility, blaming the past instead of learning from it, needing to achieve and a manipulative use of power could be at the heart of the horizontal violence.

Perhaps Taylor’s study supports the notion that whinging is an aspect of the field and habitus of nursing not just in the UK but as a consequence of the work, collegial relationships, power dynamics, ward structures and/or systems. Gail, a Assistant Head of Nursing responsible for managing clinical developments, had worked in Canada and the UK. She recognised inexperienced nurses were often targets for victimisation suggesting nurses “devour” the less experienced nurses through aggressive behaviour towards each other. She thought it was more prevalent in women working together and questioned why women sabotage each
other, linking it to: “the politics of witch-hunting – which happens on every ward” (Interview 13/6/06).

In our fourth co-inquiry meeting, Jon told a story about a patient who had been violent and abusive to her staff. The ward staff had complained to her as the modern matron that they “shouldn’t have to put up with this”. The patient had been shouting, swearing and was uncooperative with treatment. He had hit out at several of the nurses and it was unclear whether this was due to his illness or whether he just displayed anti-social behaviour. Jon was accused of not supporting her staff. She decided to ‘black book’ the patient on behalf of the staffs’ complaints. ‘Black booking’ is when a patient is refused treatment in a hospital because of ‘bad’ behaviour usually violent behaviour towards staff. As soon as Jon had done this the staff refused to support her actions saying it was unfair on the patient. They didn’t want the patient ‘Black booked’ and they didn’t want to appear as though they could not cope with a ‘difficult’ patient. She felt she could not win; she was not supporting them if she took action and was not supporting them if she didn’t. This sentiment was later echoed in Strand 3 with other modern matron’s and their staff in relation to support.

Alice and I saw this as an example of the drama triangle being played out with Jon and her staff switching between all roles of Victim, Rescuer and Persecutor. Bourdieu (1993a) noted games were central to the logic of the habitus and fields of practice. I would suggest there are different fields of practice demonstrated through this story. There is a wider field where the nurse is concerned about how she appears to others; this field can be created by further fields such as the media and society where expectations and images of what a ‘good nurse’ should be are absorbed as part of the dominant discourse. It may also be historically constituted. This produces a field where the nurse needs to show she is coping perfectly well, thank you. An academic field is generated by the university that purports patients are given holistic and individualised care. This encourages another embodied disposition whereby the nurse expects to outwardly portray that
she ‘likes’ all her patients that she can care for them individually and relate to them in a way that increases their wellbeing. This is a form of emotional labour (Hochschild 1983, James 1989) and emotional capital (Reay 2004). However, the immediate field of practice is one of not coping; of high emotions, of the uncertainty and unpredictability with a patient projecting emotions into and onto the nurse. Therefore, the nurse also experiences strong emotions and when the patient pushes her away it becomes even more challenging to nurse that person. It is easier to block out that emotion, to not feel and retain an illusion of being strong and in control.

Further, there could be a parallel process occurring where the manager is also pushed away, while for her there is a tension to protect or rescue her staff from a challenging situation. Therefore whinging in this context provides an understandable and important emotional release.

Alice suggested there might be an explanation through the ‘Be perfect’ driver from transactional analysis theory (Stewart & Joines 1987). The nurse wants to be seen as not making any mistakes; she must appear “good” as Maria described it, showing she can cope perfectly in every situation. Bourdieu’s theory of habitus and field might also explain the embodied notion of ‘coping regardless of the context’ thus ‘being strong’ and learning to practise ‘perfectly’. These could be influenced by historical expectations of the Victorian values of stoicism thereby switching off ones emotions and not feeling. Alice likened this to a ‘co-dependency’ relationship whereby a person has numbness to emotional pain. Co-dependency is linked to a loss of self esteem, neglecting one’s needs by putting others’ needs first thus ‘people pleasing’ but inwardly harbouring resentments. Co-dependency creates problems with boundary setting and difficulties with intimate relationships (Snow and Willard 1989). Nurses often feel they have no clearly defined role; “mopping up everybody else’s jobs” as Richard a Staff Nurse from the ward observed. Mandy, a modern matron from Strand 3, contended nurses have a “giving nature” which encourages them to take on others work and even feel guilty when they
haven’t completed it. Thus for some nurses not maintaining adequate boundaries could be related to appearing ‘good’.

Jon’s story shows a contradiction in that the staff didn’t want any action; that there is comfort in the whinging process itself and the status quo is maintained. Therefore, in blaming the manager, this would help the nurses pass on the emotion to their manager or distribute it among the team, while still feeling righteous indignation and resentment. Perhaps these emotions were safer and more acceptable emotions than that of anger? Were they racket feelings? This concept from transactional analysis, describes a feeling that is a ‘familiar’ conditioned response which is not necessarily generated or applicable to the current experience (Stewart & Joines, 1987). It is usually developed in the family; for example, in one family fear may not be acceptable but anger may be so the child learns not to express fear.

The danger of the drama triangle game in this case is that the manager will unconsciously persecute the nurses for their inaction so that they in turn switch to the victim role, leaving everyone feeling ‘hard done by’ and powerless. Freire (1998b) argued that without questioning, debate and critique, cynicism would set in, leading to fatalism and hopeless acceptance of situations. Alice and I felt Jon’s staff exhibited this behaviour. Perhaps whinging was about both personalising issues and projecting emotions that had built up during work. Perhaps this was why nurses (in all three strands) frequently complained about feeling unsupported by their managers? This felt like a parallel process or a projective identification to me.

Nevertheless, as Jordon pointed out there is a tension because nurses don’t have a choice about whether they nurse a patient or not, so that they sublimate their own needs while this emotional capital is not valued. It is invisible in the field of practice. Yet paradoxically, while in practice I experienced some nurses in response to the call buzzer saying “that’s not
my patient, you answer it”; sometimes walking further to tell me that rather than answer the buzzer themselves. There seemed a contradiction here. Perhaps nurses have more choice than they think?

**Gossiping and Talking Behind Your Back**

**Careless Talk And/Or Informal Agency?**

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During my time on the ward I had several snatched conversations in the sluice, in the store cupboard, and by the desk during completion of paperwork. Then sometimes there were informal chats over coffee, or at the start and end of the shift, in the changing cupboard and occasionally during handover report. This reminded me of the perhaps lost tradition of women “who gossiped over the back fence” (Etherington 2004 p.64). As women, was this the usual way we built relationships? Was gossiping the same as whinging? To me it didn’t feel quite the same. Whinging seemed to have more negative connotations. I wasn’t sure about the role of gossip
and its potential relationship with reflecting-in-action and decided to do a 
literature search and observe for it in practice. We did not discuss 
gossiping overtly in the co-inquiry meetings.

Nursing is an oral tradition consequently; it is hardly surprising that I 
observed reflecting through ‘gossiping’. As the image above implies 
gossiping is frequently regarded as a female pursuit and is ‘chiefly a 
derogatory term’ implying informal communication (OED 2006, Hafen 
argued rumour and gossip were terms that could be used interchangeably 
because they are both concerned with spontaneous current events of 
concern. While Hafen (2005 p.46) suggested “rumours start when events 
are uncertain” being “usually in the public sphere and associated with 
men” (ibid). Whereas gossip is in the private sphere and associated with 
women’s talk (Hafen 2005, Michelson & Mouly 2004, 2000, Tannen, 
1992). Similarly, as discussed earlier, Reay (2004) suggested emotional 
capital occurred in the private sphere of affective relationships with family 
and friends. Waddington and Fletcher (2005 p.379) recognised the wide 
definitions in relation to gossip from “the exchange of social information 
and knowledge” to “evaluative talk about a person not present”. I came to 
see the gendered and negative connotation of gossiping in the ward but 
found that it seemed to be a spontaneous way of reflecting in the moment 
at work. There seemed a close line between interest in others and 
gossiping.

According to the Oxford English dictionary (2006) to gossip is to take part 
in a “casual conversation or unsubstantiated reports about other people” 
and “their lives” (p. 615). However, it would seem that the meaning of the 
word gossip has changed over time. Before the 19th century a gossip was 
a more serious and worthy person than the dictionary definition now 
implies. In old English the word was spelled “godsibb” and meant 
godfather or godmother; literally “a person related to one in God” (OED 
ibid p. 615) It came from ‘sibb’ meaning ‘a relative’ from which the term
sibling derives. Therefore in medieval times “a gossip” was a “close friend” (OED ibid p. 615) implying a confidant and ‘sounding board’. I realised through gossiping I reflected informally. My diary entry below shows my puzzling attempt at understanding the difference between gossiping and whinging with a colleague, Clive.

It was useful chatting to Clive today about trying to make sense of all the data. We talked about gossip as he is relatively new to the organisation and felt gossip wasn’t always negative. Gossip at one end of the spectrum is a helpful sharing of experiences, conveying information about the organisation in an informal way. It can help to alert issues for dominant members in the organisation or issues that impinge on facets of workers roles. At the other extreme there is whinging or complaining, almost for the sake of complaining. A habit formed which can spiral negatively in a self defeating way, which both builds up emotions and the emotional impact of work and is a way of letting go of the emotions as well. The story is part of the gossip, part of the informal passing on of information or the wisdom held by organisational members. It can help to validate an experience so when does it become destructive? And when does the story slide into gossip and vice versa? Is the crucial thing – behind your back? To your face – would that be reflexive? Or is it just a matter of identity through language?

Diary Extract 13/6/06

Like whinging, I began to realise gossip was a loaded word. It could keep me informed of the politics of the organisation, of what was happening, could offer me advice on my practice. I could learn at work through gossip which I now see as a way of sharing experiences having the potential for organisational learning and sharing systemic knowledge. In other words, I see it as an informal way of reflecting-in-action.

42 Clive, a colleague gave verbal permission for me to use this dialogue and co-inquiry with myself
Whilst in practice I found I wanted to connect with those I worked with on some personal level, so that I knew something about them as a person as well as a colleague. This process involved informal chit chat. Was I gossiping if I was talking about myself? I also noticed I would chat about myself with patients as well as colleagues and sometimes shared my own experiences as a way of building that connection. Not all nurses on the ward did this; some seemed uncomfortable talking about themselves. After all there wasn’t much time and these kinds of conversations were usually done on the run. Later, I was to realise this informal chat or gossiping was important for relationship building.

Dysfunctional nurse-nurse relationships was a theme occurring in all the strands of the inquiry and seemed to have a bearing on the atmosphere in the ward relating to whether nurses felt willing to reflect with each other. Talking behind each others backs rather than directly face to face was prevalent. I suggest this is an aspect of the habitus and field of the ward as exemplified by Susan’s story and which is typical of some students’ experiences shared in university work-based study days. The story shows talking behind your back leads to invisible learning or embodied dispositions which reduce nurses’ sense of agency and confidence, contributing to an unwillingness to share mistakes and reflect-in-action in the ward.

In May 06 I was teaching ‘assertion skills’ with final year student nurses at the university using the principles of socio-drama (Moreno 1971), that is, using students’ actual experiences. I set the scene by talking about how we need to think assertively before we can act assertively and how we often have erroneous fears about others reactions or unacknowledged fears about how others will perceive us if we respond assertively. Susan told her story; it was her second shift and she was working with a health care assistant, Paul. Paul told her that he needed to go to the endoscopy suite to pick up a set of patient’s notes that had been left there by mistake.

Susan gave verbal permission for its use in this thesis.
Susan had also received a phone-call from the endoscopy suite asking for someone to pick up a patient. The usual policy was for a qualified member of staff to bring patients back to the ward. However, in this case as the patient had received a nasal spray and not an anaesthetic and was unlikely to have any complications it would be all right for either Susan, as a student nurse, or Paul as the healthcare assistant to escort her to the ward. Susan had scheduled a meeting on her previous ward to pick up her belated continuous assessment document because the staff had not had time to complete the paperwork before she had left. So she asked Paul since he was already going to the endoscopy suite would he please pick up the patient but he refused. Susan, being assertive as she thought, repeated her request to bring the patient back explaining this time that it would be a good use of time management and re-iterating that she didn’t want to be late for her appointment on the other ward. Still Paul refused saying it wasn’t his job. There was no-one else to ask, so Susan ended up going down to the endoscopy suite and then went onto her appointment, arriving slightly late and flustered.

When she arrived back on the ward there was an atmosphere. Paul had been talking about her behind her back accusing her of being “bossy”, “stand-offish” and wanting to be “matron”. Susan had heard him complaining about her to other staff and chastising another health care assistant who hadn’t agreed with his position. Paul considered she was “siding” with Susan, a mere student, because she had told him that in her opinion Susan had not asked in “an aggressive bossy way”.

A little later on the same shift, Susan and Paul were called into the office to talk about what had happened, a kind of debriefing session with the team leader. Listening to the story I was thinking “great some reflection in the team!” Instead Susan went onto describe Paul accusing her of being bossy and aggressive. She was not encouraged to put her side of the story so she plucked up courage and said in her opinion she had not acted aggressively. The team leader said it was important to talk about the
issues before they built up “into a big deal” yet didn’t seem to want to hear Susan’s side of the story. There was no resolution in the meeting and both the nursing care assistant and the student were dismissed from the office. Later, in the shift Paul pretended not to hear Susan when she asked for help so she was left to carry out care by herself as though she was being punished. At first I thought this was another example of the drama triangle being played out.

However, later that evening, in capturing the story and reflecting on the complexity of it, I wrote in my diary:

Who holds any personal power here? Why is assertive behaviour perceived as aggressive? Imagine what did this student learn? She learns she is not part of a team. Even though she is on her management placement it is not ok for her to practise the skills of delegation. She is dissuaded from being assertive in future. Rather, indirect aggressive behaviour, possibly a projection from the healthcare assistant, is rewarded because he is a permanent member of staff, not to be upset! What choices does Susan have? Having reflected on the situation she is now anxious about working with both the healthcare assistant and the team leader because she has been misunderstood. She told me she felt “gagged” and she worries what other comments will be made about her to other team members behind her back. Does she become passive and do as she is told by healthcare assistants in future or does she continue to practise her skills of delegation and assertion. If she continues to challenge the behaviour of Paul will she be labelled ‘a difficult student’? Will this result in a poor assessment from her mentor because she is not able to work in a team effectively? She seems damned if she does and damned if she does nothing; a confusing double bind. Is the culture on the ward more powerful than the teaching in college? I wonder if the team leader has also experienced being ‘put down’ and so is reluctant to challenge Paul directly herself. Is this a gender issue and/or a cultural issue?
So what does Susan learn? To keep her head down, stay silent, keep quiet, don’t say anything, and definitely don’t rock the boat. Don’t give an opinion unless spoken to. Don’t stand up for your rights, absorb the emotion, don’t become assertive, stay a victim. Know your place, you’re powerless! I imagine it is safer for Susan to talk to her mates down the pub, she can whinge about the team leader and how unfair Paul has been, how the team leader never let her speak or explain. They can agree with her - tell her how unfair the staff are behaving. She can re-feel the emotions of resentment, frustration, anger which begin to fester. She might find a sympathetic ear on the ward and whinge to her about the lack of support from management. I imagine this would take place behind Paul’s back! It is safer not to challenge and be misunderstood again. She might snap at a patient if that patient says something upsetting. The stress of working on her own might make her more guarded with patients and staff. She learns it’s not safe to be yourself, to question, rather she learns to keep her head down; become invisible. Keep quiet. Will she also fail to challenge others when she becomes a staff nurse?

Diary Extract 22/5/06

I witnessed talking behind your back many times in Strand 2 and it seemed irrelevant the grade of staff members involved or the sex of the individuals. On my second day on the ward (30/3/05), the day after an impromptu meeting had been organised Elizabeth, a staff nurse, was complaining about Sheila, the ward manager, behind her back. Because the ward had fewer patients most of the staff were eager to go home and get some ‘time owing’ back. It was a lovely sunny day but Shelia had not had chance to have a meeting for a while. Elizabeth told Sheila that she was meeting a friend and needed to leave on time. There was a lot on the agenda so the meeting eventually over ran its allotted time. Elizabeth was late getting off duty and was clearly upset but this was not noticed by Sheila.
The following day Elizabeth whinged to Pauline, a health care assistant saying how unreasonable Sheila had been and how unfair it was that she could never leave the ward on time. Pauline was agreeing with her how difficult Sheila could be. I said to Elizabeth, “have you tried talking to Sheila about how you feel, why don’t you name the issue of feeling taken for granted as you have just talked about it now”. Elizabeth looked at me horrified and said she couldn’t possible do that as she didn’t want to upset Sheila. I suggested it would upset Sheila more to know that Elizabeth was moaning about her lack of responsiveness behind her back rather than name the problem straight to her face. Elizabeth then said she “didn’t want to put her head above the parapet to have it shot down”. This was a phrase that later was to emerge in our co-inquiry to be captured on the storyboard. I felt at the time that Elizabeth needed the approval from Sheila and of course as a ward manager responsible for Elizabeth’s appraisals she had more power. I had a sense that if Elizabeth asked for her needs to be met, that somehow this could be seen as a personal attack on Sheila. Perhaps she felt there would be a backlash later for asking for what she wanted? I asked Elizabeth what it would have been like for her to be assertive suggesting when the shift was due to finish she could have got up, apologised and left the meeting. I had no sense that she felt confident to do that because she felt obliged to stay and contribute to the meeting. I had a sense of a culture of martyrdom, of Elizabeth feeling victimised and powerless; but that this was expected of her. Whinging seemed linked to a field of martyrdom and the aspect of the habitus was to feel victimised, resentful and unsupported by managers.

I do not believe this is a conscious process to deliberately hurt fellow staff members through this aspect of the field and habitus although it is possible this is the case. Instead I think it is symptomatic of the blame culture prevalent, a wider field of practice that plays out the drama triangle of miscommunication and is absorbed by those working in the NHS so that it becomes part of the habitus and field of nursing in some wards.
Silence and/or Reflection Inaction?

As the stories of Susan and Elizabeth show, many nurses learn to keep quiet, are reluctant to speak out, stay invisible, don’t rock the boat or put their heads above the parapet. Later we were to discuss this in our co-inquiry group as a further cycle of action and inquiry which is presented in the next chapter. During the non participant observations of the inter-professional team meetings, I noticed the nurses did not ask questions and remained silent unless directly spoken to. In contrast the physiotherapists, occupational therapists and doctors asked frequent questions and spoke vociferously. This ‘passive’ culture seems a long way from the radical transformative learning that reflective practice is supposed to induce (Gustafsson & Fagerberg 2004, Glaze 2001, Johns 2000, 1997, Mezirow 1990).

During our co-inquiry meetings we discussed the blossoming middle management posts in the NHS as a consequence of the policy directive called clinical governance (DH 1999). Many of these new posts focused on risk assessment procedures and practice development. There was now a managerial function associated with filling in critical incident forms (part of the reporting system attached to risk assessment). We believed these forms while supposedly there to help staff, were inadvertently contributing to a culture of blame and fault finding. However, the rhetoric of the NHS is one of moving to a non blame culture (Wise 2001). I remembered my own unwillingness to complete such a form44. Contrary to the literature above, in the co-inquiry group we suggested admitting mistakes in a field of practice that tended to blame others felt unsafe so that nurses learnt to keep quiet. They learnt not to act in relation to their dissatisfactions. Therefore, we wondered if it was safer to whinge and less exposing than reflecting. It is certainly not easy to expose ones errors to others as Maria noticed:

44 See chapter 3 when I was late giving a prescribed drug for Mary.
As you become older or you become more experienced, you have the confidence to admit how you felt whereas I think when you’re junior you lack that confidence, and maybe some competence. I know I felt very much that way. I wanted to be seen as competent and I wanted to be “good” and actually I still do now. I found it really difficult to say, actually, I’m not as good as I’d like to be at that. I think junior staff don’t share so much. I don’t know, maybe not with us, maybe with themselves they do, in groups they feel comfortable with. That’s because they don’t want to seem like they don’t know what they’re doing. (1st Co-inquiry meeting 25/1/05)

Tracey had been responsible for checking incident forms as part of her previous clinical governance role and she observed:

I think very often people are not reporting (Incidents) because they don’t think people will listen or are not in a position where people will listen and clinical governance is not well understood even now all these years down the line......I could use the system to my own benefit and I could make changes and have an impact but of course not everyone realises that is the case. I had to gather evidence and shout very loudly...You do shout loud because if you see an event, you see a pattern or a theme you make sure your staff fill out a form every time. (Final interview 28/6/06)

When I interviewed Lois at the end of the co-inquiry sessions (7/3/06) she said she had often struggled in our co-inquiry group to share her practice issues. Even though she recognised the group was supportive she found it difficult to speak out preferring to listen to others’ stories. Consequently I wondered if I had made an assumption that people were not reflecting if they did not verbalise it. Lois didn’t always bring stories that were currently challenging her but talked about safer things. She told me about her daughter who was a nurse who shared her stories of practice only with her close nursing friends. Lois’s experience resonated with what the students were telling me on work-based learning days at the university and co-inquirers’ observations. This made me aware of another tension; to what extent is reflection sanitised when told to others in a working environment? Was the private sphere of reflecting being appropriated as emotional and cultural capital and this was being resisted because the workplace was not
the usual place for this form of capital? Reflecting in the workplace has no economic capital and I was beginning to wonder if it had any cultural capital at all.

Perhaps if nurses could gain protected time to discuss more formally their work then reflecting in the ward would become the dominant culture (Driscoll 2000, Butterworth et al 1998). In the Trust where I was working, an initiative had been set up on the elderly wards providing action learning sets for newly qualified staff nurses. I went to talk with Nina who had led this initiative. She had a specialist sister role responsible for education and practice development across the elderly division; one of the newer roles created. I was interested in finding out how the action learning sets had worked as a way of reflecting at work.

Nina had organised monthly meetings for an hour to share practice issues for 6 new staff nurses on the unit and her role was to facilitate their learning. The meetings were for the nurses to talk about their experiences and to meet other staff for networking purposes thereby developing their confidence. After only two meetings she cancelled the third as staff were either off sick or did not turn up. She did not have a managerial relationship with the staff nurses which could have affected the attendance. Nina wondered if there was a deliberate avoidance of the meetings. She noticed that the junior staff were reluctant to speak out in the learning sets. She said the staff nurses found it difficult because without a set agenda they weren’t sure what to talk about. No-one talked about challenging or difficult practice experiences. They told her the action learning sets were a “waste of time”. Finally, when staff did share they cited a lack of support as the key issue yet failed to see these sessions were primarily to support them and their practice. Nina asked: “What changes do you think could be made to make you feel more supported?” And their answer was “Don’t know”.

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During the conversation with Nina I suddenly realised this happened in my facilitation of reflective practice sometimes and linked the feeling of ‘being unsupported’ to nurses’ feeling fearful and anxious about their practice. Could it be that reflecting is paradoxically silencing nurses? For me this highlights the need to pay attention to the emotions stirred by reflecting and for facilitators to have an understanding and ability to work with some of the unconscious processes that might affect learning. It demonstrates the difficulty in introducing action learning sets and reflective groups because just through creating a space for staff to come together reflecting does not automatically happen. Creating a reflective space can therefore paradoxically be about issues of safety whilst also provoking anxiety. Clearly not everyone wants to expose their weaknesses in a public place. This is actually a political act.

As Skeggs (2004 p.30) proposed “doing nothing” can be “central to social reproduction” and particularly “gendered reproduction”. She argued that “inactivity (not action and not habit) is the social glue that holds the family, gender relations, race and class together”. Therefore doing nothing could be as powerful or as subversive as doing something. I noticed whinging reduced my sense of agency and yet by sharing the complaint I had a connection and relationship with my colleague. Whinging seemed linked to “feeling unsupported”. The whinging was important; the social glue that held us together. In this way whinging could be seen as a spontaneous quasi-form of reflecting-in-action that is safe. It lacks the depth of critical reflection and seems to avoid the discomfort of new actions while also avoiding challenging those with more power such as managers or doctors. It keeps the status quo intact and preserves the power differentials. It does not challenge the social, cultural and political capital of those with perceived power but serves to reinforce the powerlessness of the nurses.
Conclusion

This chapter has questioned the relationship between whinging, gossiping and reflecting-in-action in the ward. It has focused on the spontaneous and social nature of reflecting through talking. I have argued that relationship building with patients or colleagues is a form of emotional capital normally reserved for the family and ‘private domain’. It is dependent on ‘chit chat’ or informal talk such as gossiping. Because it focuses on ‘benefiting others’ it could lead to ‘selflessness’ or ‘self sacrificing’ behaviours. I contend that gossiping could be a form of emotional capital necessary for eliciting a relational connection between staff and patients. Equally, it could be a spontaneous form of reflecting-in-action. However it appears to hold little cultural and certainly no economic capital being largely invisible.

It became apparent that whinging, a complaining form of talk which we described as “not seeing any good in a situation” is an unaware disposition; part of the field and habitus of nursing practice. It is a systemic issue contributing to low morale and reduced job satisfaction in the NHS. I have suggested whinging is an emotional process for “offloading” or as Deidre called it “letting off steam” which is also a quasi-form of reflecting-in-action, easily dismissed as having no legitimacy. It can, however, enhance relationships with colleagues through this emotional offloading process by seeking comfort and agreement with others while paradoxically sometimes being used to attack others.

Whinging could be related to a lack of recognition and appreciation by others and/or an indirect way of asking for advice. Thus it can encourage and inhibit learning. I suggest it provides a means for keeping relations going with colleagues while having a safe focus for blame such as a manager or a fellow colleague. Nurses feel victims often as a result of the drama triangle being played out, an unconscious process, which contributes to nurses avoiding direct emotions and open communication. Whinging we found is linked to feeling stressed and unsupported while
harbouring resentments and ‘feeling put upon’. Thus I tentatively propose these feelings could be ‘racket feelings’- familiar and safer emotions to exhibit in the ward producing paradoxically less discomfort- rather than experiencing the immediate raw feelings of sadness, anger or anxiety from relationships, projections or parallel processes involving patients and colleagues.

Whinging results in talking away potential action; what I have called “reflecting inaction”. By this I mean staff hold some systemic wisdom insofar as they can see the issues, are able to complain about them, but lack the agency to challenge and change the structures and systems in which they work. In this way staff remain powerless or use a form of political avoidance or silent subversion and thereby power differentials such as relationships with doctors or managers are not threatened or challenged and the comfort of the status quo is maintained. I suggest this is a political act in itself as a consequence of the work environment.

Whinging could be a product of class norms; Bourdieu’s concepts suggest questioning the educational distinctions played out in the ward. The dismissing of whinging as a reflective process may be due to the legitimacy or not, of the forms of capital held by nurses in a team. I have suggested whinging is easily ‘caught’ and displayed through the whole team as a form of "emotional orgy" which may contribute to the whinger’s complaint becoming invisible. How do we know that whinging focuses on petty complaints that may be dismissed by others in more senior positions? It is easy to label talk as ‘whinging’ and ‘gossiping’ and thus dismiss it on gender grounds or because it is informal conversation thus lacking social, academic and cultural capital.

In some wards there is a culture of mistrust (a powerful element of the field) because nurses learn early on that they may be talked about behind their back. If they do not conform to the expectations of their position in the hierarchy they may be unconsciously victimised through the drama triangle
This embodied habitus keeps nurses in their place. In this context it becomes understandable that nurses may choose to keep quiet and are reluctant to value and use processes such as reflecting as these may prove to be exposing and undermine their concept of themselves as ‘good nurses’. There is a tension relating to the reflective confessional through structural procedures such as critical incident reporting which paradoxically serve to keep the hierarchical positions intact whilst nurses retain an embodied habitus of “watching your back”.

Nurses in all aspects of this inquiry stated they felt unsupported by managers. This I have argued is related to the “watch your back” embodied dispositions and the “emotional orgy” generated in the team contributing to staff feeling negative and unsupported at work. I suggested this is part of the habitus and field of practice. Given the context of this mistrust in a ward, a reluctance to speak and share mistakes becomes understandable as a consequence of the interplay between the outer field of power, the historical influences carried in the body and system, the current systems (structures) and the nurse’s agency. This is contrary to how reflective practice is usually portrayed in the literature which emphasises problem solving, transformation, empowerment and social change.

The next chapter develops the political aspects of nurses’ agency and influence and questions how they develop their political acuity through reflection. I question the structures both visible and invisible that may affect the tensions and possibilities of reflecting in the workplace.
Chapter 6: Developing Systemic Agency

“We hear a great deal about systems; it seems there was or is an old system and that there is or will be a new system. Under the former, it is said, all was bad; under the latter, we shall behold perfection.”
A Nurse “Systems of Nursing” Edinburgh Medical Journal May 1880 cited by Williams (1980 p.41)

There is perhaps a touch of irony and cynicism in the above quote. However, the NHS does seem plagued with frequent system changes. An important systemic development in recent years in nursing has been the introduction of risk assessment posts and processes that feed into the clinical governance policies and procedures of the NHS. These include reporting adverse or critical incidents to inform organisational quality and practice development. Tracey from the co-inquiry group felt nurses had to “shout very loudly” in order to influence change and raised questions about the influence and effectiveness of these processes associated with Clinical Governance. Gail suggested nurses were involved in the “politics of witch hunting that happens on the ward”; what Bourdieu would call game playing. Bourdieu (2001) linked politics with power overtly through his notion of symbolic violence but power is also evident in the habitus and field as a tension or struggle within the logic of practice while there is always a wider field of power outside the immediate field of practice (Bourdieu 1990, 1993a). Building on the last chapter, I again focus on individual power. However, in this chapter I examine the interplay with the organisation's power that includes inhibiting aspects of the field and habitus and nurses' sense of political acuity and systemic agency.

Change is implicit as a consequence of reflecting (Boud et al 1985) while Glaze (2001) proposed through reflective practice nurses became more politically aware influencing the nursing agenda in an inter-professional environment. However, as co-inquirers we found it difficult to influence change even though it was an aim of the research. The poem Moaning
Minnie captured the difficulties and personal impact of the imposition of change processes. In the co-inquiry group we focused on our sense of agency and level of influence in our own organisations; what I have called systemic agency. We came to realise that while our main research question was *what are the tensions and possibilities of reflecting during care giving* perhaps as Alice suggested we were actually exploring: “If I don’t like this, what can I do to change it?”

In chapter 2, I highlighted Torbert’s (2001) influence on this inquiry through his three levels of reflecting, first, second and third person inquiry. The third person inquiry is about influencing practice and the organisations in which we work. It is dependant on noticing and using power effectively and reflexively, so that mutual collaboration and organisational learning is achieved. There seems to be an assumption that learning is either individual or organisational (Senge 1990) however, I argue it is a dialectic process; individual learning as well as group learning can influence the organisation likewise the organisation can influence the learning of the individual or group. Neither process should be mutually exclusive. Thus by using Bourdieu’s (1990) concepts of habitus and field it is possible to notice, as he argued, that we are shaped by the environment in which we work and the environment is also shaped by us.

In chapter 4, I discussed potential wider fields of power that might impact on the identity and status of nurses’ caring functions. Hodkinson et al (2007) noted the influence of Kurt Lewin’s work on Bourdieu while Lewin has been credited as a key founder of action research (Midgley 2000). Therefore it is not surprising that Bourdieu’s work addresses similar concepts as those found in systemic inquiry. Both theories suggest the researcher must question the social relations and interactions that include power at the micro and macro level (Weil 1998, Bourdieu 1993a). In other words it is important to focus on what has not been said to understand and

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45 See poems list for page of this poem
question underlying power, patterns, rhetoric, myths and contradictions at both the individual and organisational level. Consequently exploration and questioning of the complexity embedded in organisations that is, the interrelated patterns and connections, how boundaries are constructed, power differentials, the tensions of difference, the multiple realities, rhetoric, contradictions and unintended consequences, forms the process (Burns 2007, Flood 2001, Midgley 2000, Weil 1998, 1999). How a boundary is constructed or imagined can impact on those working in an organisation (Midgley 2000) and the power reproduced in Bourdieu's terms is seen as political, economic, social, cultural or symbolic capital as well as the field and habitus of practice.

This chapter expands the inquiry by focusing particularly on the relationship between organisational structures for reflection and nurses' sense of their own agency. The main aim of Strand 3 of the inquiry was to inquire into the organisational structures and processes that might encourage and impinge on reflecting during care giving in a hospital ward. At the same time I hoped to feedback into the organisation key learning already generated by this inquiry to understand the context in which nurses may or may not influence organisational learning. Therefore by interviewing risk assessment and senior managers I was keen to explore how they perceived, through their assessment of critical incident forms, an individual's developmental or performance issue and when that might become an organisational issue. So my core question for these interviews was “how do you decide what is individual learning or organisational learning”? However, this part of the inquiry posed several difficulties as much of the interviews were sensitive in nature and interviewees asked me not to use the stories because some of these involved litigation battles or would result in a breach of confidentiality.

can transform and widen one’s perspective (Taylor 2006, Jasper 1999, Platzer et al 2000b, Mezirow 1981) and increase self confidence and assertion skills (Taylor 2001, Platzer et al 2000b) while appreciating and being able to live with uncertainty (Bolton 2005, Bleakley 2000a,b, 1999). Yet, I have suggested that the field and habitus of nursing in the ward often acts as a force to disempower nurses. Discovering aspects of disempowerment in our co-inquiry involved exploring the habitus of being An Approval Slave and the field of nursing that supported a Blame Culture. We noticed the need to “fit into the nursing team" was a predominant characteristic of the field and habitus of practice and seemed contradictory to another finding that nurses in this inquiry were feeling isolated in practice. Could both realities co-exist? This chapter presents these findings and questions: to what extent is it possible to influence an organisation through reflecting-in-action especially a large organisation such as the NHS?

One of the shifts in my thinking since beginning this inquiry has been to appreciate more fully the impact of the system in inhibiting or promoting the actions for change and the learning from my own and other’s reflections (Weil 1998). It is “the working with the mess" (Weil 1999 p.175) and “the deep cultural barriers to innovation, development and partnership working" (ibid p.176) that systemic inquiry hopes to address and overcome to provide sustained or second order change. As I have attempted to show already, many reflections serve as an offloading process and so do not move to identifying changes in practice. I have shown in the previous chapters the powerful culture of the ward that creates the habitus and field through vicarious spoken and unspoken messages becoming internalised and embodied by the nurse and then played out without awareness with others as games. Thus the dominant discourses are kept in place and are not challenged. Given this context how easy is it therefore, to achieve changes in working practices as a consequence of reflecting? Driscoll and Teh (2001) suggest standing out from the crowd and being labelled a troublemaker can be just two of the many burdens associated with being a
reflective practitioner. The following Ivor Cutler’s poem shows how isolating and oppressive some structures may be and the effect this can have on a sense of community. I question whether this extends to learning and reflecting in a ward.

**Surviving or Thriving: Are you an Approval Slave?**

*Alone*

If you are mortar it is hard
to feel well-disposed
towards the two bricks you are squashed between or even a sense of community

Ivor Cutler (1982 p.89)

At the end of the seventh co-inquiry meeting (7/7/05), it became apparent that seeking approval from others was a theme connecting our stories. We started to wonder if nurses needed approval in order to feel they had any power or sense of agency. Nurses’ empowerment has been connected to feeling valued and nurtured in the ward (Bradbury-Jones et al 2007, Taylor 2001, Hokanson Hawks 1992). Amy remembered her sister commenting:

*All nurses must be psychologically damaged because why would you want to be needed all the time? You know it’s the need to be needed isn’t it?* (Final interview 19/5/06)

The picture overleaf from the storyboard (7/7/05) asks the question “Are you an Approval Slave?” In the final interviews most co-inquirers were
drawn to this question. In the last chapter I focused on whinging and wondered if it was linked to seeking approval. I have suggested already that nurses might use whinging to gain agreement from others and a sympathetic ear therefore it is not beyond the bounds of possibility that it might also serve as a way of gaining approval from others in the team and thus a sense of connection as well as helping to make sense of experiences with colleagues.

As Maria put it:

"If nurses were reflecting would they behave in the same way? And what the discussion made clear to me is that actually part of it is a lack of reflection on nurses' part, and also a lack of taking responsibility for their own selves. You know it's about abdication; it's always somebody else's fault. (Final interview 27/1/06)"

Could reflecting interrupt the need for approval? If a nurse doesn't get approval what effect is this likely to have? As I have shown already where I worked and I suspect in many wards, the habitus and field of whinging was more powerful than that of reflecting. In the sixth co-inquiry group meeting we talked about anger, another connecting theme for many of our
stories\textsuperscript{46}. It is clear in the picture that the cricketer has an aggressive manner nevertheless I will explore anger in the ward in the next chapter. Tracey tentatively suggested reflecting had helped her be less reliant on the approval of others and her need “to be liked”. She suggested needing approval stopped her from challenging others. She told me in her final interview when discussing the picture above:

\begin{center}

Hat

Yes that need for approval and not challenging, not standing up for yourself, not standing up for what you really believe is right and should be done. I remember that.

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Clare: But do you think its because nurses don’t know where to go with that, because when you are in the midst of giving care you don’t think wider do you, because you haven’t got time to think wider?

Tracey: No. I don’t know when I changed. I don’t know when I jumped from there from that needing approval and I did, because I don’t need approval now, I don’t care now.

Clare: And is that maturity…?

Tracey: I don’t know I think it’s a developmental thing..I wonder if it was that reflective course or education generally…(Final interview 28/6/06)

Already I have told several powerful stories about the hidden power in the field and dysfunctional team relationships (such as Susan’s and Jon’s stories in chapter 5). Taylor (2001) found changing the ward culture where nurses felt more appreciated appeared to reduce dysfunctional nurse-nurse relationships. However, this seems too simplistic an explanation and negates power and group dynamics. Maria’s story focused on accusations of bullying which demonstrates the pull and powerful effect of the team on the individual and how important it is to fit into the team. It is almost as though needing approval from the team is the most important process and I wonder if this is far more important than approval from the patient while Maria noticed it was more important than approval from senior staff.

\textsuperscript{46} See also the Fire Inside and Wounded Nurse poems.
Perhaps this was due to nurses not expecting approval from their managers and a difference in the habitus and fields of practice.

Organisational theory has shown how much group conformity takes place in organisations (Gabriel 1999, Sims et al 1993, Morgan 1986). I have suggested already that feeling unsupported by managers was a possible parallel process and game of the field. This story confirms for me that it is a characteristic of the field and habitus to have low expectations of managers which is probably historically constituted. As I shall show later this is perhaps in part because of another characteristic I noticed in practice: that staff felt Done to creating an Us and Them differentiation. This Us and Them process was used to describe organisational subcultures encompassing shared values and assumptions that are capable of creating both cognitive and emotional bonding (Sims et al 1993). In Bourdieu’s terms it would show different habitus and fields of practice at play and in systemic inquiry would show how systems are experienced and perceived differently by those working with them; that is, multiple realities and tensions of difference (Midgley 2000, Weil 1998).

Maria worked in a unit where the senior staff were accused of bullying by a colleague. This came as a bolt out of the blue because the unit was always perceived as being friendly, supportive, and the feedback from students was that they wanted to come back and work there. So to have this complaint was a real kick in the teeth for everybody. As Jon had found the staff seemed happy to moan, whinge and make accusations but when the senior staff asked for concrete examples no-one seemed willing to give any. Then 15 or so people (virtually all the staff on the unit) signed a letter to complain about the perceived bullying. Maria in her role as a practice developer had worked with some of the staff and one staff member in particular had talked to her about the bullying in depth. Maria had listened and worked with this staff member for over 6 months helping to change the environment and sorting out the complaints. They had had

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47 See this story in chapter 5
meetings, where the staff had reflected on how everyone was behaving and how they could change the atmosphere for everyone’s benefit. Later Maria had met in a one to one with several members of staff who all seemed happy that the unit had improved. So she was shocked and frustrated when a letter of complaint was sent and everyone had signed it, even the staff nurse who had told her how supportive she had been. The letter seemed to refer to an incident that had happened about a year before and which in Maria’s eyes had been resolved. Reflecting on this story in her final interview Maria said:

I just found that fascinating because I thought well, actually I did talk to her about it all. It was really interesting because there were several of them who when they realised the implications of what they were doing, kind of said, oh I retract what I said, and I didn’t mean it. But the on-going ramifications were enormous really. So that’s the kind of example where we were discussing how whinging becomes endemic. If people whinge and moan and you don’t have somebody there to say, okay let’s just stop. Let’s look at exactly what the issue is, reflect on it, what can we do differently? If we don’t have that intervention, how it can spiral out of control, it would be really destructive. Very very destructive.

Clare: Yes, but its also interesting that even though you gave them an opportunity to use their sense of agency, they chose not to do that, and that is fascinating.

Maria: I know, well for me it’s a real dilemma as to how do you encourage people to take that. (Final interview 27/1/06)

The nurse had complained even though she had told Maria she had gained support from her and felt the issue had been resolved satisfactory. So what was that about? Was it another unconscious game, possibly the drama triangle being played out?

In the co-inquiry meeting we started to question: how easy was it to put one’s head above the parapet? We selected the picture overleaf of the otter standing out from the crowd in our seventh meeting (7/7/05) as a representation of this for our storyboard. The picture questions whether agency is an individual’s responsibility, is it a group responsibility, a
combination, or purely a matter of fate? We tried to show this by placing the roulette wheel to indicate fate next to the otters while the woman remains predominately a lone figure. There is an assumption in much of the reflective practice literature that an individual can challenge and influence a system (Ghaye et al 2000). However as Bradbury-Jones et al (2008) suggest empowerment takes on different forms in different contexts. Therefore the reality of challenging a system is difficult. Does the woman in the picture need to watch her back? Is the most empowering act remaining silent and resistant?

As in Maria’s story perhaps there is safety in numbers in a collective approach to voicing dissatisfaction and asking for change. But what I find interesting in both Maria’s and Jon’s stories was how the nurses were not clear about what they were asking for and quickly retreated when their complaints were taken seriously. It feels to me that in seizing their own sense of agency and power they quickly became insecure when faced with the response of the hierarchy. Perhaps the need for approval for their actions was so great that if their actions were challenged or disapproved of
this could explain why they began backtracking. I began wondering whether watching one’s back is actually a matter of survival and under some circumstances makes obvious political sense. The game seems to me to focus on staying invisible and therefore the pull of the team is important. Thus it is safer to not be noticed than it is to stand out from the crowd.

My argument is that the effects of the ward team can both help and hinder the nurses’ sense of systemic agency. I suggest that without a strong sense of one’s worth or emotional and political resilience to those processes staff including managers can feel demoralised as they play out an unconscious game that I called earlier an emotional orgy. The nurses in this instance cannot see that they have discounted their own part in setting the complaint up to fail. Their low expectation and feeling unsupported by managers also probably contributes. Thus they retreat, a sort of fatalism or inaction takes over whereby any effort to change practice seems a waste of time possibly as a consequence of not being listened to in the past. This gives rise to further whinging opportunities adding to the Us and Them habitus.

Another way of explaining what might be happening here is through Gilligan’s (1982) notion of the Ethic of Care. She suggested “women’s approaches to conflict were often deeply instructive because of the constant eye to maintaining relational order and connection” (ibid p.xiv). She argued that women’s moral reasoning was based on principles of responsiveness in an interconnected web or network of needs, care and prevention of harm to others. This created a responsibility to others at the expense of one’s own needs; what Gilligan called “selflessness”. This ‘selflessness’ did not extend to Maria because she represented the management - one of Them - so the embodied habitus to comply with the rest of the team clearly out weighed the sense of connectedness to Maria as an individual. For Maria, the temptation to personalise this issue is great but I believe the nurses are acting out the field with its historical
mistrust of hierarchy and are not portraying a damnation of Maria as a person nor the level of support she offered or that staff received. She represents the symbol of authority and power in this instance; thus perhaps symbolic violence.

Jordon from our co-inquiry group noticed that many nursing teams were “fragmented” and that getting approval from within the team seemed important. I was discussing the picture above from our storyboard with her in her final interview when she told me:

I think this thing about approval and being part of the team is crucial to nurses, whether it draws on certain characters of nursing or whether it’s because you know to survive you have to work in a strong team. Because the worst thing is, fragmented teams. You can’t work well as a nurse if you’re in a fragmented team. And so the whole idea about approval is the key really, isn’t it? And that’s where again it comes back to the Sister role-modelling. If she demonstrates that she approves of people who stick their head above the parapet and say I don’t know, can you explain that to me? What do we do here, are we doing this correctly? If she demonstrates that, that’s a positive thing in her environment then you get approval through being challenging. If you’re head down, just get on with it; then you get your approval by not rocking the boat.

Clare: Yeah.

Jordon: My experiences in this ward where I’m having trouble is that the Sister has been head down, don’t put your head above the parapet. But she’s actually found it really difficult to implement any change, even when she recognises something isn’t going well. They will change their behaviour when she’s there but there isn’t any sustainability about the changes she proposes and that’s because underlying, the team won’t change. The approval in the team is stronger than the approval from her. This idea that the Sister doesn’t challenge has a double whammy effect unbeknown to her I think, and I’ve never thought of this before, that she’s creating an environment where approval from your colleagues is more important than the approval from the Manager because she is not challenging them. Seeing that has just brought that into my mind for that team and that’s why they don’t change. But why had they changed for me? If I tell them ..that back trolley has not been out since. That’s quite interesting, isn’t it? Whereas if you get approval from your Manager by being challenging and you create
an environment of challenge and the group think then is challenge and consider and reflect, then you get more sustained change. I'd never thought of that before, that's interesting isn't it?

Clare: That's brilliant. (Final interview 20/4/06)

Linking sustained change to role modelling, challenging skills, consideration of the need for change and the reflective process shows the embodied nature of reflexivity which will be explored further in the next chapter. It was important learning for Jordon and for this inquiry. After the co-inquiry had finished and I was making sense of the data I thought a lot about this image of the otter standing up from the crowd. The co-inquiry group put it on the storyboard to represent the vulnerability of putting ones head above the parapet. In applying this to the sister in Jordon’s story of practice above I began wondering what might stop her challenging her staff. Could she be exhibiting the selflessness that Gilligan (ibid) described? It made me consider if the exposure of standing alone was real or imagined and whether that mattered. Clearly, understanding empowerment is not straight forward (Ghaye et al 2000, Bradbury-Jones et al 2008).

Yet the otter isn’t looking behind herself watching her back, she is looking forward (often an assumption of change processes that they move the system forward) and is evenly balanced. Asking questions, a central part we found of reflecting in the moment, can be a political act in itself. So how is political acuity developed and encouraged through reflecting? In the co-inquiry political acuity was identified and encouraged by developing networking skills especially with others from outside one’s area of practice allowing for wider and different perspectives and thus the challenging of assumptions. We realised choosing the timing of challenges and change was an important aspect while naming issues preferably as they arose in the moment, was part of developing assertion, challenging and reflecting skills. The next chapter will further explore some of these processes as we came to see them as central to embodying reflexivity.
Recently I discovered in Native American medicine the otter, as a shamanic belief, represents 'woman medicine' where fear, anger and jealousy games do not feature in relationships with others. She represents beautiful womanly energy which cares unconditionally. Yet in previous chapters I have shown how much these games and feelings are present in the ward and how this can help to keep nurses feeling powerless and demoralised. The otter character traits are to always be on the move and curious. She is full of joy for others representing sisterhood and balanced female energy with power. What has this image to do with nursing and reflecting in the workplace? I suggest these images are a way of making sense of some of the tensions that nurses may face in attempting to change nursing practice through their reflective processes. The otter might actually represent the reflexive nurse who has gained a sense of her own systemic agency and is willing to put her head above the parapet. Agency can take many forms including taking in the wider world and picture as Jane described it. The nurse must be able to reflect on the complexity of the political aspects of care in a complex fragmented environment such as the NHS. Complexity here does not mean complicated although this might be the case rather it refers to the inter-relationship, interaction and interconnectivity of the different parts of the system and between the system (Mitleton-Kelly 2003).

The images above show visually the personal and private aspects of reflecting are a political act which is context specific and dependant on the relations with the rest of the nurses. We have questioned an abdication of responsibility as a possible function of the team dynamic. Would it be more effective if all the otters were standing up together? Are they like squashed bricks without a sense of community as the Alone poem above suggests? Or a sisterhood providing a trusting, helpful and solid collaborative working environment in which each person is valued for the part they play in the whole?
If I don’t like this, what can I do to change it?

In the storyboard in our sixth meeting, we created the picture of the female bodybuilder who represents strength and fitness juxtaposed with the back of a woman’s face wearing half a policewoman’s hat. Images and metaphors were part of our shared reflective experience (Clarkson & Nicolopoulou 2003) however the co-inquirers did not comment and weren’t drawn to this image in their final interviews. Nevertheless for me, this picture represents the constant tension deep within myself; between the policewoman that is my critical voice (the “silencing policeman” Milner 1986) who censors my thoughts and actions (or as Lois from the co-inquiry group, called her “the thought police”) while the bodybuilder represents my strong powerful voice that is up for a challenge and has a sense of my personal power.

I have noticed this critical voice reduces my ability to reflect encouraging me to whinge rather than follow through on issues and initiate changes while the strong voice recognises my creative strength and my political and systemic influence within the organisation. Yet for me, these different voices (aspects of my multiple selves) do not always work together, they often work against my intentions reducing my effectiveness. As Alice said in her final interview:
For me the image of a body builder also shows the tension of using one’s influence in an organisation. Throughout the whole inquiry process I had a strong feeling that I had little or no influence which was particularly strong when I was in practice. Was this another parallel process? This could have been due in part to my insecurity about carrying out action research and my expectation that the social change required had to be something major so how could I possibly as an individual influence a large organisation such as the NHS? It felt a daunting task. It seemed tempting to pass over the issue to a person with more influence and consequently this abdication as Maria had noticed meant giving away one’s power. Sometimes it felt easier to whinge about a problem than take up the responsibility to change it.

As I found when dealing with the ethics committee it can be difficult to know who to go to with an identified problem requiring change because of the fragmented system in the NHS. For example, in the ward as part of Strand 2 of this inquiry, several nurses were discussing whether a patient due for a small operation under local anaesthetic was required to remove her body jewellery pre-operatively. There was no mention of body piercing in the Trust policy and there wasn’t a policy for removing jewellery prior to having a local anaesthetic. Therefore there was no policy guidance for staff and it was also impossible to discern who was responsible for the policy or who could be contacted to discuss the problem. Staff did not know how the policies were updated and who had responsibility for this task. Therefore it was easier and saved staff’s energy to just not bother

48 See chapter 2
raising this as a systemic issue. So while there was some reflection in the team around this problem there was no systemic follow through with action. Wisdom within the system was lost to the organisation as a whole. Deidre, a specialist sister summed up the feelings associated with change in the NHS:

![Image](https://via.placeholder.com/150)

*Sometimes it feels like you’re banging your head against a brick wall! (Interview 17/4/05)*

We discussed in the co-inquiry group how the hierarchy in nursing seemed to dis-empower nurses. Alice said:

![Image](https://via.placeholder.com/150)

*It sometimes feels as though the answer lies within the power of the people within the room and that there are things that we can change about our practice that will address what we are talking about. Sometimes it feels like there are things that need to happen beyond the room with other people and I suppose in my mind that’s where it tends to go into an organisational role and where we need to engage with other people in order to address some of the issues. (7th Co-inquiry meeting 7/7/05)*

Alex suggested that getting changes to happen when you have no authority and influence is not easy:

![Image](https://via.placeholder.com/150)

*I can do something to change my own bit of practice but there are some areas that you can’t do anything about. It involves a lot of work and because you haven’t got that power, you feel you haven’t got that authority to influence the people at the top to discuss… the only thing you could do, the best you could do is just to lay your concerns and hope they are listened to. (Final interview 31/10/05)*

In the co-inquiry group Alex seemed frustrated by the lack of will to take ideas and possible changes forward. She highlighted how boundaries (usually imagined) are constructed in the field of practice that impact on whether the ideas and changes may be taken forward or not and how this can contribute to the *Us and Them* aspects of the habitus and field:
At times you feel you don’t have any say it’s, you do what you are told to do, not just what you think you know. Reflective practice makes me be aware and to challenge an issue, but the problem is you don’t know the best person to go to because if you go to matron or the sister they say well, that’s the system and you can’t go to the doctor on your own at times because they’ll say who are you to do this. (7th Co-inquiry meeting 7/7/05)

Tracey felt change was difficult to achieve in the NHS because as part of being politically aware you had to shout loudly to be heard which took energy away from already tired staff. Jane had only managed one co-inquiry session but had completed a reflective practice course in the past so I was interested in whether she felt reflecting had enabled her to feel more empowered. She told me she was more willing to fight for what she believed in now:

If we need staff then I’ll fight for staff. If we need a ‘Bank’ nurse, then we need a ‘Bank’ nurse. If it’s the weekend then you have to go to the ‘on-call’ manager who may have to go to the ‘on-call’ executive. If we need staff then we need staff, I’ll do whatever I can to get staff.

Clare: And would you say that has changed since reflective practice, or was that always the case?

Jane: No it’s changed, it’s not just the reflective practice. I think it’s come with doing other courses as well. That’s given me more confidence and, also seeing the wider world and the wider picture. I’m keener too to meet other colleagues. (Final interview 9/2/06)

Jane highlights the need to look outside her environment to connect with likeminded colleagues which is similar to Glaze’s (2001) findings describing the development of political awareness. Jane’s willingness to fight for resources and to look critically at the system, developing strategies to change it, seemed different from my experiences in practice. I wrote the poem below after attending an in-service mandatory manual handling refresher study day before I worked on the ward. It was based on a story told by a healthcare assistant working in theatres.
A Manual Handling Incident

Let's move this patient
From the trolley to the bed
How are we going to do this?
The health care assistant said

All hands to the deck are needed
We could really do with six
Better still, use the slide sheet
Cos we've definitely judged the risk

But the slide sheet can't be found
It's not readily at hand
Oh let's move her anyway then
But be careful how you stand

Fill in the incident form, later
That'll do the trick
But how safe is it to whistle blow?
Cos mud will often stick

Hurry up, time to go home now
The stupid form can wait
We're really fed up of staying behind
So today we won't be late

You need lots of incident forms anyway
Before managers will ever act
What’s the point of even trying
There’s no money and that's a fact

Staff shortages and cutting corners
Are now part of the working day
Leaving the workforce feeling, what?
And unwilling to have their say?

Clare Hopkinson 14.4.05

While nurses recounted their experiences of manual handling, I was struck by the power of the group dynamics which seemed to silence the objections of moving the patient without the slide sheet and a lack of will to feedback through the organisation the unavailability of slide-sheets that was impacting on their practice. On the study day it was suggested that using risk assessment forms (called critical incident forms) could be used
to gain more resources and to flag up risky and weak practice. In other words they could reveal the systemic patterns or problems in the organisation. It was suggested these forms were there to help practitioners have more influence in their organisation. I realised these forms were in part a reflective process and could be a way of influencing systemically nursing practice. However, as I found with reflective practice generally, paradoxically they seemed to be seen more often as a ‘policing tool’. If these forms like reflecting itself, connected staff to feelings of discomfort, guilt, shame, uncertainty and incompetence then perhaps it was inevitable that they would be perceived negatively by staff thus adding to the watch your back culture.

The poem raises questions about integrating theory and practice and I try to capture that practice does not always follow the theory propagated in the University or in the Policies laid down by the Hospital Trusts. In applying Bourdieu’s (1990) Logic of Practice I now see this as a clash between the different learning cultures present in the university and the ward. I used this poem with student groups in the classroom and with the senior nurses from the facilitation group. They all resonated with the lack of will to fill in the forms and passivity to follow through with systemic issues. Frequently the response was either “there is no point trying as no-one would listen” or it was implied that the system was unclear and unwieldy therefore “who would you discuss the issues with?” I was struck in the facilitation group consisting of senior staff, how they saw it as the bedside nurses’ problem and did not see their own connectedness. Later I fed this back to Gail, the deputy nursing director and her response was that the: Critical incidences are the organisational way to have a quality assurance and safety culture.

Gail admitted there was work to be done on upgrading and reviewing policies but suggested many nurses did not use the policies sufficiently to inform their practice. Yet this did not seem to represent my experience of working on the ward. The lack of communication after filling in a risk
assessment form from managers, coupled with the watch your back culture, meant frequently nurses in this inquiry felt they were being blamed when care went wrong and saw it as a stick to be used against them by their managers. Whether this was real or just imagined did not seem to matter but did seem to be a factor for not always filling in the forms. This felt like a mismatch between how managers perceived these processes and how those involved in using them perceived them; a potential Us and Them scenario with possibilities for game playing processes. Therefore I realised I needed to inquire into the processes related to the risk assessment forms and interviewed three senior staff whose primary role was to work with the issues raised by the forms.

When I asked Steph a risk assessment manager:

How do you decide what is an individual learning process and what is a more organisational learning process? She replied

Steph: I suppose it is just through discussion and reflection- that sounds a bit of a cop out doesn’t it? (Interview 22/2/06)

Steph noticed staff were shifting their way of seeing her role because they were beginning to ask for advice so that her role was becoming more of a two-way process. Much of our discussion was confidential while most of the forms related to patient safety issues, involving stories of current investigations and potential litigation. So I have not included these stories or many direct quotes from these interviews at the request of the participants. However, one of the risk assessment managers, Laura used the imagery of nurses acting like rabbits caught in the headlights which I re-presented in the following poem.

Caught in the Headlights

Caught in the headlights
Frozen in the brightness of still time
Longing for the warmth of the warren
Deep, and vast in the soft earth
The rabbit twitches its whiskers a fraction
Can it get away, run and hide?
The isolation is as heavy as the roar of the car
But the legs won’t move, inertia is the stronger force

It stays stock still inviting invisibility
Realising too late that moving would have worked
Wounded, it gains pleasure from its suffering
To be forever a martyr, safe in the familiarity of this role

Clare Hopkinson 14/10/05

This poem recognises that fear, a powerful emotion, can reduce one’s ability to realise change. There is safety in feeling hard done by and the poem questions how effective reflecting in isolation can be. Can this actually create inertia? The poem also shows the illusion of invisibility in the workplace as a way of creating a sense of security for oneself. I tried to capture Laura’s frustration that nurses would not always take responsibility for the mistakes they had made.

During the interview with Laura, a risk assessment co-ordinator, she talked about creating the role for herself, how she made the road by walking it. It was her job to investigate the incident forms, to encourage the development of those involved in the incidents and to recognise systemic patterns where the organisation needed to change and learn from those mistakes. She talked about conducting a root analysis which took into account the context of the mistake as well as those involved in it. Steph talked about using an Incident Decision Tree to analyse the incidents; a kind of algorithm. All of the risk assessment managers worked across all of the professional disciplines. Whilst on the surface this seemed like a way of working based on systemic thinking, it struck me that “It is assumed that ordering the mess will solve the problem” as Weil (1999 p.177) argued.

Laura noticed on interviewing nurses in relation to the incident forms, that they would fall into two camps, those who owned up and admitted their mistakes straight away and those who “froze like rabbits caught in the headlights” and who would “want me to sort it out for them rather than take
responsibility for their own actions and admit they had made a mistake”. This was different from most professional groups she dealt with. We wondered whether the nurses who were more willing to own up to mistakes were more confident in their abilities to nurse effectively and whether it was part of reflecting-in-action.

Laura sometimes felt squashed by what she saw as a political act in the way information was used by some of the more senior managers to block her requests for systemic change. She suspected this had more to do with keeping the books balanced than always embracing the necessary changes. She told me that senior staff would ask for more information from her which she felt was actually “a stalling tactic, because you know we have no money”. She implied it was code for “not a high priority”. She was concerned about the impact of freezing certain posts that could lead to mistakes being made at the clinical level. Laura was passionate about making a difference to practice and recognised the

![drip, drip effect of change is what makes a difference, not always the major changes, you just have to keep plugging away.](https://www.example.com/drip-effect)

She used a roll of wallpaper as a poster to display the root causes of the incidents and the patterns she had identified as part of her scrutiny of the incident forms. She asked senior managers to walk round the poster and give her comments. She was relational in her practice and tried to work collaboratively which was not the impression I gained from all of the risk assessment managers I interviewed. After the interview I noted in my diary:

I’ve come away feeling energised! But I’m left with a tension between finance and humanity or as Fletcher (1999) would call it relational practice and balancing the books. If the culture in the Trust at the moment is all down to targets and money then this must indirectly or directly devalue the staff?
She talked about the freeze on posts and the real pressures that staff are working under which can contribute to mistakes happening. Yet I realise it is not so simple as to blame the managers for the financial constraints and reduced posts. I’m also struck by how determined and reflective she was, questioning herself in her role. How she role models, works with people, doesn’t jump to blame them but how much it bugged her that many nurses wouldn’t accept the responsibility for their mistakes which seemed different from other professions she dealt with. What is that about? One of the claims for reflective practice is empowerment but I’m finding it’s not as simple as that! Empowerment in the NHS is a complex issue!

Diary Extract 9/6/05

**Reflecting to Order?**

The picture above was chosen by Jon in our first co-inquiry meeting because she sometimes felt like an elephant getting onto the bus; she just didn’t fit many of the expectations asked of her in practice. For me this picture has come to symbolise the difficulties of using power within a large organisation like the NHS. When I was busy giving care I found it difficult to think wider about the organisation, my head was stuck inside the clinical aspects of care-giving like the elephant’s head is in the bus!
In my role as action researcher I was determined to influence an effective change. I wanted my research to really make a difference. So when I was asked by Jon a modern matron from the co-inquiry group, to attend her hospital modern matron’s meeting on 1st March 06 where the focus would be to produce a tool that would link reflecting with the Trust’s quality processes, I jumped at the opportunity to influence practice.

The meeting included several matrons from one Directorate within the Trust and two Training Officers from the Staff Development Leadership and Management Training department who were not clinically based but worked across the Trust, having previously held nursing posts. The modern matrons had identified a problem in their areas whereby staff making clinical errors especially drug errors, were not necessarily learning from those mistakes. It was difficult to track how the individual’s practice had improved. So they wanted to produce a reflective model of their own which could be used by the person making the error and which would incorporate some evidence of practice development while at the same time provide information for the Trust about risk management. It was hoped to produce a carbonated form that could be used across the whole Trust and which the individual would keep in their portfolio. Furthermore, some parts could be kept in work files or checked for patterns across the Trust by the risk assessment team. The group decided to keep anonymous the parts that would be sent to the risk assessment team so that confidentiality was maintained.

I was asked to present various reflective models and I talked through the pros and cons of each of them in relation to developing staff49. I argued there was no perfect model and talked about each of the models strengths and weaknesses in promoting and directing learning from experience. I suggested key questions to include on this new form. In particular, all the models focused on the individual and there was very little about the

context in which the person may be working, reflecting the dynamic nature of clinical settings, such as patient needs, staff shortages due to sickness etc. It was also important to include questions which would relate to potential organisational learning and not just focus on individualised learning. This would hopefully encourage patterns to be seen across the organisation allowing for a systemic response by the organisation. The modern matrons felt pleased they were creating their own model of reflection.

Jon suggested producing some guidelines to go along with the model with explanations relating to its purpose, where these new forms would be stored, who would have access to them and how long these reflections would be held on the person’s file. Initially the group felt the form should be constructed with small boxes to be completed for each of the questions posed but I convinced them this would limit potential learning by pre-determining the expected length of response. As the conversation moved on, later I suggested perhaps an action plan, which could focus on personal development and be linked with the competencies and personal development plans of the KSF (Knowledge, Skills Framework, DH 2004a). This recent government policy directive across all Trusts in England and Wales was currently pre-occupying many of the senior staff as they were expected to operationalise this policy with little clear cut direction.

By the end of the meeting it was agreed that one of the modern matrons would continue working on the form and would stay in email communication with myself, as advisor before sending the draft out to the rest of the group for comments. (See appendix 8 for draft reflective model produced).
heard me when I said about the importance of naming the feelings which can get in the way of learning such as fear, anxiety, anger, guilt, and confusion and, how they need to help the person filling in the form let go or reframe the emotions before they could learn from the experience. Nor that they need to work with the person doing the reflecting in a non-threatening and appreciative way. I wonder how this will be implemented. How will it be received by the practitioners, will it be another stick to beat them with? I so hope not. I do actually feel positive about their intentions in designing this piece of work, but time will tell!

Diary Entry 1/3/06 following meeting

Eventually, after several emails sent on my part, I was asked to make some amendments and to provide references. As I had predicted no acknowledgement of my input was evident. Although I tried to make contact with the modern matron who had taken the lead on producing the form I was never contacted again. There was no follow up conversation although I had suggested that the form should be evaluated and piloted before sending out to all the wards. I received no feedback on how the form had been received or evaluated or whether in fact it was being used at all. I was left feeling staff were going to be ordered to reflect - another directive.

Now reflecting on this experience with some distance of time I can see that the issue was not that I wanted recognition for myself or that I felt undervalued for my contribution rather it was how my knowledge seemed to be extracted as a short-cut and quick fix solution enabling the modern matron leading the project to do less work and no literature searching. The lack of communication was devaluing and interestingly similar to how little feedback nurses’ on the wards told me they received from managers when incident forms were completed. Was this another parallel process? I wonder about implementing this new model without the depth of understanding of the support staff will need to encourage them to reflect. I
imagine staff will feel personally attacked and this will kill the potential learning. Is lip service being given to the reflections by this process so that staff may subconsciously be picking up “going through the motions” without any real passion for the reflective processes themselves? Staff must *Reflect To Order* or is it really ‘BY ORDER’? No wonder there would be a reluctance to share your private world especially with someone you didn’t trust. Interestingly the NHS organisations are called Trusts and how ironic this is given the little trust I have observed whilst in practice or in meetings with senior staff.

Over and over again staff felt unsupported by their managers, by not paying attention to the emotions experienced by staff I believe nurses will continue to feel used, unsupported and devalued. But why would I want to share my vulnerability with others and expose my lack of knowledge if I feel this is going to be used against me in the future? This is potentially likely to be more so when all nurses are reviewed against the Knowledge and Skills Framework competencies (DH 2004a). Of course staff mistrust reflective practice; reflecting to order, whose interests is it serving?

*Developing Political and Systemic Resilience: It’s a Waiting Game*

In the poem *Just a Pair of Hands*50 I tried to capture the disempowerment and anger at being regarded as just a pair of hands and later I will show how this also translates into not being taken seriously when the organisation could learn from nurses’ reflections. Bradbury-Jones et al (2007) noted students were often regarded as a “pair of hands” and they linked this to disempowerment in the ward whereby learning opportunities were therefore lost. Nevertheless, this inquiry identified several structures available to staff which could be used to facilitate reflection and thus

50 See list of poems for the page of this poem
learning. These were: handover, case reviews, incident de-briefing, staff meetings, teaching sessions, individual developmental performance reviews (IDPR) also called appraisals, action learning sets, and finally some senior staff had informal supervision arrangements although this appeared not to be widespread but was mostly for Band 7’s and above. Alice felt her yearly IDPR:

Alice felt her yearly IDPR:

Feels like it is a regular space where you can reflect and identify what you want to do in the next year. I guess it’s always about how that’s facilitated really, sometimes those are really, really good and others say there is less room for feelings and more about what we need to do for the organisation. So I guess the structures are only as good as the people that facilitate them really. (Final interview 1/12/06)

I will come back to the issue of how reflection is facilitated in chapter 8. Because the Trust was introducing a new appraisal scheme I asked Nina about her role and the impact of the policy Agenda for Change (DH 2004b) on it. She was responsible for implementing this change in her Division which required the Trust to evaluate all the staff’s baseline level of competence in order to create a strategic plan of future training and development needs. As part of this process each staff member required an individual action plan that would form the basis of their appraisal or IDPR. Staff were encouraged to work towards the next banding competency. Nina had originated the idea for her role and had put forward a business plan for it that focused on developing inter-professional education across her division. However, it had taken well over a year to get this post agreed and the effort drained her energy. Now she was working on creating a database that would “flag up 8 weeks before an appraisal was due” so that staff could be re-appraised before their increment date. They would be sent a pack encouraging reflection on their role and performance. Her aim in creating this database would ensure accurate records and enable equal training, support and development opportunities for all staff.
We discussed how this process would impact on reflecting-in-action and possibly the culture in her area. Nina was convinced this would place greater responsibility on nurses who wanted to progress to demonstrate the higher competencies. She felt many nurses concentrated their learning around clinical skills and saw learning primarily taking place away from the bedside while skills such as communication and patient management were often undervalued or ignored by the nurses.

Nina also found perseverance and resilience were needed including a sense of when to “time suggestions for change” in her organisation. Her experiences of change always seemed even slower than she might anticipate, frustrating her. She felt she had to keep referring issues upwards because the suggested change seemed stalled somewhere in the organisation. I had just asked how she decided, based on her reflections, if there might be an organisational issue requiring her to instigate a change through the organisation. She told me the following story.

Nina noticed when she began her education role that the Trust had lots of different training departments providing the nursing staff with mandatory training and specialised clinical skills updates. There was a training department for Health and Safety which worked totally on its own, a Medical Directorate Department, the Professional Development Department and all the different Departments that did their own clinical training courses that nurses might need to access depending on the individual’s clinical subject need. Consequently there were at least three main training managers all working in isolation unaware of the training provided by each other. A further complication was that Registered Nurses needed yearly mandatory training updates as stipulated by the Nursing, Midwifery Council. Nina gave an example of a band 5 nurse (the lowest grade of staff nurse) and formulated a list of all the clinical skills she would need to look after the clients on her ward. She worked out the total time spent on training and all the courses that they’d need to do, such as:
perceptorship, a course for mentoring students requiring yearly updates as part of a four year cycle, the NVQ (National Vocational Training) for assessing unqualified staff such as health care assistants and any updates associated with the different aspects of the job. She worked out the time spent in actual hours on these courses including how much study a person would need initially for that role, and how many hours would be spent on yearly updates. The total time was phenomenal and most of the problem centred on an hourly session here, a two and half hour session there, not to mention the overlap of content. Staff were not attending because as I had found earlier they were working clinically and could not be released. Therefore they would miss sessions and so the learning targets were not being met. She realised nobody had the bigger picture of exactly how much time nurses were expected to spend on training every year. She took this problem to her clinical supervision session and was encouraged to create a plan of all the training needs and work out staff replacement costs, then book appointments with all the senior training managers to discuss it. She sent the plan including staff replacement costs to the Director of Nursing but she heard nothing. She wasn’t even contacted to discuss the problem. As Nina described it:

There were obviously cost implications because the ward would have to have replacement costs for their release and it just wasn’t physically possible, in my opinion. So I met the Training Manager and it was like oh, well we work kind of like this and we work kind of like this and it’s just a requirement. So I sent it to the Director of Nursing, as well as every other Training Manager I could think of. But nothing ever happened.

Clare: How long ago was that?

Nina: Oh, must be when I first started my education role, so it must be three or four years ago. And its only now, that they’ve decided that some of the two and half hour sessions will be incorporated with other two and half hour sessions and hour sessions to make it a full day. (Interview 25/4/06)

In Nina’s story there is a systemic issue relating to the cost and time implications of fragmented mandatory training whilst at the same time
exposing the imaginary boundaries associated with different roles in the organisation. An unintended consequence of this story I believe contributes to the habitus whereby learning and empowerment is undervalued in the ward. The conflicting demands placed on staff means they are like elastic bands pulled in multiple directions creating a tension in the field. Clearly, the replacement costs for the release of staff may not be forthcoming. Even though there is clear economic capital in using Nina’s suggestions the organisation is unwilling to learn from her. Staff are still expected to attend sessions at times which may be inconvenient and when they are not easily replaced. Staff could be berated if they fail to meet the attendance targets; thus they are caught in a double bind. Nina showed in this story her ability to assess and work systemically within the organisation. Yet she has little power to influence the organisation and thus limited social and political capital. Further I suggest this is evidence of symbolic violence by thoughtlessly rejecting her ideas potentially encouraging resentment and resignation and perpetuating the status quo. Thus, the Us and Them fields are maintained. Nina can see the whole picture and the “silos in the system” that are not interconnected but work against each other (Weil 1999, 1998). Because of her lack of status, Nina felt senior staff were not receptive to suggestions from “too junior” a member of staff and consequently organisational learning was lost.

Jane, a co-inquirer had also noticed the waiting game in relation to initiating or asking for changes from her senior managers. She told me how she had to keep going with issues; what I have called political resilience, because change would always take longer than anticipated. She had to make the system and policies work for her even for small changes. She described developing her ability to network in and outside her organisation and now could “see the wider picture”. She would use Trust policies to help support the changes she felt were necessary and she called this “using political awareness”. For example, she would use health and safety and clinical governance policies and said she was more
tenacious in following through with issues of importance for her staff and patients.

Jane told a story of how two nurses needed name badges that cost approximately £5-8 each. She emailed the director (the boss above her boss) to ask for replacement badges but he contended there was insufficient funds to cover their cost! So Jane emailed again arguing through clinical governance patients had the right to know who was looking after them. She suggested the lack of badges reduced their ability to provide a quality customer service but again this argument was rejected. The reply was still not enough funds. The irony is that it will have cost the organisation more because of the extra time spent on trying to get the badges than issuing them in the first place! Now she intends to try another angle through the uniform policy which says name badges must be worn at all times:

So when that comes out I shall just put in another chitty for it and say: “Well what are you going to do about it?” (Final interview 9/2/06)

Jane could not believe how literal the emphasis on cost-savings had become. To her it seemed silly while demonstrating how frequently systems create unintended consequences and unanticipated problems (Midgley 2000, Weil 1998). I suggest both stories show the unwillingness to learn from those working in the systems. It shows how policies often contradict each other and systemic working is about recognising these “tensions of difference” (Weil 1999, 1998). Unless nurses are encouraged and listened to when they spot disabling working patterns I suggest they will continue to have mistrust in their management and working systems and continue to feel disempowered. Nurses are discouraged from initiating changes because these changes involve such a long waiting game. Given the habitus of the busy syndrome nurses, I suggest, will be more likely to give up and just accept the systems they are working in. Thus reflecting-in-action without a sense of emotional, political and systemic resilience is
unlikely to encourage political or systemic agency. Consequently, the potential learning and benefits from the reflection may be lost to the organisation.

**Conclusion**

This chapter used Bourdieu’s concepts alongside a systemic inquiry perspective. It has suggested that reflecting-in-action can develop nurses’ systemic awareness, an aspect of clinical governance that is associated with quality practice (DH 2004b). However, it has shown how hierarchical attitudes and imagined boundaries pertaining to roles still work against more junior nurses in allowing them to initiate and influence systemic or even little changes in their practice as a consequence of reflecting. This produces a tension, requiring energy and I would argue emotional, political and systemic resilience is necessary in order to persevere with the changes. Slow responsiveness and a possible lack of will to see the interconnected patterns or unintended consequences of systems means a *waiting game* ensues where junior staff can become frustrated, angry and disillusioned. I have suggested that because communication often is lacking from managers in relation to form filling this also devalues the process and encourages a habitus of mistrust and passivity with the process. This in turn can encourage a field of *Us and Them* in which ward nurses may feel *Done To*. Thus organisational learning as well as individual learning is not fostered.

I have suggested it is possible for nurses to feel both *isolated* and a *need to fit into the team* as a consequence of requiring approval. Weil (1999) would recognise this as a multiple reality and a tension of difference associated with a complex system. I have shown that some managers try ordering the mess and complexity in the NHS rather than working with it. Consequently there is a move to force nurses to reflect which I have called
reflecting to order. This I believe will prove to be counter-productive and will not meet the intentions of managers but will further add to the habitus of nurses feeling unsupported by them. This is a complex process which paradoxically will feed nurses lack of will to take responsibility for making mistakes. However, I believe managers also fail to see their part in this game. The tension between the human relational managerial functions versus the financial aspects creates a binary polarisation which is unhelpful for nurses at the bedside involved in direct care and is counterproductive for their managers creating further whinging possibilities in the ward while increasing the likelihood of an emotional orgy in the team.

Furthermore organisational learning as a top down approach and not a mutual process has been exposed. For collaborative working a dialectic relationship where the organisation learns from the group and individual and the individual and group learns from the organisation seems missing in the stories told in this chapter. Yet the rhetoric is that organisational learning is developed through reflection and critical incident forms while a fair blame culture, as Steph (a risk assessment manager) described it, is purported. Even in seizing their political power nurses in the lower grades are often not taken seriously confirming their lack of political, social and cultural capital and thus power. No wonder reflection is seen as a waste of time.

Linking sustained change to role modelling, challenging skills, consideration of the need for change and the reflective process, points to the embodied nature of reflexivity which will be explored further in the next chapter. Hence, I focus on how embodying reflexivity in the ward is more than just asking questions, more than just emotional resilience, political and systemic agency or even conflict management, it is more than just talking; it is more than just a good gossip.
Chapter 7: Embodying Reflexivity: Developing a Culture of Relational Inquiry

“Censor the body and you censor breath and speech at the same time. Write yourself. Your body must be heard.”
Helene Cixous (1975) "The Laugh of the Medusa"

I argued earlier that the literature is confusing in regard to the conceptual meanings of praxis, reflection-in-action and reflexivity. I see these concepts as describing a similar process. Here I use the term *embodying reflexivity* where previously I have used reflecting-in-action. In using this change of language, I hope to signify my changed understanding that captures the body in the moment of nursing and also Bourdieu’s notions of habitus and field, the symbolic, social and cultural capitals, the historical influences and wider fields of power, that I now see are part of reflecting-in-action.

*Embodying reflexivity* involves different ways of knowing practice; some of which are unconscious, intuitive, deliberate, imaginative, individual and relational. In trying to capture this process on the page, it has proved elusive and difficult to work with. I have found I wanted to pin the concept down providing a definition that brings the findings together nicely in a box. However, the reality of embodying reflexivity because it is from and in the body is messy, complex, dynamic and time dependant so it does not lend itself to be easily written about. I suggest in this chapter embodying reflexivity uses the context and process of practice as a form of relational inquiry which hinges on knowing one’s body in the moment of practice.

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51 See chapter 2 for definitions. For example, in the research literature it is common to find reflexivity while in professional practice the literature tends to focus on reflection-in-action and in critical pedagogy, feminism and philosophy praxis can often be found.
Furthermore it is the relational aspect of reflecting which makes the process dynamic.

Bourdieu (1990 p.73) argued: “What is learned by the body is not something one has, like knowledge that can be brandished, but something that one is” and is shaped by the interplay between the field and habitus of practice. While de Beauvoir (1973) suggested the body was “a situation” endowed with cultural meanings. I will show embodied reflexivity can become an established aspect of a nurse’s habitus and thus part of the nursing field.

Previously, when considering the art of poetry I suggested through performance it is possible to shed new light on one’s practice. Similarly, Schon (1983 p.130) described reflection-in-action as an “artistic performance” responding to the complexity of the experience “in what seems like a simple, spontaneous way”. Here I suggest by considering nursing as a performance we may become aware and question the complexity involved in nursing practice and the systems and politics underpinning it. Consequently, I present embodying reflexivity as a process that tunes into this while noticing our emotions, behaviours, physicality, spatial awareness and thinking in the context of caring for others.

Knowing our whole body is not just an understanding of our emotions or sense of agency or political actions but is dialectic with the context, and those we work with. Marion Milner writing about diary keeping in the 1930s, described two ways of looking at oneself: a narrow focus which she saw as a blinkered view “with the centre of awareness in my head” representing the “way of reason” and a wide focus “which meant knowing with my whole body, a way of looking which quite altered my perception of what I saw” (Milner 1986, p.15). Consequently, I argue embodying reflexivity is a process of situated social learning and inquiry enhancing compassionate and collaborative practice, notwithstanding the historical,
cultural and systemic tensions already discussed. Schon (ibid) partially questioned the constraints to be found in organisations, their social construction and impact on reflecting but he didn’t overtly acknowledge emotions, the body or use of space in his theory of reflection-in-action or how these influence our thinking and actions and the field in which we work.

Nurses work with bodies in intimate ways. Although predominately in adult nursing the focus is on the patient’s body rather than the nurse’s body while bodies are for the most part ignored or censored in the classroom. hooks (1994) argued the predominance of rational thought and lack of recognition of the body in the classroom was due to power differentials and a gendering of education. She proposed “the person who is more powerful has the privilege of denying their body” (ibid p. 137) and yet paradoxically, we refer to the body of knowledge as though this has a life of its own. I see embodying reflexivity as similar to the skill of immediacy (Egan 1994) which promotes an awareness of parallel processes and noticing feelings in the moment of counselling practice to encourage explicit communication. By implication this allows us to recognise possible ratchet feelings\(^{52}\) and games reinforced and embodied in the field. Finally, as I argued earlier\(^{53}\) recognition of these processes and of transference and counter-transference may be possible because through this bodily awareness the impact of one’s self on others may be achieved. Hence, a partial understanding of our multiple selves in context: ‘what is my stuff and what is your stuff’ is attainable. I suggest embodying reflexivity helps nurses to look after themselves while also effectively caring for patients. As the Cixous (1975) quote above suggests, censoring the body censors voice, living and responding with full awareness. Usually we focus on a linear continuum between the opposing dichotomies of the mind and body rather than process, performance, context and bodily awareness and

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\(^{52}\) That is: ‘permitted’ feelings learnt in childhood that are re-experienced in stressful situations and may be maladaptive to the current situation but which may serve to hide the “unpermitted” authentic emotions.

\(^{53}\) See chapter 3 and 4 for a fuller description of these concepts
understanding. Consequently, I propose there is a paradox here, that while nurses work intimately with patients’ bodies they deny their own. As I have shown earlier nurses do not always take a toilet or lunch break, thus denying their own bodily needs, by putting others needs above their own.

Emotions are expressed in and from the body. First, this chapter explores the place of angry feelings in the ward (our 5th action-reflection cycle) and its relation to reflecting. I highlight through a powerful story of sexual harassment how anger is not always channelled effectively and how difficult it can be in the moment of practice to notice what one is feeling. I suggest not noticing the parallel processes can leave nurses feeling tired, exhausted and powerless. Nevertheless, in the co-inquiry group, we sometimes used anger constructively to help us “rise above the wailing wall” as represented on our storyboard. Getting angry encouraged us to notice our sense of agency and practice values becoming a signpost for change. Second, the chapter addresses pragmatic aspects of embodied reflexivity through Careful Talk, that is: through Pausing and Posing Questions and Naming Emotions and Difficult Issues in the moment. I tentatively propose challenging others weak performance is difficult for women due to gendered stereotyping and systemic changes such as staff shortages. I link this to Gilligan’s (1982) ethic of care. Finally, the chapter proposes using our vulnerability as strength to encourage empathy and relational inquiry with others as a counterpoint to the drama triangle game and the victimhood or martyrdom culture discussed earlier.
Rising above the Wall: Getting Angry as a Signpost for Change

Imaginative Practice

Being bold
Not always doing
Just what you are told

Listening
With warmth
Unlike the professional scold

Compassionate
Co-feeling
That leads to sharing the load

Questioning
And stepping
Out of the restricting mould

Challenging
And discovering
The hidden pot of gold

Courageous
So carrying
Just what you can hold

Being bold
Allowing your
Life to reflexively unfold

Clare Hopkinson 19/5/05

The poem and image of Mary Poppins (from the storyboard) show the co-inquiry’s interpretation of reflecting during care giving. The qualities and skills cited in the poem are taken out of a context highlighting the tension of portraying reflection as just a series of skills. Alice, a clinical psychologist, viewed Mary Poppins as a hopeful, creative and reflexive
figure, able to rise above the day to day hassles of work. We juxtaposed her with the man with his head in his hands hiding behind the wall, to show the invisibility and powerlessness embodied in practice by some nurses. So Mary Poppins represents the possibility of rising above this feeling through reflecting in the midst of action. It is interesting to compare her open umbrella with Sarah Gamp’s closed one\textsuperscript{54}. I see this as representing the openness and honesty required for reflexivity (Parker 1997, Dewey 1938) while the umbrella also has the capacity to shield the nurse, thereby providing some protection.

**All in a Day’s Work**

He touches her breast  
Chirpy, swallow, she isn’t sure  
His black eyes undress her  
She becomes a dead bird

He grabs her bum  
Easy prey swooped upon.  
Now she’s sure, imagine  
How can she nurse him as before?

It’s only a bit of fun. Fair game  
Part of the job  
Shower, scrub, soap away confidence  
Down  
the  
drain

Clare Hopkinson, 1/4/06

This poem draws attention to nurses’ working with challenging clients and focuses on an experience of sexual abuse. I wrote it after Jenny shared her story during a work-based learning session at the university. She had worked with a male patient for a few days when he started making lewd suggestions as banter and then when she was working close by progressed to touching her body with sexual intent. Jenny was on her last placement; she was a mature woman with children. Instinctively she wanted to smack his hands away but the nursing code of conduct (2008)

\textsuperscript{54} In chapter 4 see page 132
does not permit this kind of action. She couldn’t remember what she said to him but felt constrained to remain professional. He did not have a disease process causing this sexual abuse so she reported the incidents to the senior staff. The charge nurse just laughed and said she was a good looking woman what did she expect; “just tell him to stop”. So she tried but this seemed to make matters worse. She found herself reluctant to go into the bay whenever he was there. Finally, she spoke to a female staff nurse who went marching off immediately with Jenny left trailing in her wake. In a loud voice in front of the whole bay of men she shouted “if you ever do anything like that again I will call the police and have you forcibly removed from this ward”. Jenny, inexplicably found herself feeling guilty and ashamed after this outburst. She was sent to work in the ladies’ bay and had no further contact with the patient. This incident was not discussed again by any of the staff. Jenny felt silenced.

In class she realised she felt powerless and angry because she hadn’t dealt with this incident herself. She felt let down by both staff responses and questioned was there a better way of dealing with this? I suggested she might be experiencing a parallel process that is, experiencing the same emotional response as the patient (feeling guilty and ashamed) and as her colleague (feeling angry). She felt angry with herself for not controlling the situation and angry with the charge nurse for not supporting her more effectively. Had she been able to notice her emotions at the time and had an understanding of transference and counter-transference I suggest she would have had more information to increase her choice of actions. She could have named how angry and abused she felt and said this directly to the patient. It could have enabled her to manage the situation more effectively by directly confronting his poor behaviour in a way that was assertive rather than passive and not aggressively as the Staff Nurse had done. What Jenny learnt was to ignore her body; losing confidence through such an assault. She did not notice her strong feelings of guilt, anger and resentment at work; this surfaced in the classroom. She noticed keeping busy helped her but she felt permanently tired and lacking
in confidence. By challenging his behaviour clearly and directly she might have let go of the tiredness, some of the powerful emotions and the impact of this abuse.

So far, many of the stories in this thesis have been multilayered. Several have focused on my own and nurses’ frustrations, resentments and anger at systemic problems (the macro level) others focus on dysfunctional relationships (the micro level) and the personal cost for the nurse. Jenny’s story shows all three processes and typifies how some nursing experiences can leave their mark. Consequently, there is the likelihood of a build up of angry feelings and a sense of powerlessness at both the system represented by the staff in charge of the ward and herself for her own inactions. I suggest left unresolved strong emotions such as anger, frustration and resentment are carried in the system and the nurse’s body leading to tiredness, cynicism, a lack of trust and disengagement. The wider field of practice shown in this story denies the emotional impact on Jenny, the Staff Nurse and the patient. My argument is that in noticing our emotions and their bodily impact during care-giving we can channel that information into being reflexive leading to changed action.

I now move on to explore our co-inquiry relating to anger and reflection which was our fifth action cycle connecting our shared stories (9/6/05) and was represented by the image overleaf. For a month we noticed when we became angry and what happened as a consequence. I also analysed my diaries looking for entries that focused on feeling angry at work. As Jenny’s story showed, I found plenty of anger present in the ward that was not openly acknowledged. It seemed to reduce the possibilities for learning and reflecting; instead it promoted whinging and sometimes an emotional orgy. As Powell (1989 p.829) found in her observational study of reflection-in-action, practising nurses failed to extrapolate learning opportunities in the ward. Twenty years later, with more educated nurses than ever before, why was this still the case?
At the bottom of the power station in the image above, we placed a clip from a TV soap saying ‘the game’s up’. I was perplexed by this for a long time recognising it had some deeper meaning for this inquiry. Eventually, Alice and I linked it to the drama triangle. I have suggested unconscious games are played out in the nursing field, whereby roles of persecutor, victim and rescuer are dynamically switched, as a form of implicit communication (Karpman 1968). This I argued served to keep nurses feeling powerless and victims. In Jenny’s experience everyone was left feeling “hard done by” suggesting another example of the drama triangle game. In the co-inquiry group through reflecting, we saw ourselves as vulnerable rather than a victim, as responsible instead of rescuing others, and we had a sense of our own power and influence rather than persecuting others. We worked collaboratively and could admit to not knowing all the answers when we practised. We saw this as a possible alternative to the drama triangle game (Hay 2007, Choy 1990) and a way

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55 See chapter 4
of caring for ourselves, our colleagues and patients thus *Treating People Well*.

We proposed rather than becoming overwhelmed and consumed by anger, it was possible to channel it as a way of using our power within the organisation: *If I don’t like this, what can I do to change it?* This gave us a sense of responsibility to rise above a situation like Mary Poppins liberating our “*stuckness*” with the system as Alice described it and providing the fuel for action. However, we did not envisage its use as exemplified in Jenny’s story but by naming the issues with others in an assertive way, a dialogue and inquiry could be cultivated in order to dissipate the emotions whilst also meeting our own needs.

My diary entries often referred to feeling angry, cross or frustrated in the ward. I learnt anger can be stimulated by unpredictability, not feeling in control and the uncertainty in situations. Patients and relatives could be angry about their illness or prognosis and the uncertainty of their futures. I noticed I felt resentment and anger towards my colleagues. Now I see this as an aspect of the habitus of the field; a safer and more acceptable process than directing such feelings towards patients. As the diary quote below shows I linked being angry to not feeling trusted and this happened when I felt personally criticised or attacked by other nurses. (*Are you an Approval Slave?*). I notice here the temptation to reduce the emotion to the more acceptable one of frustration. Women are not expected to get angry. In the Whinging Wilma piece I was reluctant to feedback to others the consequences and impact of their actions therefore I would whinge. Perhaps this could explain why getting angry is not openly acknowledged in the ward; it is channelled into whinging.

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**Why was I so angry on Friday? I was with the registrar who was putting a scope down Mabel’s nose to check her chords**

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*56 This is a Trust's motto and strategy document. It refers to effective communication with patients.*
when the staff nurse who I imagine was pretty anxious to get all the jobs done on time took out the nasal packs from one of my patients. Did she think she was helping me? But I wanted the experience of doing that because I haven’t done it before. Students say in work-based learning sessions that this happens to them all the time. Did I feel angry because I felt she didn’t trust me to do a good enough job?

Diary Extract 4/4/05

The exploration and expression of anger in organisations seems underexplored in organisational theory (Sims 2005, Brescoll & Uhlmann 2008). Rather, the tendency is to focus on a psychodynamic analysis of anxiety, shame and fear based on the individual (Fineman 2000, Sims et al 1993, Gabriel 2008, 1999, Hoggett 1992, Menzies-Lyth 1970, Orbach 1999). While conflict resolution and coping with conflict and change tends to focus on emotional resistances in self or groups and how these can be overcome (Meyerson 2003, Carnall 1990, Senge 1990, 1999, Morgan 1986). Fineman (2000) suggested there are regulatory codes in organisations relating to the expression of emotions. For example, as Bolton (2000 p.583) noted, “nurses must always appear kind and caring but also calm and detached”. I have shown that “quick and efficient” are dispositions nurses absorb and display in the field. So the rhetoric is of the calm, kind and caring nurse but the field does not always legitimate these dispositions; they have reduced symbolic and cultural capital. Bolton contended:

“Even though it is not an acknowledged part of the professional education programme it is made clear that to show feelings of anger, distaste or sorrow is to be unprofessional and that “one must not give in to one’s own feelings (Penson 1990 p.147)” (Bolton 2000 p.583).

Furedi (2004) proposed emotions are often pathologised as either positive or negative thus requiring management. He was critical of the cultural shift in society emphasising emotions over reason whereby people were re-cast as emotionally damaged rather than seen as stoic. I suggest we need both
reason and emotional resilience to overcome the more challenging nursing situations as demonstrated in Jenny’s story. However, it seems to me nurse education focuses mostly on reason with the mind/body dichotomy evident. As I have argued before, there is a lack of legitimacy or cultural capital given to caring functions in many wards and this can be explained through an historical expectation of stoicism to the suffering and pain nurses witness. This is probably influenced by the army and religious nursing influences. Consequently, the impact of the patient on the nurse’s feelings is negated. This doxa creates a field where nurses are required to be impervious to emotions and yet give emotional support and compassion to patients and relatives creating a double bind for them.

It is possible to see Furedi’s analysis in relation to anger which is usually regarded as a negative emotion requiring management. Brescoll and Uhlmann (2008) suggest anger in the workplace is subject to status conferral and gendering. When men expressed anger at work they were conferred a higher status and their anger was attributed to external circumstances while for women the anger was regarded as personality characteristics.

“However, professional women who express anger may experience a decrease, rather than an increase, in their status. Women are expected to be kinder and more modest than men, and they evoke negative responses from other people if they fail to conform to this prescriptive stereotype”. (Brescoll & Uhlmann 2008 p.268)

Jordon a co-inquirer and modern matron working in elderly care found getting angry could be a trigger for changing working practices and starting a dialogue with staff. She told me about becoming very angry while working on one of her wards because her staff had used a back trolley. This way of providing pressure area care hadn’t been recommended for years and was contrary to the latest practice standards and research. She surprised herself at how angry she felt and how expressing this galvanised the team into action:
So when I lost it, on the ward, I mean I didn’t shout but I know that I was demonstrating anger in my body language. I know I was because I was so angry and had to work hard to keep my voice, and tone reasonable. That went through that team like wild fire, apparently there were people calling each other at home, the Sister got phoned at home, the Senior Staff Nurse got phoned at home. So when I came to do my next bank shift the ward was immaculate.” (Final interview 20/4/06)

Here Jordon shows she is tuned into her body, its possible impact on others and is conscious of *Treating People Well* thus embodying reflexivity in the moment. She named the difficulties straight away and challenged the poor performance of her colleagues. In analysing my diary, I realised my unwillingness to challenge others was related to uncertainty – I couldn’t be sure how the other person would respond to the challenge. I didn’t want to hurt them or appear critical. I started to wonder were women more reluctant to challenge each other or was it a nursing disposition? In the co-inquiry group and conversations with students and practising nurses, this idea of not upsetting the other person through challenging was voiced time and time again. I now see this as an aspect of the field which also reflects Gilligan’s (1982) ethic of care but serves to keep nurses feeling powerless. Brescoll and Uhlmann (2008) suggest women may face a backlash in response to showing anger:

“Professional women face a dilemma: On the one hand, anger may serve as a powerful professional tool – for instance to compel other people to fulfil their responsibilities, or to castigate them for incompetence (Shields, 2002). On the other hand, to achieve and maintain a high social status, professional women may have to behave “unemotionally” so that they are seen as rational (Albright, 2003). Thus, it is important to identify strategies that professional women can use to express anger without incurring a social penalty.” (2008 p.274)

Alex described getting angry when she felt pressurised or overwhelmed with too much work. She said:
The work load at times on the ward or in the clinical area makes me a bit stressed out and in the process you can get a bit angry. So when people talk to you sometimes you snap unknowingly. It’s frustrating when everybody wants you to do three things at the same time which you know is not possible.

Alice: I think anger is something that people find very hard to express and quite often that can be a key to really opening something up. I think there’s quite a lot of trying to dampen down people’s anger.

Lois: Yes so if you find out what the anger is about, it is quite often a signpost to something that is not right…

Alice: Which is actually what reflective practice is about isn’t it?

Alex: Yes.

Alice: Whereas if you are feeling that anger isn’t all right and you can’t be angry because that’s not done, then it means you’ve less access to knowing what it is that’s going wrong or what you’re concerned about. You haven’t got the material for reflective practice because you are trying not to feel it and you are trying to fit in to the team you are working with. I think there is a lot of trying to be good isn’t there?

Clare: Say more

Alice: Like professionals, trying to be a good professional and that’s not about being angry.

Clare: So are you saying reflective practice gives you the confidence to get back in touch with your emotions?

Alice: Yes I am. (7th Co-inquiry meeting 7/7/05)

Notice here how reluctant Alex is to own feeling angry using ‘you’ rather than ‘I’; a form of disembodied talk. The emotion is distanced from herself. Alice linked the ideal of being a good professional which I have suggested originates from the Victorian ideals of ‘a good woman’ with not showing anger. She felt getting in touch with ones feelings, in particular anger, led to a consideration of the question: If I don’t like this, what can I do to
change it? Thus getting angry could be empowering and a signpost for change.

I began noticing how much talk in the ward seemed disembodied, e.g. “The Trust”, “Them”, “the admissions”, “the discharges”; the faceless and bodiless people. Originally, in this chapter I told the story of working with Mary\(^{57}\) and using the poetry in the ward showing the embodied multilayered nature of poetry. I wanted to highlight the emotions and politics evident in practice as part of the embodied dispositions of nurses. By removing this section I have potentially distanced the embodied and political dispositions from this discussion thereby mirroring what seems to happen in practice. I am not advocating that Alex should get angry with patients although this does exist, as Jenny’s story shows. Rather, I am arguing that noticing our anger can be the first stage of becoming political and having a sense of agency thereby encouraging practice changes. We seem to deny the presence of anger in the ward. Anger is easily transferred from person to person and I have suggested can be dissipated through the nursing team via projections onto others creating dysfunctional working relationships and an emotional orgy. As Tracey, a manager in a PCT noticed:

> I might have upset somebody or put something a little harshly because in the panic of the fight of getting the job done sometimes I can be a bit like that but at least I have noticed that. When I have noticed it I go back to the team and say I’m sorry, they say “oh no that’s fine” and I say “let’s take it forward step by step, this is what we need to do. OK tell me next time.” (Final interview 28/6/06)

It is a doxa that nurses don’t exhibit emotions in the ward and we need to address this more openly by naming what we are feeling in the moment of practice. Menzies-Lyth (1960, 1970) showed nursing systems were set up to avoid feeling anxiety and here I extend this by arguing it is not just anxiety but anger, sadness, uncertainty and fear that nurses also probably unconsciously want to avoid. Thus the field of nursing mostly ignores the

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\(^{57}\) See chapter 3
nurse’s body and the emotional and cultural capital involved in nursing work. The field promotes rationality, certainty and detachment whilst denying the existence of emotions. After all, emotions have no economic, social, political or cultural capital in the wider field of the NHS so why should they have for nurses?

**Careful Talk: Pausing and Posing Questions**

A common theme in the co-inquiry meetings was our willingness to share and use our experiences for the benefit of others. In the moment of practice we identified firstly: “standing back” in the most chaotic and busy environments, asking questions, and considering options. Powell (1989) and Schon (1983) referred to this aspect of reflection-in-action as “consciousness raising” while we called this considered practice. In our second co-inquiry meeting Jon coined the phrase *Pausing and Posing Questions*. Amy linked reflecting to role modelling and Jordon saw it as part of coaching. Jon noticed the intention behind the questioning was an important part of the process with others. Co-inquirers described *facilitating reflection* in relation with others. Secondly, Alex and Maria considered *passing on practical tips* was part of reflecting in the ward and this worked best by informally *sharing stories* and *using humour*.

*Pausing and posing questions* was central to all the co-inquirers’ practice and modelled a relational inquiry process while contributing to a learning culture. We realised we were less likely to become defensive about not knowing the answers. Uncertainty could promote reflecting. For example, Jordon shared her difficulties managing a Ward Sister’s performance. Jordon had written down the discussions as a reflection-on-action when she had had time to stop and think so she could pay attention to her own feelings during the process. This helped her check if she had treated the Sister well in a difficult situation while also ensuring collaborative working
by creating a dialogue. Similarly, Schon (1983) highlighted the interplay between reflection-in-action and reflection-on-action for reframing situations and developing practice choices.

Jordon used these reflections including her feelings as the starting point for the next meeting with the Sister. She noticed the Sister found it helpful to see her re-visit their discussion and actually use her reflections in this way. Jordon was role-modelling reflection, naming the issues and challenging the Sister in a supportive way. Finally, she posed herself key questions. Through this process the Sister was facilitated to reflectively inquire and learn. Jordon further reflected after the experience which is similar to how Schon envisaged reflection-in-action. He wrote: “Reflection is at least in some measure conscious, although it need not occur in the medium of words” (1987 p.28). It is a process that can occur “without being able to say what we are doing” (ibid p.31) that requires “a reflective conversation with the situation” (Schon 1983 p. 265) and “surfacing and talking about differences” (ibid p.254). We found for the most part it was a deliberate, informal and social process occurring in relation with others. This was different to the intuitive process suggested by Stockhausen (2006) below in relation to reflection and role modelling.

Stockhausen (2006) in Australia, used an ethnographic study involving participant observation to investigate how experienced nurses taught nursing to undergraduate students during clinical placements. She found experienced nurses used unnoticed and unappreciated reflection-in-action during nursing episodes where students vicariously observed the care giving. She called this process “metier artistry” a term she defined as “reflection, experience and being in the moment as it unfolds” (ibid p.58). Later she argued that metier artistry “extends the concept of role modelling” (ibid p.58) even though the nurse is unable to articulate her practice in a way that the student can make sense of. She suggested “By interrupting the event, the artistry within the moment would be lost” (ibid p.59). This study implies that student nurses learn about being a nurse
serendipitously and without clear direction or understanding of the processes involved in the care giving. Perhaps, Stockhausen (2006) was influenced by Benner’s (1984) Novice to Expert model, which suggested the art and knowledge of nursing develops with experience, becoming intuitive and taken for granted; therefore the experienced nurse is often unable to articulate her practice. However, we found embodying reflexivity involved usually a sharing and inquiring conversation.

Jordon: I am by nature a reflective person, but I didn’t really have frameworks to pin that on so it was very informal like driving home in the car. I probably didn’t recognise the importance of what I was doing. It was just something I did because of my nature. Whereas I think doing that module [reflective practice module] impressed home to me that what I was doing was valuable and that I did learn things from it. So I do change my behaviour as a result of it [reflecting]. (Final interview 20/4/06)

Noticing our values in the moment of practice and a willingness to keep learning seemed an important part of the reflecting process. All of the co-inquirers used their reflections in a more structured way by going back to staff. Jordon again gave an example:

Actually I’ve reflected on what we discussed yesterday and I think I might have to change my mind on that. Or I would want to clarify something else in a bit more detail with you which I probably wouldn’t have done before. I probably would have thought, oh I didn’t handle that very well, oh dear well I’ll know for next time. Whereas I’m more confident about saying well I’ve reflected on it and on reflection these are now my thoughts on it. (Final interview 20/4/06)

This pausing was also really important for Maria to allow her to connect with her feelings, her own personal qualities and to consider how they might impact upon her work. She highlights the importance of timing in challenging and giving feedback to others while trying to practise what she preaches. In other words through embodying reflexivity she tries to be congruent in her actions and words:
I’ve always focused more on practical things including my skills. Reflection did make me reflect more on how I felt about things, and about malpractice…. …In a way it’s made me stop, and now I don’t always say what I think straight away. I have learnt through reflection that I tend to say what I think because it’s not in my nature to hide things and to say one thing and mean something else…. So now I’ve reflected I have thought maybe I would have been better to just take it away, thought about it more and approached it in a different way. (Final interview 27/1/06)

Jordon noticed the importance of repeatedly asking staff questions not in a blaming way but in a relational inquiring and facilitative way:

I might be looking back with rose tinted spectacles but I did question staff…. I’d say to people routinely, we seem to be having a bit of a problem with that aspect of care, are we sure we’re ok with that? What is the current evidence on that? Charging people with little projects about things that I thought would improve the care. I’d say to people I don’t really know what I’m doing here, do you know? And then it would become apparent nobody knew and then we, as a team, we’d think well what are we gonna do about that? That is not happening widely anymore. (Final interview 20/4/06)

In the first co-inquiry meeting (20/1/05), Maria recalled a time when informal reflection and humour encouraged learning in her midwifery unit. A mother was about to deliver an 11.2lb baby in a birthing pool. The baby’s shoulders were stuck which required an emergency procedure that could not be carried out in the birthing pool. Meanwhile a midwife had tidied up the bed space and put the mother’s bags on the bed when the mother was in the pool. This created a problem in getting the mother back to bed in time for the delivery and was a safety risk in case resuscitation procedures needed instigating. However, because the mother had walked to the bed this seemed to ease some of the baby’s positioning difficulties. Maria shared the story informally at the nurses’ station when nurses were completing their paperwork. It could seem like gossiping but identifying and connecting with the emotions in the story was important for the staff. She felt humour relieved the tension and sharing how she felt in the moment of the panic was powerful. Jon felt the key aspect was reframing
the experience into a positive process but Maria disagreed and felt sharing how she felt in the moment carried the message through the team.

These examples show the complexity and relational nature of nursing so that understanding how we perform it becomes part of reflecting. We found a real tension in passing on practically “what works for me” through storytelling because nurses were often isolated from each other due to the environment. In England over the past 25 years the number of hospital admissions has doubled and the average length of stay has fallen by more than 20% (King’s Fund 2008) creating pressure on establishing patient-nurse relationships and patient centred care. As shown already, the predominant doxa tends to limit reflecting, thus role-modelling by senior staff does not always happen creating fewer opportunities for junior staff to ask advice, pose questions, or learn vicariously and tacitly. Given the lack of cultural capital for senior staff to be by the bedside (as already proposed due to historical embodiment) this reduces potential reflecting opportunities. We suggested there was less time for staff to get together whereas in the past, shift handover gave the opportunity for some sharing. Jordon noticed most of her wards used taped handover so the time the ward manager spent was not wasted repeating the report to part time and bank staff. This was thought to be a more efficient system and had cut out unfavourable aspects of handover such as gossiping and labelling patients, thus reducing the overlap time for nursing shifts. This tension between providing patient centred care and what constitutes efficient practice is now recognised as a dilemma in hospital healthcare (Kings Fund 2008). We realised the teaching aspect of handover was being lost along with the opportunity for nurses to ask questions and for senior staff to role model and facilitate reflection and thus learning in many nursing teams.
Careful Talk: Naming Emotions and Difficulties with Others

Beautiful Practice

How my shoulders ache
I hear the rumbling of my stomach
The heaviness of my breath
The fleeting notions of my death
And yet I am not scared
Even though I feel unprepared
Because I am hopeful too
As I experience life alongside you

Clare Hopkinson 22/06/04

Heen (2005) proposed noticing and sharing one’s feelings could shed light on important organisational issues. As I have already shown and throughout all strands of this inquiry naming issues, difficulties and feelings in the moment while working with others was considered an important part of embodying reflexivity. This acted as a counterpoint to the predominant habitus and field where nurses followed orders in an unquestioning way (an historical embodied disposition). This inquiry suggests the process of naming difficulties and emotions can sometimes result in systemic shifts at the micro and/or the macro levels in the field of practice (Weil 1998). Alice said in her interview that:

We talked in the group how people can be quite reluctant and maybe even the nursing profession particularly, of talking about vulnerability and feelings. It feels that was quite important in our process; that somehow being able to name the feelings that are going on opens up the potential for being able to move it forward somehow, I don’t quite know how that works but it does seem key. (Final interview 1/12/06)

Maria, a co-inquirer, saw naming issues directly with people as using her personal power (at the micro and macro level); what I would call assertiveness:
I remember saying to somebody, because they said oh I couldn't tell her that, and I said what do you think this person's going to do if you disagree, what are they going to do? Power is what you give somebody; to let them have power over you. (Final interview 27/1/06)

Jon, a co-inquirer and modern matron, shared a story where she talked openly with her line manager about the difficulties in their relationship. She had been fearful to tackle the issue as it felt risky and she could be labelled as not coping. Furthermore, it was unusual to challenge staff in more powerful and senior positions. This “not coping” label had been discussed in our co-inquiry meetings which we identified was part of the wider field of nursing (culture) where talking about your feelings was seen as a weakness (Gray 2009). (Don't wear your heart on your sleeve; just get on with it). Jon found it difficult to approach her boss. She found herself naming the difficulty:

I said “I do find it difficult to come to you, because you might perceive me as not coping or not good at something”. (Final interview 22/2/06)

This opened up the conversation and was also a way of showing respect for her manager. We talked about this as “Treating People Well”. Even though Jon held a senior position she still felt intimidated by strong personalities but noticed doing nothing to tackle the difficult working relationship would generate emotions that would adversely affect her:

It didn’t matter how she might treat me afterwards because I felt I needed to say it. And I would have felt worse to think I'd never tackled it. She’s never shouted me down for anything since. I know it’s about her character and I know I’ve supported her through her own vulnerability in looking at that too. (Final interview 22/2/06)

She felt liberated when she achieved a better collaborative working relationship rising above the wall, like Mary Poppins. Alex, another co-inquirer, also noticed a development in her collaborative and inquiry skills through reflecting on her practice:
Alex, a senior Staff Nurse, was more confident challenging others now. Her listening had improved; she was aware of how she approached difficult feedback and was more willing to understand others, recognising she had developed empathy with her colleagues. Alex talked about a Staff Nurse in her team who had made a drug error. Alex raised this in a team meeting but the team were able to identify the Staff Nurse who consequently felt insulted through raising this issue. By reflecting and noticing the Staff Nurse’s body and discomfort Alex realised it would have been better to meet her privately and discuss it. Then in the staff meeting she could generalise, maintaining confidentiality so that the Staff Nurse could not be identified and feel hurt and blamed. Paradoxically, gaining some distance from this incident including the emotions raised by it was important in this case. I am trying to show here the importance of context for reflection; a blanket approach to reflecting doesn’t work. It isn’t just a process of developing a set of skills. And it isn’t always appropriate to reflect with others immediately. In this context the timing of feedback and the challenge of another’s performance is required. Here I am suggesting paying attention to the physicality of the environment and when to raise issues while picking up signals from one’s own and others’ bodies makes it possible for collaboration, relational and systemic inquiry.

In contrast, Jordon who oversaw several wards as a modern matron noticed a change in the last few years where Sisters seemed unwilling to challenge any weak performance. She felt this was a direct consequence of staffing shortages and unfilled vacancies causing Sisters to feel anxious about challenging others. Jordon felt Sisters did not know how to get the balance between being supportive and challenging. This meant when staff were challenged it became ‘scarier’ and difficult to accept thereby creating
more defensiveness in staff. Frequently the process was aggressive as shown in Jenny’s story adding to the blame culture.

Snowdrops: Using Vulnerability as Strength; Developing Emotional Resilience through Embodied Reflexivity

In the last chapter I argued political resilience was an aspect of reflecting-in-action and suggested this involved gaining political acuity such as timing and learning how to work with the systems that created slow and stalled responses to change (The Waiting Game). Here I suggest emotional resilience is also a necessary part of embodied reflexivity which we called using our vulnerability as strength. Platzer et al (2000a) suggested one of the barriers to learning from reflection was that it induced feelings of vulnerability and exposure preventing nurses “from openly discussing their practice in a critical manner” (p.1003). We reframed this process seeing the vulnerability as part of our ability to inquire relationally.

Alice drew the picture above of the snowdrop pushing through a crack in a pavement in the fourth co-inquiry meeting (12/5/05) because it: “captured the fragility of life”. So while it may seem delicate it was actually a strong flower because it:" tenaciously pushed its way through the crack in the
pavement”. This image came to represent developing resilience in the workplace through reflecting; a way of looking after ourselves and a way of coping with the field of The Waiting Game. As Steph found in her risk assessment managerial role:

Keeping yourself going against the frustrations of the job is not easy. I try and keep motivated to ensure positive practice changes are carried out by others”. (Interview 22/2/06)

Alice suggested the phrase using our vulnerability as strength which meant showing our humanity when working with others; a form of Treating People Well. She acknowledged the difficulty in owning up to mistakes and linked this to defensive behaviour that ran systemically throughout the NHS:

Because there is so much power in such a small plant [the snowdrop]; it gave me some hope. I found it was possible to be vulnerable, and its ridiculous isn’t it because we are all vulnerable, we are all human beings, we are all fallible, we are all limited and yet we somehow create this illusion among ourselves that we aren’t. (Final interview 1/12/06)

Jane, a Minor Injuries Sister, recognised using her vulnerability as strength made her less defensive when work didn’t go according to her wishes. She acknowledged:

Now I’m quite happy to say “I did this, now could I have done it better? To question myself; before I would have admitted it but I don’t think I would have been voluntarily admitting, do you know what I mean? I would have been quite defensive. I still can be defensive but I know that now, so I will look at things in a different light; I will try and unravel them. I think it is really important that you allow people to say they felt vulnerable but empower them to actually use it so next time it’s done differently. Okay I may have done that that time, but I can turn that into something positive. (Final interview 9/2/06)

In the co-inquiry we regarded using our vulnerability as strength as a way of acknowledging our interdependence as nurses on patients. That is, it is a two way caring process; a dialectic relationship often unacknowledged in
the rhetoric of professionalism. I am not suggesting that patients “care for” nurses so that the relationship is fully reciprocal rather I am saying as nurses our needs are also met through our caring functions and it is easy to lose sight of this in the field of practice. When patients are ill they are possibly at their most vulnerable. I am suggesting as nurses we can look after ourselves in the toughest moments of care giving (even difficult experiences that Jenny’s story highlighted), by using our vulnerability as strength. Sellman (2005) proposed clients experienced varying degrees of vulnerability and acknowledged everyone feels vulnerable sometimes. He coined the term “ordinary vulnerability” as a response to uncertainty (ibid p3). Our co-inquiry suggested nurses also experienced vulnerability in care settings but what are we vulnerable to?

Nursing is a difficult job and we have to carry out a variety of activities that society would prefer to ignore. We slowly or suddenly watch someone we have cared for die; we lay out the dead – a body – which requires orifices packed in an un-human like way. We wipe patients’ bottoms, change night clothes covered with vomit, encourage patients to spit into sputum pots, clean strong smelling wounds, and scoop faeces into pots to send to the laboratories, to name but a few of the more unusual tasks. We see bodies of all shapes and sizes; in the shower, in the bath, on the commode, in the bed; usually at their most vulnerable moments. We interact with people living chaotic lives and those experiencing suffering and pain. Some hurl abuse at us from confused states of being and can become violent; others acquiesce almost childlike in their acceptance of the care we offer. While this can be a privilege – it can be shocking and takes some adjusting to as the poem tries to capture.
What I am saying is this exposure to seeing people in a vulnerable state must leave its toll on nurses whether we are aware of it or not. It is easier to hide behind the professionalism, including the busy syndrome, to absorb the rhetoric of not feeling and attempt to *Be Perfect*. However, I suggest we need to recognise our vulnerability in ourselves if we are to develop a therapeutic relationship with patients and their families. This means recognising we gain something from the encounter. I am not pathologising vulnerability as Furedi (2004) has argued but suggesting *vulnerability as strength* means noticing our emotional responses, having empathy with others, being assertive, and recognising our own frailty as a human being. For me, this is more complex and nuanced than simply...
having emotional intelligence or providing emotional labour as it is context specific. It also involves being more confident in not knowing all the answers, accepting the uncertainty, sharing some of ourselves as people so that a hopeful and powerful sense of self can be maintained even in emotional and difficult situations. We become a ‘godsibb’\(^{58}\) i.e. a close friend, connecting with the person and sharing something of ourselves so that patients come to know us as people they can trust and relate to.

Noticing our vulnerability is difficult in an environment that values control, order and perpetual busyness. We fail to recognise our own needs in such an environment, ignoring our bodies. Alice said:

> It seems shocking to me how can you expect a nurse who has just been bereaved to work with someone who has just died. In some way the system brutalises them so that they end up not looking after themselves. How barbaric a system is that if no one recognises or has any sensitivity to the needs of staff. What does the system do to nurses when it allows no expression of feelings? (3rd Co-inquiry meeting 14/4/05)

Emotions connect us to our bodies in ways we often ignore or fail to pay attention to. Emotions can be linked to dis-ease. What might be the impact of not noticing or connecting to emotions generated by work? The following story was told by Catherine, a surgical modern matron from Strand 3 (the action learning set).

Catherine, had been very busy involved in redeploying staff which she found exhausting and emotionally draining. She wanted to give staff the jobs they asked for but it wasn’t always possible. Some staff felt resentful and angry towards her. She wanted to compromise but needed to put the overall service above the individual needs. This left her feeling inadequate; had she made the right decision? She felt guilty if she tried to put herself in the shoes of the staff. At the same time she was involved in a difficult disciplinary case where a member of staff was dismissed. Catherine had

\(^{58}\) See chapter 5 for a fuller definition of this historical term for a gossip
to come into work on her day off to be at the hearing. She felt she was also on trial; had she completed all the processes correctly?

She knew this nurse had made a serious error and it was unsafe to keep her employed. Nevertheless, she did not like to think about the consequences for the nurse because she felt responsible for her losing her job. Intellectually Catherine knew she wasn’t responsible; she had done her job well. This was her first disciplinary process and it was a horrible experience. The nurse was dismissed as expected and Catherine mulled over whether she had done the best she could.

After the hearing, arriving home, she tried to park her car on the drive as usual. It had a brick wall on either side and she crashed the car into the wall damaging her car extensively. She sat in the car shocked and after what seemed an eternity burst uncontrollably into tears which was unusual for her. Catherine felt she could not return to work; she felt so stressed. But she had a strong work ethic and dutifully went into work the next day. She found herself staring at the email requests not being able to focus properly on what she had to do. She didn’t do her normal round on the wards because she couldn’t cope with any more problems. Instead she found herself hiding for a day or two in the office. Finally, a colleague noticed her distress and suggested she bring forward her clinical supervision session where she could reflect on the problems of work. She found herself naming her emotions in the supervision session. After just one session of being listened to and because she had talked about her distress to someone who both supported and challenged her she felt a weight had lifted; she was able to cope with the pressure of work again and went back out onto the wards. Connecting to her vulnerability allowed a shift in her emotional state.

In my own nursing practice I noticed I used my vulnerability with patients during care giving. I liked getting feedback from patients and reflecting with them but this created a tension for me because I did not want to appear
incompetent. For example, Lillian, a retired teacher and patient, told me I seemed in control, concise and commanding. This was not the picture I had of myself rather I felt dithery, compelled to check out what I was doing with the permanent staff, meek and slow most of the time. Lillian told me she could tell I had a lot of experience. I chatted to her about my past and why I was updating my nursing skills. The next day I was taking the redivac drain out of her neck. I didn’t see the stitch under the white plastic cover so I tried pulling the drain out and realised this was hurting her which it shouldn’t have done. I went to get Teresa, an experienced staff nurse, for her opinion and she hadn’t seen a drain like this before either. I suppose this made me feel a bit better nevertheless; I still, felt awkward and foolish when Lillian said “I think it’s stitched”. I hadn’t considered this so I apologised, cut the stitch and removed the drain.

Writing about this experience later made me feel better because I was able to let go of the emotion triggered by my mistake. I stopped thinking about the incident over and over again in my head and getting it out of all proportion. In processing the experience I was able to look at my communication with Lillian. She had told me to stop worrying about hurting her and I had joked that I really needed to update my nursing skills and wasn’t so in control as she had first thought. In being straight with her about the incident and not trying to cover up the mistake I think she appreciated my honesty. Now I see this as an example of using my vulnerability as strength. I did not get defensive. I did not try to justify myself although I found comfort when the staff nurse was also not sure what to do. I was still uncomfortable about the ethical component and expectation that as a nurse I was not to harm patients. I wonder now if Lillian experienced a minimising of the power relationship in this process through my admission of vulnerability.

Lois raised a useful question in her final interview (7/3/06) when we were discussing using our vulnerability as strength: could it be a smokescreen
for incompetence? In describing vulnerability as strength perhaps we are really considering incompetence?

This has challenged me to consider the notion of vulnerability as strength in more depth. In considering it detached from any context I notice how I have unwittingly polarised the ideas. Either we are vulnerable or we are incompetent but as Cixous (1975) has suggested this categorisation of ideas creates a set of hierarchical values which often hides the political, philosophical and power dimensions on which such dichotomies are founded. She argues for a dialectical relationship between such ideas. In other words I can construct my vulnerability as strength and it can also mask my competence and incompetence. I hold the capacity given the context to be both and it is the interplay between the two extremes where my learning occurs and I believe inspires reflecting during care giving. Perhaps the more dominant discourse sets invulnerability in opposition to incompetence and is a process which hides power between the professional and the patient.

I suggest vulnerability as strength is also about developing an emotional resilience to the pressures of work helping to ease the build up of emotions by naming them before situations can get out of hand. As I found through the meditation\textsuperscript{59}, using my vulnerability as strength provides a sense of being centred and connected allowing me to deal with whatever might happen. In other words, I put situations in perspective, control and work with my emotions, noticing my body’s reactions while feeling empowered to reconstruct events in a way that I can manage. It gives me choices in the moment. As Susan found\textsuperscript{60} nurses who ignore their emotional responses to working and caring for others can become hardened to the suffering and sadness they may encounter, losing touch with their humanity and empathy for others. Dealing directly with

\textsuperscript{59} See Whinging Wilma writing chapter 5
\textsuperscript{60} See chapter 5
colleagues when there is a problem helps to reduce *talking behind their back*.

I was exploring with Nina, (a sister with responsibility for education in the elderly wards), my ideas about the *emotional orgy* occurring in nursing teams. She said this had happened in her team particularly when the ward became larger (increasing from 17 beds to 27). Consequently, the ward required more staff, mainly recruited from overseas who needed extra training and support. The workload was heavy and demanding. Morale became low and there was a sudden exodus of staff compounding the negativity. She found the *back-biting* got worse so that staff were set against each other. The ward manager became aware of the problem but couldn't identify who was responsible. Most of this back biting was indirect and staff felt they had to *watch their backs* so as not to be the next target. The Sister challenged the staff at a ward meeting telling them in-fighting wasn't good for anyone. She noticed it was interfering with the team-working and support for each other. This helped change the atmosphere somewhat. Nevertheless, it took a long time for the *back-biting* to stop. The staff needed to be challenged from time to time to finally interrupt the process. It is evident from this story that continued naming of problems may be needed over a period of time. Part of the skill in supportively challenging others then hinges on learning to become resilient to the emotions provoked by such a process. In other words it requires learning to cope with the *Waiting Game*.

I argue developing resilience to work pressures and becoming “*emotionally stronger*” as Tracey called it is also an aspect of embodied reflexivity during care giving. Tracey from our co-inquiry group and now a general manager for a PCT (Primary Care Trust) had often worked with staff who she considered were “hard” and unable to recognise their faults. She said:
They don’t see that they have got any problems; it’s always somebody else’s fault. They allow repetitive behaviour and repetitive mistakes without picking it up and I would hope that I am reflective enough to stop that happening…. I am a different person than I was 18 months ago, isn’t that funny and so much stronger.

Clare: *In what sense stronger?*

Tracey: *Emotionally stronger I think. I could have been kicked down quite easily in my previous post and I think that was because I felt isolated there…it was a big remit….I think that isolation made me feel quite, vulnerable. Am I doing the right thing? Nobody ever fed back to me, nobody said you are doing a good job, not until I was leaving and then of course it was too late.* (Final interview 28/6/06).

Tracey linked isolation and not feeling appreciated to her uncertainty about her own performance which she found generated further emotions. Recognising this she now praises her staff and thanks them when they have gone the extra mile. *Treating her staff well* reduced the *watch your back* habitus as staff were more willing to talk directly to her creating an effective collaborative and collegiate working team. We found throughout this inquiry the informality of “chit-chat” was important for collaborative working. It was different to whinging because the talking was careful, and face to face.

**Conclusion**

The process of embodying reflexivity is complex, nuanced and purposive involving not only an understanding of our ‘multiple selves’ in the messy context of practice but also our relationships and interactions with others and our performance as a nurse. This chapter has sought to show the importance of embodied reflexivity for nurses’ learning in practice and has argued this hinges on noticing and not denying our bodies at work. Embodying reflexivity is more about spontaneous acting in the moment involving a variety of ways of knowing that are creative and imaginative. It
is not necessarily about thinking per se but afterwards articulation of what we have been doing and why is possible. Embodied implies a set of dispositions tacitly understood. I have argued this involves reason and emotional awareness; the ‘and/both’ of mind and body not a mind and body split. We bring our whole body to the process. Nevertheless, it is also a product of the field so that we must have a sense of agency in order to influence the field and facilitate reflection in others. Embodying reflexivity means connecting nurses to their bodies, emotions, visceral reactions, their social relations, political sense of injustice, sense of systemic agency and political acuity while caring with others.

**Embodying reflexivity** uses the context and process of practice as a form of relational inquiry. In the co-inquiry we described it more pragmatically as “encouraging practical tips to be shared”, involving “standing back in the moment of practice to pause and pose questions”, “careful talk: naming difficulties with others”, “sharing and recognising our vulnerability as a strength”, “treating people well” and “becoming emotionally stronger”. In chapter 6 I showed it involves questioning power dynamics through developing a sense of systemic agency thus noticing and questioning the systemic, cultural and historical doxa, contradictions and paradoxes to be found in practice. Consequently, issues are named, doxa are challenged thus encouraging empathy and effective caring.

I have argued noticing emotions and difficulties when working with others and naming them directly through careful talk can improve the performance of nursing and collaborative working relations. This may lead to relational inquiry. Therefore, embodying reflexivity is dependent on emotional resilience, a process which does not see and notice emotional deficits in others but one which tunes into our own emotions, body space, physicality and responses to others enabling us to work with parallel processes. An understanding of transference and counter-transference is important here because a separation of ‘what is my emotions and bodily
responses’ and ‘what is yours’ requires reflecting upon and usually naming.

By embodying reflexivity we are able to recognise our vulnerability and use this as a strength when working with patients and colleagues. By this I do not mean emotional vulnerability - baring our soul – rather it is about being kind to oneself and others; treating others well, sharing, listening, empathizing and inquiring together in a collaborative way. In other words it means being intentionally open to critically reflecting on our own limitations and acknowledging the potential for 1st (personal), 2nd (relational) and 3rd (organisational) collaborative inquiry and learning. This has the capacity to shift the system at a micro and macro level.

In this chapter I used poems as a way of naming some difficult nursing experiences and as a process for questioning and inquiring into the politics and doxa of practice. Earlier in the thesis I showed they sometimes re-connected nurses to the emotions generated by nursing which are more usually denied or suppressed in the field.

I have argued it is important to notice the power of what we are feeling and risk exposing ourselves as vulnerable people through sharing this with others. Timing and respect for others becomes important in this process. We won’t always communicate well but the intention behind the communication is important. If we let the anger, uncertainty, anxiety, sadness and fear fester we will play it out in the field unconsciously as games. The weaker team member may be picked upon, the awkward patient could be ignored or shouted at, the difficult angry relative may be banned from visiting, and we will ignore our own needs and play this out through conflict with others, to name but a few examples. Compassion can replace efficient detachment which can in turn seem uncaring to others who feel vulnerable as a consequence of requiring care. I have argued embodying reflexivity can be an antidote to the busy syndrome, watch your back, whinging and emotional orgy aspects of the habitus and field.
Embodying reflexivity may include both reflection-in-action and reflection-on-action to facilitate working more effectively with others. Bourdieu suggested noticing what has not been said is important as well as noticing power differentials. I have suggested reflecting with patients and colleagues can also reduce power differentials in the ward and provides a counterpoint to the hierarchical culture. Reflecting in the moment of practice can involve patients so that we have a greater understanding of our impact. The common doxa of caring is that it is done to people or caring ‘for’ them. I am arguing it is a two way process – a dialectic that is relational and context specific. The nurse gains her job satisfaction through feeling she has made a difference to someone’s life but this can be forgotten in the field of practice when seeing so much pain and suffering.

Embodying reflexivity could seem like ‘a good gossip’ or emotional intelligence but has the potential to be more than this. We found it was easier in positions of power. Nevertheless, for nurses who have less control over their work I propose it can help them cope with the stresses and pressures of the job. Therefore, embodying reflexivity uses cultural, emotional, political and social capitals in a relational process. It is more than just asking questions, more than just emotional resilience, political and systemic agency or even conflict management. It is more than just talking; it is an intuitive and a deliberate mind, body and spatial awareness that on the surface can easily appear as informal chit chat. Embodying reflexivity is more than a good gossip.

The next and final chapter looks back at the significant learning from this inquiry and how this might influence the education and dispositions of nurses. It focuses on invisible learning in the field of nursing practice and questions systemic learning for the NHS organisation. It explores the tension of the dominant doxa in the nursing profession that suppresses and wastes the potential for agency and change by assuming reflective practice is a waste of time.
Chapter 8: Invisible Learning: More than a Good Gossip?

Ideas
Too tired to think
Almost on the brink
Of a discovery so profound
Don’t think
Let it sink
Into the soul
Soft and whole
Down into the swampy ground

Soon to pop
Maybe flop
Into a passionate space
Listen and talk
Alert as a hawk
Smile and wince
Question and convince
Arriving in a new place?

Clare Hopkinson 6/12/04

As Baudrillard (1990) argued “the further you travel the more clearly you realise that the journey is all that matters” (p.168). In this chapter I do not attempt to tie up the content neatly with a bow nor advocate a schema nor promote the reflective models devised collaboratively that I originally saw as outcomes of this inquiry. Instead, I aim to show the interrelated nature of the ideas presented, offer a critique of my learning and process and propose further inquiry questions. As the poem suggests the arguments presented here are partial interpretations which can be contested. I am not claiming that the culture I describe is evident in all wards nor am I claiming a definitive truth. Rather, this interpretation is provisional and one of many that are possible. The cultural patterns and nurses’ embodied dispositions described here, show the complexity of nurses’ invisible learning while giving care that both enables and discourages reflecting in the ward. As the poem above indicates, ideas often require a dialogue before coming to
fruition so that as already shown nurses in this inquiry preferred reflecting in relation with others through the spontaneity of a good gossip.

The chapter begins with the section called Second Thoughts, where I reflect on the action research journey and significant learning returning to the principles of storytelling and the use of Bourdieu’s concepts. I consider the unique contribution this thesis has made. The chapter then explores organisational and systemic learning for nursing and for the NHS from this inquiry. Finally, possible organisational learning for nurse education is addressed. I am left with a final question: where does storytelling begin and gossip end and vice versa?

**Second Thoughts: Learning from this Inquiry**

**Reflecting on the Journey**

How can I possibly show the full significance of this research? My muddy shoes have left their footprints throughout this inquiry so it could be argued this work has been a justification of my practice although clearly this was not my intention. Rather, I wanted to show my positioning, values and interests so that it was evident how I arrived at creating this epistemology of practice. I gained the impression that reflecting and the process of sharing stories was not valued as a way of learning in the ward because it is invisible and informal.

Angwin (2007 p. 68) suggested “Story can shape what we think and believe and how we live” while all stories are selective being usually crafted for a purpose (de Vault 1997). Bourdieu referred to research as a process similar to that of a “writer or novelist” arguing its aim is “to provide access to and to explicate experiences, generic or specific, that are ordinarily overlooked or unformulated” (Bourdieu & Wacquant 1992 p.205-
206). I have tried to demonstrate such a process in this thesis by presenting some of the contradictions and paradoxes related to embodying reflexivity in the ward.

Parker (1997 p. 142) has questioned the myth of “the meta-story- that some stories can be shown to be better than others”; post-structuralists believe there is no overarching story, all stories are valid - they are just different with different purposes. What has this story offered? I wanted to create a compelling story and like every good story it has had one overriding plot – what are the tensions and possibilities of reflecting in the ward? I have argued this has been underexplored by the bedside as it is a difficult, complex concept to problematise, deconstruct and/or explicate. I have suggested reflecting in the ward is demonstrated through the relational, cultural, systemic, political and historical influences evident in the field and the interplay between nurses’ embodied dispositions (the habitus). Further, this is influenced by the legitimacy given to the different capitals in the field and dependant on wider fields of power. Therefore I have used the term embodied reflexivity to show the complexity of this concept and to highlight paying attention to one’s body not just one’s thinking in the midst of action.

Stories begin with some form of trouble or a disruption (the research question), so that the reader becomes interested in how the trouble gets worked out through the building of tension and suspense along the way (Frank 2007, Clandinin & Connelly 2000, Culler 1997). In trying to create suspense and interest I have developed several sub-plots (my significant findings) as all good stories possess. Mostly this is not new knowledge for nurses but I have packaged it differently in the hope that it will resonate and challenge practising nurses (like a good story often can). In an effective story the characters go through significant development and the plot hinges on their choices (Frank 2007, Culler 1997). Consequently I have tried to show my choice points, struggles and learning throughout this thesis.
Also, I have tried to marry the form of this thesis with its content, so that the re-presentation here could be criticised for being a repetitive text. However, this is what life, action research and stories are like: partial, recycled, repetitive and emerging. Some may find the language colloquial and poking fun at the research process by regarding it as a story of experience; just an illusion of a systematic and rigorous process that edits out serendipity, formal and informal ideas arrived at in relation with others in conversation, observation or through written texts. I found this was the reality of the research process; some of it is intuitive or creative whether we acknowledge it or not. I am not saying I have not been rigorous in my methods, I am suggesting as Bourdieu argued that: “In contrast to the search for literary quality, the pursuit of rigour always leads one to sacrifice a neat formula” (1993b p21).

A good story is driven by characters that connect the reader irrespective of whether he/she is liked. My central theoretical character has been Bourdieu whose wisdom I have used alongside my important pragmatic and situated characters: the co-inquirers. All of these characters have developed my understanding of embodying reflexivity. Bourdieu’s concepts have not yet widely penetrated the nursing research or philosophy debates. Nevertheless, I have used them as the backbone of this thesis alongside feminist ideals and a systemic inquiry perspective.

Bourdieu was resistant to his work being labelled preferring to regard it as a science of human practice (Wacquant 2006). Nevertheless, his concepts have been criticised by some feminist authors61 who suggest he was contradictory about gender; paying less attention to the generative aspects of the habitus (i.e. the person’s sense of agency). They accuse him of seeing the habitus in a determinist way so that the embodied dispositions tend not to focus on the potential for social change, thereby reducing the sense of hope and agency62. I have not interpreted his work in this way as

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62 See his notions of symbolic violence
I think this misses the point of Bourdieu’s insistence on the hegemony involved in the struggles and reproduction of the bureaucratic and capitalist fields through symbolic violence and domination. Indeed his work encouraged me to consider the historical hegemony and impact on current nursing practice. At the same time, I recognise the systemic tensions for the individual in instigating sustainable change in the NHS. However, I have shown through embodying reflexivity it is possible to influence one’s place of work. For the co-inquirers, at the systemic, that is organisational or macro level, it involved gaining resources, demonstrating effective leadership and influencing change and policy. At the relational level, improved collegial working relationships resulted, whereby collective negativity in the ward could be overcome. And at the personal or micro level, it was possible to manage the complexity of the emotions present in the ward, reducing job stresses and improving job satisfaction.

Bourdieu was criticised for not recognising and highlighting the importance of emotions in his concepts so that emotional capital was identified and used by feminist theorists. To be fair to Bourdieu, the rise in interest in emotions has happened since his death. This inquiry has shown that highly charged emotions are present in the ward, such as anger and sadness but these tend to be denied, disappeared or suppressed. Consequently emotional capital is invisible.

Finally, because of his insistence on reflexivity being a product of history he failed to account for the physicality of the body while professing that the habitus was of the body. This inquiry has shown, in the performance of nursing, it is crucial to notice and become aware of one’s body and reflect upon one’s embodied dispositions to collaborate effectively with others.

A minority view suggests Bourdieu’s work contains some contradictory binary dualisms which Bourdieu argued he was trying to overcome (Jenkins 2002). In addition his critique of Masculine Domination (2001) has been distanced by some feminists including those who have used his
concepts (Witz 2004). However, I found it difficult to avoid binary oppositions here. Equally, I am sure I have been contradictory in this thesis because I am human and this is an aspect of the dominant cultural discourse that forms my history. Thus it is an aspect of my habitus and field of practice.

Some conversations can throw a powerful light on these blind spots and taken for granted assumptions while they may have the capacity to sustain organisational change (Shaw 2002). This supports our finding that relational reflexive inquiry in wards could instigate practice developments and changes. Shaw (2002) argued the invisibility of everyday conversation is important for understanding systemic organisational patterns and, I would add, can be a spontaneous reflective process which is why nurses feel they do it all the time. However, it is not always this purposeful (Brookes, 2001) and easily slips into whinging. The facilitation of an effective reflective process is in part dependant on supportive challenge which has been proposed by other writers. Nevertheless, patterns overtime may be lost through reflecting via conversation reducing the potential systemic and political agency available to the nurse.

I used Bourdieu’s concepts to move away from the body/mind binary uncovering and questioning some of the unconscious game processes occurring in the ward which I believe has enhanced this work. For Bourdieu the unconscious and conscious distinction was not important in the immediacy of practice (Grenfell & James 1998). He was more interested in whom we become, arguing political theories and knowledge theories are inseparable (Bourdieu 1993b). This encouraged consideration of different ways of knowing as aspects of embodied reflexivity, consequently, systemic and political agency became important aspects of this concept. Looking back, this is surprising and could seem contradictory given my original grounding in critical pedagogy through Freire’s work. However, whilst I had understood Freire’s ideas cognitively for years, I

came to embody and experience them emotionally in the ward. Previously, I failed to really see the interplay of agency, organisational structures and policies, the pull of the ward team and the complexity of power dynamics and relationships and their impact on the bedside nurse. This is common in presenting reflective practice as a process which stresses the therapeutic nature of self 64.

Now I see the complexity of the historical, cultural and systemic structures and constraints invisibly learnt which can limit nurses’ abilities to orchestrate change in the mechanistic bureaucracy of the NHS. And also, how nurses undermine their own potential power in the systems in which they work (Farrell 2001). Clearly, it is easier to be critical of a system than provide a new vision to enhance practice. This seems to mirror a further tension relating to reflective practice so that nurses see it as a waste of time. Coming up with ways of improving practice on one’s own (providing a vision or a change in one’s own practice) can be daunting and difficult without a relationship that challenges and supports attempts at trying different approaches. This becomes compounded in an environment where there is a blame culture that discourages experimentation and gives further weight to the need for relational inquiry at all levels of the organisation.

Traditionally, most action research concentrates on how the research has made a difference and contributed to social change (Gergen 2003, Reason & Bradbury 2001). There is little published literature on the problems in carrying out action research which can provide as much insight into the hurdles and challenges experienced during an inquiry (Grant 2007). Therefore it is useful to consider why I felt much of the inquiry was problematic; especially my attempts to engage practice staff with the notion of reflection and to influence any long term practice changes.

64 See for example Johns 2006, Glaze 2001, Titchen 2001
Initially, I saw this inquiry as successful. In the ward a teaching room, where nurses could relax on their break (if they got one), was created. There were positive evaluations from the co-inquirers in Strands 1 and 3, with evidence of their learning about and for their practice: an initial and key aim. I had produced some well and some not so well crafted poems which for the most part nurses received positively, connecting with them in a surprisingly open way. Some poems produced deeper and more meaningful conversations and reflexive inquiries in the classroom, in the facilitator’s meeting, at conferences and in the ward allowing nurses to re-connect to their values, practice intentions, emotions and bodies. I came to see poetry as a legitimate epistemology of practice; as a way of knowing nursing experiences and a valid embodied co-inquiry process. The emergent use of poetry has therefore been a significant sub-plot showing cultural, political and systemic wisdom.

Strand 1 co-inquirers produced a storyboard; an emerging process which enhanced the findings of the inquiry providing valuable images, metaphors and new insights that was especially helpful for me during the data analysis and writing of this thesis. Furthermore, it allowed for recycling the findings during the interviews thus encouraging a further collaborative inquiry cycle. However, in using the storyboard during the interviews it quickly became damaged. I had not anticipated how important this aspect of the inquiry would prove to be and in future would use cardboard backing rather than flip paper. This was an example of how we used different creative forms of reflecting which have the potential for producing personal, relational and organisational or systemic inquiry. Unfortunately, this inquiry suggests the dominant doxa in the nursing profession mostly suppresses and wastes creativity through the watch your back element of the field that supports standardisation and conformity. Nurses are in danger under these circumstances of becoming invisible; just another brick in the wall, cemented in their place, thus the potential for a collective approach to change and possible organisational learning through and from nurses can be lost. Yet there are positive examples in this thesis that
change can be orchestrated, sustained, and that nurses hold valuable systemic wisdom that can influence and encourage organisational learning.

I felt I had achieved several action-orientated outcomes. I facilitated an action learning set for some modern matrons and attended organisational meetings where I was able to feedback the new appreciations from this inquiry thus creating an illusion of completing the action research cycle. Two of the models had been arrived at through a collaborative process, one with a charity aimed at complementary therapists and the other as described in chapter 6 through working with a group of modern matrons from a local Trust. I had introduced a systemic perspective into the models reflecting my new learning based on my new understanding of the three levels of inquiry, that is, personal, relational and organisational (Hopkinson 2009). The co-inquiry produced emerging questions, not generated and controlled by myself, that were helpful for developing and questioning our practice. The images of the storyboard helped me re-present the metaphors and images named by the co-inquirers showing our collaborative learning process.

Originally, I felt these outcomes were tangible but as the inquiry continued and especially through the writing process I have realised they are unlikely to be long lasting influences which will make a difference to the organisations involved. Indeed now I see the use of the language of outcome as limiting, clichéd and management speak (Watson 2003). It is not very helpful when considering learning in all its complexity which may not be confined to the immediate time-frame and can be already invisible.

What has been the unique contribution in this inquiry? So far I have not seen the use of the parallel process as providing valuable research data in the nursing field. I suggest it is possible to notice one’s body and relationships with others in the midst of action to provide research data. The researcher experiences parallel processes in and away from the field of inquiry which provides important embodied knowing for the inquiry.
have proposed noticing such parallel processes is part of embodying reflexivity, alerting the nurse to transference and counter-transference processes, aiding collegial relationships and nurse patient caring relationships. Finally, I have used poetry as a valuable and legitimate research process which I have not found cited in the nursing press to date. In the following sections some new understanding of the culture of nursing (sub-plots) is presented so that I now discuss the interrelatedness of these significant sub-plots or key findings and their implications for practice.

**From Reflection Inaction to Embodying Reflexivity**

I found being a good nurse was an important embodied disposition and tentatively suggested this was influenced by the Victorian ideal of femininity and being a good woman. Perhaps reflective practice is a middle class justification of its values thereby possibly disadvantaging the working class nurses? Evans (2009) in a study on working-class girls in higher education found these women had to balance strong family ties, were often caught up in caring roles at home and had a strong sense of obligation and selflessness. This reduced their aspirations while ambition was seen by them as confrontational and selfish.

I noticed the disposition of *selflessness* in the ward, which I saw as a paradox. The *selflessness* creates a difficult double bind for nurses whereby stoicism and not feeling become the coping strategy learnt in the ward and contributes to the culture of *martyrdom*. Mantzoukas and Jasper (2004) reported nurses played out a power struggle game while I described nurses unconsciously acting as victims through the drama triangle game. Patients may be drawn into this game unconsciously expecting to be rescued as they have less resources and power available to them through their illness. Or they may be invited into the game by the nurses encouraging a victim or persecutor role. Managers can also unconsciously play this game, feeding into the aspect of the habitus and
field of feeling unsupported by managers. Once in the game, managers may unconsciously persecute the nurse, who becomes a victim so that roles are switched and the nurse feels personally criticised. In this scenario everyone feels bad about their job, devalued and hard done by producing the ingredients for an emotional release through whinging and creating an environment of low morale, bullying and job dissatisfaction. If the patient is also part of this scenario, they will not view the nurse as a good nurse thus creating a vicious circle to be played out again and again. And this cycle, I suggest affects the wider social field such as the media portrayals, where the image of the nurse is attacked leading to nurses’ feeling further personally criticised. Thus reinforcing nurses’ need for approval; re-affirming it is not safe to put ones head above the wall and demonstrating a wider field of symbolic violence and domination. But to what extent does noticing these games and embodied dispositions and aspects of the field allow for cultural change? The nursing field seems to work hard to maintain the status quo through legitimating traditional forms of cultural capital that potentially make it difficult for nurses to use their systemic agency.

“We don’t need no education
We don’t need no thought control
No dark sarcasm in the classroom
Teachers leave the kids alone
Hay teacher leave us kids alone
All in all it’s just another brick in the wall
All in all you’re just another brick in the Wall”
Roger Waters 1979 reproduction permission given 2007

I have quoted the Pink Floyd song above, to draw attention to the metaphor of ‘The Wall’ used several times in this inquiry. For me this song describes the anti-intellectualism I found embodied in practice which is probably historically influenced. Again, this could be influenced by class differentials and is worthy of further investigation. I have also interpreted the song as questioning the educational system, in particular teachers that produce like minded and conforming invisible students whilst the students
also subtly undermine their own education. It highlights the difficulty of influencing a rigid established system; coming up against the brick wall. Similarly, I wish to draw attention to this political phenomenon in nursing in the ward and classroom, questioning why reflecting is seen by many as a waste of time thereby creating reflection inaction. So that while nurses may see the systemic problems and have wisdom to contribute to the organisation they feel unwilling to put their head above the wall to influence changes that might make a difference.

I picked up a silent subversion in practice around the concept of reflective practice. Why did so many staff agree to be interviewed but then cancelled the appointments so that they never happened? This could have been due to the dynamic nature of the ward. Nevertheless some of the staff had control over their diaries. What did this inaction and silence tell me about the concept of reflection? I suggest this silence is because reflection is not seen as important in the ward because it is not linked to learning about practice but is seen as offloading which is also not valued in a martyrdom culture. Paradoxically, this martyrdom produces its own emotional orgy creating a challenging environment for the reflexive nurse to work in. I found because reflective practice processes generate so much discomfort it is easy for nurses to dismiss the process and rationalise that dismissal because we either do it all the time, therefore ‘we don’t need to be educated’ in reflective practices. This leads to, as the song says above, becoming just another brick in the wall, that won’t make a difference to the organisation. Or we are too busy to reflect because we are busy getting on with the work we therefore don’t have time for no education. Or the system contributes to the disappearing of some of the nursing wisdom which has a disempowering effect on our sense of agency and possibilities for changing and improving the system we find we are in.

In my opinion this is not just about limited leadership and organising skills as suggested in new initiatives such as The Productive Ward (2007) and Confidence in Caring (DH 2008a). It demonstrates some practising nurses’
silent subversion, their felt powerlessness and their need to stay invisible like the bricks in the wall. Consequently, many nurses give up the political drive to influence their workplace even though they are the largest professional group employed by the NHS and can see the problems. I found in practice several nurses lacked political acuity, did not recognise their possible power and were unsure how to use the system and policies for their own advantage. Walls can be both real and imaginary; they can be high, oppressive and separating or knocked down representing freedom and power. As this inquiry has demonstrated it is sometimes possible to rise above the wall and influence the workplace by embodying reflexivity in the moment and/or through a reflective conversation after events through creating a relational reflexive inquiry. Many of the co-inquirers could encourage and facilitate a reflective culture, in part by having powerful positions within the hierarchy and in part by recognising their own power through embodying reflexivity.

At all levels in the organisation, I found nurses were unsure of their level of authority contributing to the felt powerlessness. Bourdieu would suggest this is a process of recognition and misrecognition which serves to keep the social and cultural capital of the hierarchy intact (Wacquant, 2006). This is worthy of further research inquiry. I suspect nurses do not feel they have authority and legitimacy to influence the structures and for nurses working in a ward this may be an unintended consequence of the rise in specialist nursing roles and staff vacancies. Mantzoukas and Jasper (2004) similarly found nurses were unwilling to instigate changes through reflective practice in the ward because they felt they were not the “right people” to attempt such changes. This suggests to me that nurses’ powerlessness can be both real and imagined. The Productive Ward (2007) has elements that may address some of these issues but is likely to fail if the embodied dispositions of nurses are not addressed through education to increase nurses’ sense of their systemic agency. As shown in the image of the elephant and the bus it is difficult to see the wider social world when nurses are stuck in the busy syndrome sometimes created by
management policy and sometimes from their own embodied dispositions. This also applies to managers in a possible parallel process.

The ward is a complex environment to work in. I have suggested there is a strong element of the habitus and field of *watching your back* and *feeling unsupported by managers* that serves to both disperse emotions and perpetuate them. I linked this to experiencing racket feelings and projections of feelings, drawing attention to possible transference and counter-transference processes happening in the ward. I proposed nurses experience what they expect to feel, that is, unsupported, resentment and powerlessness. Therefore current raw and potentially overwhelming emotions such as anger, anxiety, fear, uncertainty and sadness generated by caring for patients and working alongside stressed colleagues remain unnoticed; they are edited out, being invisible for many nurses. This may be a legitimate way of dealing with the emotional component of the job but is in my view a mal-adaptive process reducing intimacy and effective relationships.

Another sub-plot of this inquiry focused on the exposing and confessional nature of reflection that paradoxically creates *reflection inaction* because it is intertwined with the *watch your back* and *reflecting to order* aspects of the habitus and field. For example, I anticipate the Trust reflective model created in this inquiry, is likely to be appropriated and codified in a similar way to other reflective models in use. This may happen because the senior staff introducing it failed to respond to my requests to evaluate its effectiveness before introducing it Trust wide, so that the views of those who would use the model (the nurses in the ward) were not solicited. Furthermore, without appropriate facilitation it is likely to create *reflecting to order* adding to the *watch your back* element of the field. This will in my opinion, increase the emotional stress of the job by introducing shame and uncertainty producing further *powerlessness*, silent subversion and inaction while simultaneously increasing the aspect of the habitus and field of *feeling unsupported by managers*. 
I suggest a lack of two-way explicit communication between the bedside and managers contributes to this inaction. There is a link here with the embodied disposition of being an approval slave and feeling personally criticised which is both a reality and an imagined process in the ward, thereby reducing the possibilities for learning or openly acknowledging and taking responsibility. As nursing is a physically demanding job it can have a devastating effect on the nurse’s energy levels which I believe results in a “too tired to think” disposition. Sometimes just getting through the shift is sufficient but this encourages the nurse to lose sight of her values, her ability to make a difference to people’s lives, and the wider fields of power. A balance between looking after herself, her patients’ needs, and gaining political and systemic agency is required. The scales can easily tip the wrong way in the dynamic field of practice due to the emotions and historical tensions present in the environment. The nurse can give so much of herself she becomes burnt out, or becomes defended through a selflessness and embodied martyrdom losing empathy and intimacy with patients. She can lose sight of using her vulnerability as a strength with others; reducing her humanity, power, caring and compassion.

I have shown becoming aware of one’s own personal power through embodying reflexivity can reduce the approval slave and the unsupported by managers aspects of the habitus and field. Therefore, it is possible to address the practice question: If I don’t like this what am I going to do about it? My hope is that the ‘I’ is replaced by ‘we’ in this question so that nursing teams have a clearer sense of their political and practice power.

The aspect of the habitus and field of reflecting to order I suggest focuses on individualised problems consequently many long term systemic patterns become invisible in the NHS. I propose this may be due to nurses possessing limited systemic awareness, an unwillingness to make changes or silent subversion by those involved in direct care giving. It seems easier to blame the individual who already feels powerless rather than address the fragmentation of the service provision and the impact of
structures on the nurses by the bedside. Thus reflecting to order can be seen as a symbolic system of the wider field of management power that can survey, appropriate and control nurses’ learning while adding to the Us and Them and watch your back aspects of the habitus and field. This symbolic system is a form of domination that constitutes the nurses’ socialisation and dispositions and emphasises the personal or individual problem or fault finding. I contend this reflects the wider social field (society) that retreats from analysing or interpreting or criticising the wider social world but prefers to blame and scapegoat individuals. In other words, it is easier and quicker to blame the individual than address the systems and structures that create problematic nursing practices.

Similarly, many organisational structures such as pre-printed care plans, clinical risk forms, toolkits, protocols and taped handover undermine nurses’ practice judgments and ability to ask questions. They provide a short-cut to undermining learning and instead of developing nurses’ practice they probably contribute to the watch your back culture. This further contributes to the aspect of the habitus and field exhibiting powerlessness and reflection inaction. Feeling powerlessness is thus reinforced by the work structures and power differentials which I have argued are also historical embodiments. It is not simply nurses being unwilling to take responsibility; this is too simplistic. Perhaps nurses feel criticised through reflective processes because they lack awareness of the political underpinnings driving care. Because nurses are fearful of challenging others as they do not want to hurt them, paradoxically, reflecting turns into whinging usually carried out behind the person’s back contributing to the watch your back culture which actually leads to hurting others.

I have argued that the embodied dispositions of whinging as an emotional orgy, is a safer and invisible process that can disseminate and heighten strong emotions present in the ward throughout the team. Whinging can be seen as a form of emotional capital eliciting a relational connection
between nurses while talking away any political action thus keeping a habitus of powerlessness (i.e. a lack of agency and autonomy) and an Us and Them field intact (e.g. between nurses and managers, and nurses and doctors). I have suggested Whinging is a quasi-form of reflecting in the moment of practice which can be paradoxically destructive to collaborative team working because it feeds into the aspect of the field of talking behind your back. Nevertheless, Whinging because it is usually gendered as women’s talk, is dismissed as having no legitimacy in the field so that if it did contain any organisational wisdom it would be lost to the system because the complaints are personalised to the individual.

Even with sensitive facilitation as Nina found, there was scepticism about reflective processes possibly due to a fear of reflecting. This could be because reflecting can generate uncomfortable feelings evoking past experiences, or could be due to a fear of revealing oneself to ones managers, or it may result from experiencing weak facilitation of such processes. As, Nightingale said: “how little can be done under the spirit of fear”65. Consequently, if nurses are fearful of reflecting they are more likely to dismiss the value of the process. While there is also a paradox here, because managers don’t always support their staff. They hold a tension between the strategic and financial aspects of their role and the relationships with their staff so that Treating People Well can be easily lost in this process. The potential for a relational reflexive inquiry into aspects of nursing care can therefore be lost. After all, these processes take time and managers are extremely busy people, being also prone to the busy syndrome, while staff may be unavailable due to reduced overlaps and unfilled vacancies.

Another sub-plot highlighted the paradox of the busy syndrome arguing it is based on historical hierarchical attributes and dispositions in the ward. It may be evident in other bureaucratic organisations. I suggest it discourages organisational learning creating a potential managerial

65 From wikiquote http://www.en.wikiquote.org/wiki/Florence_Nightingale
unresponsiveness to the workforce whilst simultaneously creating dispositions of powerlessness and whinging in staff. I have proposed there is a systemic game called *the waiting game* present in the NHS. This aspect of the field in relation to change processes increases staffs’ sense of powerlessness and lack of agency. I contend it is a symbolic system or pattern of the wider field of management power, being contradictory to the aspect of the field and habitus that values being busy. Consequently, this encourages nurses to lose the will to influence the organisation feeling they are not listened to, thus becoming powerless. They lose energy to continue with the wait because the busy syndrome produces an expectation of quick solutions. Nurses often have to repeat their request which saps their energy reserves and prolongs the wait. I suggest *the waiting game* contributes to the *Us and Them* dominant aspect of habitus and field in relation to management in the ward. Thus staff become suspicious about their managers while at the same time feelings of being unsupported are generated which can be both a real and imagined processes. Furthermore, it will be compounded by a lack of communication from managers (e.g. in relation to form filling). I see here a parallel process with patients’ experiences of powerlessness, inadequate communication and inaction from staff in meeting their needs (Kings Fund 2008, Confidence in Caring, DH 2008a).

I have argued the habitus and field of *the busy syndrome* is a historical doxa that devalues giving emotional support and physical hygiene care by focusing on fast and efficient care. Emotions in this environment are invisible and go unnoticed and would be seen as time delaying. Arguably, I have proposed *the busy syndrome* paradoxically could be an unconscious defence mechanism that denies the emotional impact of nursing on the nurse while at the same time can be a real phenomenon due to increased complexity of care, staff shortages, too much work and unfilled vacancies. It creates the conditions for blindly following rules and anti-intellectualism because the focus is on doing rather than doing and thinking, feeling and being. Nurses who operate in an environment where *the busy syndrome* is
evident may feel physically tired thus becoming “too tired to think”. Equally, this happens as a consequence of staff shortages and sickness, so that energy needed to instigate change is not always available to the nurse. She cannot see wider than her immediate care giving and her sense of systemic agency is unavailable to her. Like the elephant in the bus, her head becomes stuck in the immediate priorities of organising and managing care. She does not see wider than her own ward.

Some research has shown that reflective practice develops nurses’ political awareness (Glaze 2002, Taylor 2001, Platzer 2000b). Glaze (2002 p645) found nurses would take into account others agendas cultivating “likeminded colleagues in order to influence the health agenda”. While Platzer et al (2000b) suggested nurses became less rule bound, more confident in their decision-making processes and willing to challenge the status quo. Taylor (2001 p.411) argued that developing a culture that included acknowledgement and “positive strokes”, providing strong leadership, dealing with issues as they arose directly through using policies and procedures, engaging with conflict resolution, looking at the determinates in a situation to “turn them around”, encouraging nurses to support each other and develop a “united front” to senior staff enabled effective nursing. The findings of this inquiry are remarkably similar. However, I would add to the list: an understanding of “timing”, developing effective relationships with managers and colleagues by naming the difficulties through supportive challenge, pointing out the contradictions in the system, challenging as well as working with hospital policies, wider networking, managing the unconscious games played out in practice, and possessing a tenacity to follow through with actions for change. These are all aspects of developing systemic agency.

We do not need to be defensive about our practice but this is understandable in a political environment where a person can be picked off when they put their head above the wall, paradoxically reducing the likelihood of admitting mistakes and taking responsibility for one’s actions.
It is safer to be invisible in the crowd and feel hard done by. After all, the historical exploration in this thesis seems to indicate that disabling patterns will continue to be repeated that disadvantage nurses by the bedside. Without this political perspective reflecting in the ward will not significantly improve patient care but will remain as an individualised process and the wisdom nurses hold within the organisation will remain untapped. In one sense this is not new knowledge for nurses but understanding why there is a tension in the nursing ward about reflecting and changing practice has I believe not been explained in this way before.

Hannigan (2001) posed the question: How does reflection assist in the development of more effective nursing? Embodying reflexivity is multifaceted, complex and nuanced. Embodying implies an ability to hold and contain the process nurses are working with while simultaneously performing it and thinking about it. As shown through embodying reflexivity, co-inquirers reflected with patients and colleagues. They were able to pause and pose questions no matter how busy they were to enhance nursing care while concurrently facilitating reflection with staff. Co-inquirers achieved this facilitation pragmatically through the questions they asked, naming the difficulties and challenging aspects of the relationships which interrupted unconscious games and enabled explicit and honest communication while also Treating People Well. They tuned into their bodies in the moment of practice noticing their emotions (such as feeling angry which could fuel practice changes), and using their vulnerability as strength thus sharing their doubts, experiences and feelings as appropriate. Consequently, the co-inquirers used their bodily awareness and imagination to explore their intentions, knowledge base and care choices providing considered and relational practice. Co-inquirers were not frightened to follow through with actions, showing tenacity and coping with the Waiting game. Finally they questioned themselves, their teams, their organisations; that is, they engaged in relational reflexive inquiry processes at the personal, relational and organisation levels of inquiry.
Embodying reflexivity mostly uses spontaneous ways of reflecting informally which could be seen as gossiping and is therefore potentially open to dismissal and being labelled through gendering processes. This is dynamic and easily talked away, while written reflections are fixed, so that systemic patterns over time can be disappeared and remain unnoticed. Hence political actions resulting from reflections are in danger of being lost in a system that already devalues nurses’ contributions. Yet I suggest it can form the basis of relational reflexivity and political acuity and systemic agency. Gossip can establish intimacy and be seen as an interest in people (Tannen 1992). It can alter existing power inequalities (van Iterson & Clegg 2008) and release emotional tensions (Waddington 2005). Tannen (1992 p. 97) further argues “when people talk about the details of daily lives it is gossip; when they write about them it is regarded as literature”. Nurses can use this interest in patients reflecting with them to reducing power differentials and increase collaborative, considered and relational practice. Further research could focus on exploring the relationship between gossip and storytelling and to what extent is it a gendered process?

**How might this Inquiry Inform Organisational Learning and Ward Practice?**

**Timid**

Tasks to be done and rules to be followed  
Interrupted frequently, quickly  
Meeting targets and standards  
Involved in incessant change  
Done to and told what to do

Clare Hopkinson 11/6/06

I mirrored the culture of the ward by getting straight into the inquiry rather than reading and consolidating my understanding through *standing back and pausing and posing questions*. I found as my experience of co-
creating the Trust Reflective Model showed there is a tendency to cut to the chase, *crunch your 30 seconds in* as Amy called it, so bypassing deeper and more meaningful learning. I now see this as a clash of the fields and habitus of learning and expectations between the university and practice and the philosophy underpinning critical reflexivity. But surely this is understandable if patients are put at the centre of the caring process; our focus should be on them? This is another contradiction I suggest, because whilst nurses claimed and probably thought they were patient centred from my observations they often were not; a tone of voice, a bossy command, knowing what was best for the patient, not telling the patient what they were doing, ignoring the buzzer because they were doing something more important such as paperwork. Shouldn’t nurses’ learning assume second place to doing nursing?

My argument is that through embodying reflexivity it can become integrated during care-giving, allowing nurses to have more choice about how they practise, and encouraging a collaborative and relational process that reduces unnoticed power between themselves and their patients. There has been a lot of media attention recently focusing on nurses’ lack of compassion and dignity with their patients. Reports such as the King’s Fund (2008) have suggested a move away from rigid target setting to recognising the caring aspects of nursing. The historically embodied dispositions are unlikely to change the emphasis in practice around care-giving unless the culture is addressed, which is no easy task. How do organisations give legitimate cultural capital to patients’ hygiene and emotional support needs when the wider field of society does not and historically has not valued these functions? A systemic inquiry through all levels of the organisation could begin to address the lack of legitimacy and capital given to nursing procedures. This is not a phenomenon just related to Britain, Salvage (2006) argues that nurses’ work is trivialised and undervalued across all continents. Increasing staffing levels and attention to the environment nurses work in may help in some areas, but this is not
a blanket answer because being overworked as I have shown is not always the reason for neglect of these nursing functions.

As Gavanta and Cornwall (2001) suggest large scale change must happen at all levels in an organisation and sustainable change does not happen overnight, it often takes considerable time, especially cultural changes. *The busy syndrome* creates an environment where quick fix solutions and shortcuts are the norm so that organisational and systemic patterns overtime become invisible and not noticed. Waiting for the slow burner of change to happen becomes untenable. I believe this process is a disabling pattern within the NHS. It may result from the wider field of political short term domination that stamps its mark on the NHS policies requiring instant success, solutions, standardisation and targets, thereby discouraging systemic inquiry. It contributes to the plethora of toolkits and protocols where individual and team thought and criticality is more often implicitly discouraged through the invisible implicit suggestion that ‘this is the right way to do it’. A recent directive Confidence in Caring (DH2008a) appears to provide a systemic perspective but simplistically tells nurses what to do and could be interpreted as blaming. For example, “get to know your patients”, “be seen” “keep the mood upbeat and friendly”; the context is completely ignored and managers’ responsibilities are missing here in relation to staffing ratios. Equally, if the proposal that nurses will be rated on empathy and compassion (BBC News 20/6/08) is realised this could further blame and undermine nurses.

Paradoxically, as shown in Nina’s story, managers often made staff wait when suggestions for change were initiated. Unless results are immediate and obvious then less value may be placed on them. For example, the Facilitator’s Network has now disbanded and the co-ordinating post discontinued, likewise the Clinical Supervision Co-ordinator’s post. This was to save money for the organisation that was in financial difficulties. It is difficult to see tangible results from such posts because when facilitation works well it is often invisible therefore staff think they have done it all
themselves. However, the aims of the facilitator’s network related to the NHS Plan and Modernisation Agenda and now the political drivers are somewhat different. These were:

- “to support the roll out of the NHS Plan and Modernisation Agenda in terms of Change Management and building a flexible team based working environment
- to offer facilitation as a means of generating creativity and innovation to achieve our Trust’s objectives
- to offer facilitation as a means of supporting and developing new and existing teams through team meetings, team time out and team away sessions and service improvements” (Trust Document).

Do staff no longer need these aims to support their practice endeavours?

As Jane’s story of the name badges highlighted, some managers’ responses seem inappropriate to staff requests and showed the system to be rigid creating walls where these need not exist. Hence it does not use or allow the communication and wisdom from the bedside to flow up through the organisation in a meaningful way. And Nina’s story showed how a needs assessment review of nurses’ training is required in the workplace because unrealistic expectations are placed on staff. This should not be a blanket approach but one that allows staff some choice to meet the needs of their service and nurses need to have some control over this; not be Done To by others who do not necessarily understand the difficulties and complexities of nursing poorly patients on a daily basis. Hopefully this will happen as a consequence of the recently established NHS Constitution which aims to provide staff with personal development and access to appropriate training, while involving them in decisions (Santry, 2009a). However, I am somewhat sceptical that this will be the case, given the historical patterns already highlighted.

In the ward the time saving device of care planning has had other unintended consequences by reducing nurses’ direct contact with their patients and encouraging them not to assess and think about the care they deliver. The staffing shortages and external political drivers (wider field of
power) concentrate on time saving, efficiency and targets, further feeding into the busy syndrome. Fawcett (2007) is sceptical about the professed worldwide shortage of nurses claiming that if nurses focused on nursing and not filling medicine’s gaps then we would be able to nurse. My historical explorations seemed to indicate that recruitment has always been problematic (Maggs 1983, Abel-Smith 1960). Fawcett questions: “why do physicians write orders? If the activities really are medical activities, why do nurses perform them?” (2007p.98). She further contends our willingness to take on medical roles serves to keep nursing undervalued. We need to cultivate this level of critical questioning in practice itself; to develop our systemic agency and influence in the organisations in which we work.

We need to work with contradictions in practice rather than pretend they don’t exist. Nursing is not an easy job and many people could not do it, day in and day out. It is physically demanding, cognitively demanding and emotionally demanding. Nurses can become cemented bricks squashed between competing demands and unrealistic expectations about what it means to do ‘a good enough job’. I am not advocating justifying or hiding bad practice but suggesting that nurses need to be gentler with each other, acknowledging that we face complex messy situations and are contradictory beings capable of making mistakes, showing compassion, honesty and empathy. Rather than attack each other we need to support each other as the medical staff seem to do. However, this is difficult in a wider field of power that expects a health service where mistakes do not happen.

Embodying reflexivity as I have shown encourages nurses, at least in this inquiry, to make a case for more staff and resources and gain the confidence of timing thereby developing political acuity and systemic agency that can make a difference to their patients’ care and their relationships with colleagues. Explicit communication, naming difficulties in the moment and an awareness of the games in the field with an
understanding of why they have become like this is part of the education
nurses need. For me this is the reflexivity required in the workplace. It is
difficult to turn around a culture where speed is valued and opportunities
for nurses to get together, is seen as gossiping and inefficient. Why do we
assume nurses’ chatting is inefficient? Is this a gendered process? It has
the capacity to be both the social glue for the team and thus efficient and
an opportunity for whinging and watching your back and thus inefficient.
What are the class and gender issues or the social and cultural capitals
exposed by reducing opportunities for nurses to connect with each other?
Perhaps this is another example of symbolic acts of managerial violence?
Managers would not consider getting together to discuss their strategy
was a gossiping session but it will include informal “chit chat” that may
have value to the organisation. Indeed, Goodwin (26\textsuperscript{th} May 2009)
recommended the NHS Trust Boards should:

“Ensure there is a good balance between formal and informal board
time together. Informal time allows the opportunities for board
members to get to know each other and for relationships to build, to
debate key issues and explore the future in a more relaxed setting.”

The volume of patient complaints has continued to rise over the last 20
years with the most common cause being, staff attitudes and
communication deficits (Kings Fund 2008). This inquiry suggested that
reflexive collaborative inquiry encourages empathy and improves explicit
communication thereby improving patient centred care and also as, I have
argued, job satisfaction. It seems to me it is possible to improve working
relations and encourage nurses to re-connect with their values that can be
lost in the ward. I propose there is a fine line between caring for someone
and potentially playing out an unconscious game in the field of practice.
Recognising that reflecting is predominately an oral process and can be a
way of valuing nurses’ practice, it therefore needs bringing into the ward,
via meetings, handover, and informal chit chat or gossiping whilst
recognising this is more effective if facilitated purposefully (Titchen 2001).
Healthy disagreement needs fostering rather than attacking each other, so
that a questioning (inquiring) approach to care can be achieved.
Many of the training needs and changes in practice result from the wider political field. For example, nurses have little control over political legislation such as the Human Rights Act 2007 (House of Lords, House of Commons 2007) and the Health and Social Care Act (2008) which aim to protect patients. However, there are often contradictions through policy documents and in the economic recession with tighter budgets I wonder how likely is staff training to be honoured? The latest political drivers focus on infection control, risk assessment, quality care, dignity, compassion, direct or patient centred care, patient safety, partnership and involvement of patients including collecting illness narratives or patient stories ⁶⁶. If nurses are unwilling to tell their own stories how will they be able to facilitate storytelling in others as a way of improving the quality of the service? But with a change of government these agendas may change again. Nurses need to learn to harness policies rather than feel powerless. By doing this reflective practice can be linked to improvements in patient care. As the co-inquirers showed sometimes they were able to use policies to their advantage to gain extra resources for their areas.

Perhaps, in the light of such policy directives, it is more appropriate to consider that nurses are doing a disservice to patients by not reflecting with them and about the care given which I have argued encourages collaborative and relational practice. Collaborative working from my experience in the NHS does not seem to question the power differentials and different social and cultural capitals embodied by different professional groups. When I carried out non participant observation at multidisciplinary meetings, nurses were the only profession not asking questions. This habitus is powerful in the field of the ward. Staff keeping busy reduces the opportunity for students to have their questions answered. Pausing and Posing Questions needs facilitating and senior staff have a role to play in encouraging this, not in a blaming way but in an inquiring way focusing not

just on the individual but all three levels of inquiry (personal, relational, and organisational).

Bullying, negativity and low morale is clearly multi-faceted and a huge problem for the NHS and its managers. 12% of the NHS workforce it is claimed have experienced bullying, abuse or harassment from work colleagues in the last year alone so that a new anti-bullying hot line has been set up to take phone calls, emails and letters from NHS employees (Santry, 2009b). Santry (2009b) noted bullying is not just from managers but also from colleagues who may be in quite junior positions and sometimes it comes from patients. Stories from this inquiry support her findings. She suggested line managers are more likely to be bullied than those with no line management function. This gives weight to my understanding of the culture that perpetuates and embodies feeling unsupported by managers. I believe, becoming aware of the destructive possibilities of whinging and at the same time the legitimacy of whinging might encourage managers to gain organisational wisdom from those giving care. The tricky part is not getting drawn into the game of the drama triangle whilst valuing the person and challenging weak performance; embodying reflexivity can give the nurse a better chance to achieve this through noticing processes as they happen including conscious and unconscious processes. As Jordon noticed, creating an environment where approval from the manager and patient is more important than the pull of the team can create a new dynamic in the ward. Anger and conflict can be used positively in the team, instead of being seen as a threat or becoming dispersed in the team as an emotional orgy, thus encouraging debate on practice.

It is difficult to sustain any change and influence in a complex and fragmented system such as the NHS, because I suggest the Waiting Game and Busy Syndrome keep the field in equilibrium. Thus there is a redoubling of the tension in the field and habitus to keep discomfort, strong emotions such as anger, instability, uncertainty and unpredictability at bay,
creating an illusion of control and standardisation which is not the reality of practice. For nurses wishing to influence such a field as I have shown, it can feel like banging your head against a brick wall when trying to initiate even the smallest change draining valuable energy. Inaction is as powerful a political statement as action. This inaction to new initiatives, I suggest, is a disabling cultural pattern in the NHS that will undermine many policy initiatives because the facilitation of relational and systemic inquiry is not noticed or addressed in introducing effective change. Systemic inquiry encourages working with the mess and complexity in context reducing the managerialism that provides an illusion of control while simultaneously using the wisdom from staff at all levels in the organisation (Weil 1999, Wallace & Hoyle 2005). This aspect of political development has been largely missing from the discourse on reflection.

Embodying reflexivity can make the nurse emotionally stronger. Other writers contend reflective practice develops empathy thereby improving patient care (Gustafsson & Fagerberg 2004, Glaze 2002, Taylor 2001, Titchen 2001, Platzer et al 2000b). I found because the field contains the watch your back aspect it is easy to feel personally criticised so that managers’ demonstrating empathy for nurses may help to reduce this aspect of the field and habitus. One day while I was in practice there was an audit by a manager. On that particular shift the complexity of patient care was heavy with several operations; we were genuinely very busy as a staff member was also off sick. The nurses felt resentful that the manager was more interested in whether the toilets had been cleaned than helping them get more staff to cover the work. The manager and the nurses did not appreciate each other’s needs and differing priorities. I am suggesting that by opening up the debate about practice in an inquiring way and Treating People Well, rather than a blaming way, new insights about practice can be achieved. This debate needs to take place at the three levels of inquiry (personal, relational and organisational) so that nurses are not shot down when they put their head above the wall for trying to challenge the systems they work in.
How might this Inquiry Inform Organisational Learning in Nurse Education?

Bourdieu argued education can be a byword for power and privilege and thus class because of the legitimacy afforded to different cultural and social capitals in the field. Wacquant (2006) noted class shapes our cultural and therefore educational preferences - this is often disguised as a matter of taste- while also keeping certain knowledge elite. Consequently knowledge is political. This inquiry has touched on issues of class suggesting it may have a bearing on the attitudes and use of reflecting in the ward. I am left with the question: To what extent does class play a part in the adoption of reflective processes? Could the ‘good woman’ of a higher class or nursing status, who has received more education (such as nurses in specialist roles and senior staff), use reflection to legitimate her position within the NHS? Some of the co-inquirers showed this is possible at least some of the time.

We do not like to address class differentials anymore and this has not been explored in the recent nursing literature. It can be seen as a Marxist influence that is now passé in some quarters but Bourdieu’s work has forced me to notice this. We focus mostly on nursing as a homogenous group only differentiated by hierarchical grades. But we clearly aren’t, and the tensions in the field of different embodied ways of being could be further explored having potential educational implications. This has significance with the current moves towards an all graduate profession, the rise in specialist nurse roles and the creation of associate practitioners thereby creating the potential for replicating historical embodied patterns in the ward and classroom.

I have shown how powerful the ward is in shaping the dispositions of nurses so that this learning is invisible and becomes embodied. I have argued it is not easy to identify one’s own learning needs. However it is
possible to learn from stories irrespective of whether they change over time (Beyea et al 2006, Ramsey 2005, Clandinin & Connelly 1994). Nevertheless, as shown here, some stories do not seem to change at all so that as Bennett and Royle (1999 p.60) suggest the power through stories may be the “only strategy left for the weak and dispossessed: without narrative power, they may not be heard”. Through stories it is possible to develop systemic understanding and agency and relational reflexive inquiry so that nurses are heard in the organisation. Consequently, explicit communication, questioning power dynamics and the external and embodied influences in the ward through the facilitation of reflective practice can be achieved.

Do we as educators buy into the Busy Syndrome so that deeper learning is avoided by focusing on quick fix answers? We need to pay attention to the paradox that we are introducing by embedding reflection in the curriculum through mechanistic devices such as models of reflection that reduce the self direction of the nurse and give an implicit message that ‘you do it this way’ perpetuating a Done To approach. Thus nurses’ thinking for themselves is subtly undermined. No wonder many nurses think “reflection, oh no a waste of time” and therefore discount it as having little worth. Do we cultivate a powerlessness through using reflective models forcing nurses to reflect to order?

Nurses don’t have to be an invisible brick in the wall, we can make a difference to people’s lives and this must not be lost in the rush to complete tasks and to appease our managers by appearing or keeping busy (the busy syndrome). I would like to see more emphasis in the curriculum whereby nurses’ explore how they work with others by examining transference and counter-transference processes, their communication processes and the realities of group dynamics in order to process and understand conflict (Bion 1968). Relationships matter, even more so at times of failing health and increased vulnerability. I believe we need to facilitate nurses to examine psycho-social aspects of care so that
the key learning from this inquiry could I believe help student nurses’ practice. Patients remember the human touch, using our vulnerability as strength can enhance this connection. When I was a student nurse the dominant discourse was caring and patient assessment; now it is standardisation and competence. A recent draft philosophy for our new curriculum didn’t even include the word caring let alone associate it with nursing; perhaps it was an oversight or perhaps it reflects the wider field in nursing or just my institution, that caring is no longer important? As we move to an all graduate profession perhaps it reflects our history that qualified nurses will carry out co-ordinating functions rather than direct care giving? So how do we ensure reflective practice does not continue to be dismissed?

Nurse educators need to discourage the mind and body split in nursing education. This can be overcome through storytelling and the creative arts; processes that encourage social learning and thus reflective practice (Wildemeersch et al 1998). I suggest by using the creative arts and introducing nursing history into the nurse curriculum, nurse educators can encourage critical thinking, noticing emotional, political and embodied knowing thus allowing for critical inquiry into nursing practices. We need to move away, in my opinion, from individualised learning as a focus to social and organisational learning because using the three levels of reflective inquiry can give a more critical perspective. It can encourage nurses to see the wider picture and to notice and question systemic disabling patterns such as race, gender, power dynamics and historical embodied processes. This can be mirrored in the classroom by addressing the here and now of the groups. Consequently, through reflective practice or work-based learning there is an opportunity to focus on process rather than content in sessions which would promote less solution focussed immediate action (Linklater & Keller 2008). I argue this would encourage nurses to think for themselves. Nurse educators’ can enable nurses to see that constructing our vulnerability as strength can shield our competence and incompetence. It is the capacity given the context to be both and the
interplay between the two positions where learning occurs and that I believe inspires reflecting during care giving. We need to facilitate nurses to be comfortable with discomfort and strong emotions in ourselves and in others.

**An Epistemology of Practice through Poetry**

I have learnt to view poetry as an epistemology of practice that can be used in the classroom to deepen the reflexive conversation. Poetry as an embodied process has the potential to open up multiple ways of seeing the world, to tune us back into our body, our senses, our ‘multiple selves’. There is no right answer with poetry. Pickering (2000) warns however, that any genuine engagement with poems is unpredictable and therefore they should not be used for any external ends. Therefore this approach could act as a counterbalance to more mechanistic ways of facilitating reflective practice. Poetry can promote questioning of values and practices encouraging a new way of feeling the experience through the poem. Poetry can express the ineffable and the difficult aspects of practice that we do not usually focus on. I have found that poetry is a way of expressing some of my raw emotions and I can release this emotional tension through writing poetry. Poetry can develop empathy. Writing from the perspective of another helps me see alternative perspectives. Performing the poems with students increased my vulnerability and potentially reduced the power differentials thus creating a more intimate environment and mirroring connection with others.

Through connecting to feelings some nurses who have absorbed the habitus of a distanced professional can re-connect to why they came into nursing. I have argued direct patient care and emotional support have little social, cultural, political and symbolic capital as a consequence such caring is de-valued at the expense of co-ordinating functions. As I have argued earlier not everyone can nurse yet as long as caring is de-valued in
all nursing fields including the university then nurses who gain their job satisfaction from it will continue to feel powerless and victims promoting a culture of *martyrdom* that hides power over patients. I have argued that it tends to be seen as *caring for* rather than *caring with* patients and relatives, and this is new learning for me. Recognising there is a reciprocal relationship can be useful in helping nurses pay attention to their own bodies and this can be addressed in the classroom through experiential learning processes. Through reflection and inquiry into practice nurses can create their own story of practice becoming *emotionally stronger*, politically aware, develop systemic agency and effective communicators; thus embodying reflexivity just as the co-inquirers in this inquiry have demonstrated. Embodying reflexivity in the ward and classroom can be seen as more than just a good gossip; it can be argued it is an imperative.

**Reflection-in-Action**

- Response Ability
- Negative Capability
- To Act
- Or not to Act
- To Be
- Or not to Be
- To Belong
- Or not to Belong
- To Imagine
- Or not to Imagine
- Practising the Tolerance of Ambiguity
- A Risky Business of Uncertainty
- Of Choice and Fuzzy Logic
- But no choice about Becoming

Clare Hopkinson 19/5/ 04
Final Thoughts or Beginnings? Reflections on the Viva Voce

In these final thoughts I reflect upon the viva voce conversation which explored my ontological positioning of this work, the hidden power in the process, the ethical considerations and questioned some of the key decisions I made during this inquiry. The viva was carried out in the spirit of co-inquiry, that is, stories were shared by all, and the process was conducted as a dialogue or conversation rather than as a defence of the thesis, as I had expected. I came to the viva with a sense of ambivalence about ‘defending’ it, probably, because I often feel at odds working in the academy, due to my feminist dislike of arguing against or defending a line of argument. Rather, I prefer to see the advantage in differing points of views.

The viva felt like a coming together of equals. Of course, this disguised the power dimension and power inequalities embedded in the examination process. And perhaps, the examiners’ power mirrored my own power, in relation to the co-inquirers in this inquiry. I have learnt through this journey, that there is always a power dimension in any facilitation even when choosing to do nothing. By convening the space in the first place, I had hidden power and how I used that space through the interpretations I have made, also holds power. Therefore, I tried honestly, to show my use of it and to credit the wisdom from the co-inquirers that have influenced my interpretations.

I return to my Whinging Wilma and Co-inquiring Clare characters to explore my reactions to the viva voce. As Whinging Wilma, my initial reaction was one of being asked, as I proposed earlier, to reflect to order. I questioned how I could, in this reflection, give the examiners what they wanted, especially as they had left this open, so that I could re-visit the last chapter and reflect as I saw fit. On the one hand, this could be seen as
empowering but on the other, it seemed contradictory and I felt confused. I didn’t want to write any more, the thesis was long enough and surely this was shifting the goalposts? I realised this mirrored one of the tensions I had identified with my own students, who worried about producing what the marker wanted, thus the process created anxiety and uncertainty. As I found with my students, these feelings have the potential to sanitise my response in order to give the examiners what I perceive ‘they want’, or to produce reflection inaction (although this was not an option for me in this case), reducing my own empowerment. I felt angry; I had finished where I wanted to finish, nicely on a poem.

This reflection was further complicated by the fact I had written the thesis at least four months ago. I had very little memory of the viva, as my nervousness had got the better of me, and the celebrations on the night dulled my memory even more! I didn’t get round to writing my own reflection of the process as I whinged and talked it away with colleagues. I whinged rather than focused my energy on writing; again another parallel process and confirms to me that we write often about our own issues in research. Whinging is a complex process so that I hope to further explore it particularly in relation to gender, class and culture. In the viva I was asked if I thought whinging occurred with men. I did see men whinging in practice and have experienced male student nurses whinging in class. However, is it more prevalent in women or is this a gendering stereotype? I don’t know, but intend to further investigate this phenomenon.

As Co-inquiring Clare, powerful learning came from being challenged to see that whilst I thought I held an ontological post-structural position, in using structures such as the parallel process, transference, counter-transference and the drama triangle to help explain and make sense of my observations, these were actually structural in nature. This shows that my values do not always match my practice. Similarly, I have highlighted this phenomenon in the ward.
I was further challenged to consider, from the patients’ perspective, the ethics of nursing after a gap of ten years. I am still a registered nurse, I received training prior to working on the ward and was supervised to a greater or lesser extent. The ward in return, did not pay me and saved money by not ordering bank or agency staff on some shifts. Was I competent to nurse? I think so, as I was able, at times, to embody reflexivity while also making mistakes. This binary of competency and incompetence, I believe inhibits learning in a variety of settings and is particularly disempowering in the NHS.

I was asked to consider the ethics of who owned the work; was it myself or the co-inquirers? This was an issue I had continually reflected upon throughout the PhD, as I worked with the realities and practices of co-inquiry based research. Each of the co-inquirers gained something from taking part as recorded in the interviews, and this learning had an impact on their practice. Was this more or less than traditional research? I do not know.

Systemic inquiry is a new concept in the nursing field. I have learnt that we all play out parts of the system while each part of the system is interrelated. Thus, collaborative inquiry is a useful way of drawing attention to, and possibly challenging and changing, the multi-layered complexity held in a system. Systemic inquiry involves questioning and staying open to the possibilities of connections that have not been noticed before. In using the three levels of reflexivity I was able to show the complexity and nuances to the elusive phenomenon of reflecting. I used a multi-layered approach instead of the usual mechanistic approach to action research found in the nursing literature.

It was suggested that action research is about 'little changes' and yet in this last chapter, I chose to focus on what I saw as the systemic issues. These are harder to tackle, but I think there is a need to focus on the systemic issues involved in working in the NHS. We can easily console
ourselves as action researchers, in thinking we have influenced and changed a system when in reality an appreciation of the possibilities for change is what has occurred. Yet, in naming the connections and systemic and cultural processes this can be the beginnings of implementing sustainable change. And what has ‘action’ meant in this inquiry? This has been a challenge to articulate. I have realised action takes many forms, both tangible and intangible. Here, I have shown it embraces processes that involve ‘talk’ or ‘conversation’ such as poetry, whinging, gossiping, and relational inquiry. Action, here, has involved noticing and reflecting upon one’s body and own internal and relational processes.

As with all reflections, just when you think you’ve finished there is always something else to reflect upon! Cycles of reflection and action could carry on forever, so that I have experienced a tension in when and where to stop, potentially repeating and diluting the potency of this thesis. For me, this confirms the value of relational inquiry especially in determining one’s own values, blind spots or sense of power in situations. And the poetry has been the form that has allowed me to use my power in a connecting and distilled format.

It was suggested that I could have been more positive and bolder about the unique contribution of this thesis. This in part reflects my unwillingness to ‘sell’ myself and my ideas, while it also reflects my belief that new knowledge is rare; rather knowledge tends to be re-named, re-positioned or applied in a new context. I have struggled to overcome this notion throughout the duration of the PhD and this may have been reflected here in this last chapter, where I may have shown my own powerlessness by playing down, discounting or possibly undermining what I have to say. This I believe, as I have shown earlier, is what seems to happen in practice to many nurses when trying to take up their leadership to instigate changes. Yet, I believe that while my next task is to disseminate what I consider to be the key learning from this thesis, it is for the reader and the co-inquirers who took part in the inquiry to identify whether this thesis resonates and
has value. My hope is that this thesis, whilst not necessarily providing tangible outcomes, provides an insight and understanding of a nursing culture which may inform nursing leadership and organisational development in the NHS.
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Information Sheet for Participants who have completed a Reflective Practice Course at UWE (First Strand of a Co-inquiry into Reflection-in-action)

A Collaborative Inquiry into the Tensions and Possibilities of Reflecting in the Context of Care Delivery

This is an invitation to take part in one aspect of a research doctoral study sponsored by the Faculty of Health and Social Care, UWE, Bristol about reflection in practice. Reflection has been described as a way that practitioners can learn from practical experience, and in the process, question, understand and learn from the “messiness” of practice because actual practice does not always fit neatly into an appropriate theory (Schon, 1983).

Before you decide it is important for you to understand the project, and what your involvement will be. **There will be an introductory meeting about the project which will allow for any questions you may have to be answered.** If you decide to attend the meeting it does not mean you have to take part in the study. If you choose to take part in this inquiry you would be free to withdraw at any time. No reasons need to be given and any information you wanted withdrawn would be honoured. Please take time to read the following information, discuss it with colleagues, relatives or friends or contact me for any further information before deciding whether to take part.

What is the Purpose of the Study?

This inquiry forms part of a doctoral study which I am currently undertaking with SOLAR, (Social and Organisational Learning as Action Research). It is a research and development centre based in the Faculty of Health and Social Care, University of the West of England, Bristol and encourages a collaborative approach to action research. Put more simply, this means the researcher and research participants’ work together to learn and understand practice encouraging improvement and changes in practice.

This study aims to explore learning from practice through reflective processes in practice settings during actual care delivery. This has been described by Schon (1983) as “reflection in action” which means “reflecting while doing”. You may be familiar with reflection as a looking back process sometimes known as reflection on action. This involves learning from practice and is usually performed away from the bedside e.g. on educational courses, often through critical incident analysis or diary keeping. Or you may be aware of, or involved in the recent initiative in this trust, relating to clinical supervision of practice, a process which involves some reflection on practice. I am interested in whether reflection is valuable in practice. Is it time consuming? Does it make any difference to the quality of the service provided? Does reflection have to be through writing or are there other ways of reflecting? Does reflection happen...
individually or as part of a team? Does it happen in work time or is it another add on to the job? Does the thought of reflecting leave you cold and uninspired, just another fad? Could reflection be supportive?

**Why have I been chosen?**

As part of the inquiry I will be joining your nursing team for one day a week in practice for about 9 months. It is 10 years since I regularly worked in a hospital ward and I will be keeping records of my own reflective processes while also delivering nursing care. This will also involve observing reflective practices as they happen in the nursing team and inquiring into the tensions and possibilities of these processes. This will involve asking questions about practice some of which I hope to record using a tape recorder. In addition I would also like to invite some of you to join me in a small co-inquiry group of about 6 people which will hopefully represent all the grades of staff in your nursing team to meet in work time for about an hour and a half in order to help make sense of the stories of practice gathered. I hope to explore together, whether and how reflection makes a difference to our practice and to patients. You don’t have to think reflection is a “good thing” to take part in the study. You don’t have to have studied it in the past. I want to engage with practitioners who are willing to be open and questioning about their practice and have a range of views about reflecting in practice.

**Do I have to take part?**

This is entirely voluntary and if you choose to take part, you will be able to leave the study at any time. Any information you do not want included in the study can be withdrawn at any time.

**What does a Collaborative Inquiry Group mean?**

A collaborative inquiry group is a group of people who come together to explore issues of concern and interest with the aim of developing and improving their practice. So in this instance the focus will be around reflecting in practice. It is similar to an action learning set which involves reflection and action. Not only will I be noticing my reflective processes but I would like to invite you to also do the same so that in between meetings, you and I will be trying out new ideas and actions in practice, some of which may work and some may not. However, in action research of this kind, it is an important principle to question, make sense of and learn and therefore work towards changing aspects of our practice for the better.

**What will happen if I take part?**

It involves meeting regularly as a group, probably once a month at a mutually convenient place in the hospital. The meetings will be negotiated at the introductory meeting but would probably be for about an hour and a half – two hours. The aim is to have between 6-12 meetings. Again exact timings of these meetings will be decided through negotiation by the group and ward manager.

Each time we meet we decide on a particular focus in relation to reflection-in-action. We will share ideas, stories, questions, contradictions and then we will all go back into practice to possibly try out the new ideas about our practice that has been learnt in the group. The meetings will be taped and transcribed allowing us to rigorously make
sense of the research material. You will be observing both your own practice and those you are working with and then come back and reflect on those actions. It could involve you keeping a reflective diary or field notes. Although we will have to decide together whether we adopt this process as this is not what usually happens in practice. I want this to be a realistic study of the possibilities of reflecting during practice. We will be developing our own theories of reflective practice through this process of inquiring together. The group will devise its own ground rules but it is envisaged that facilitation will be shared at different points by everyone in the group. We will probably use storytelling and other forms of data gathering as a way of talking about our practice, observing it, and making sense of it.

Collaborative inquiry is based on a democratic process. We research together rather than the researcher holding all the power and researching on you. We together decide the research questions to investigate around the issue of reflection in practice. It is also important that we negotiate roles within the group rotating these as appropriate. For example, as the named researcher I would probably transcribe the meetings from the audiotapes and be responsible for keeping them safe and anonymous. However, the sense making from those meetings would be arrived at through activities and debate by everyone in the group. This collective process produces a combined understanding and shared sense making of the data we have produced.

**What are the possible benefits for me in taking part?**

This type of research may be different to what you are used to because if you choose to take part you will be more active in the process. This could help to develop your research skills in terms of collecting data, analyzing it and drawing conclusions and interpretations. Part of the process will be to produce interim papers some of which could be published at conferences or in professional journals and these would be jointly owned with co-authorship envisaged.

The university has some post qualifying modules called evidencing work based learning at levels 2, 3 and M and it may be possible after the co-inquiry group has disbanded to use some of your learning from the collaborative inquiry towards one of these modules if you would wish to do so.

As with all action research it is hoped that the research will produce improved changes in your practice that make a difference to you, your team, your organisation and ultimately client care.

**How do I know that what I say won’t be traced back to me (confidentiality)?**

Again, we will talk about this issue as part of our ground rules and they will also be subject to our ongoing review. Your name will not appear on the tape or transcript and all information we use will remain anonymous. Your contact details will only be passed on to other group members if you wish it. You will be given a code name for the study. Any stories used as examples would have names changed or removed and no details of where you work would be identifiable. I would also involve you in such decisions and any changes. This will also help in keeping information confidential. When not in use the tapes will be locked away and destroyed at the end of the study. Transcripts of meetings will be shared and agreed by the group. In addition outcomes will reveal negotiated differences and contradictions rather than my interpretation of reflection in
practice. You will be free to delete information and change ideas as you like. In fact you have far more input and control over the analysing and interpretation of the information than in traditional research approaches. The tapes will not be used for any other purpose.

**Are there any potential disadvantages in taking part?**

The inquiry group asks for a commitment in terms of effort and time. You have to be willing to inquire and chart developments in your practice. There may be times when the stories brought can be upsetting or the stories may highlight working tensions that may need addressing. However, because of the culture we will have created in the group and also my experience of facilitating similar groups over a number of years, such occurrences will be handled sensitively with support and where appropriate challenge. There would be opportunities to speak to a clinical psychologist outside the group should anyone wish to do so.

**What if something goes wrong?**

Action research is essentially a learning process. It is as safe as any process of education where there is a risk of challenge and change. In fact some of the most important learning for me has been triggered by difficult and demanding situations. Action research is not a form of therapy either but it does ask those involved to question what they are doing and this isn’t always easy.

As this is a doctoral study there are no special compensation arrangements. If you are unhappy with any aspect of the research in the first instance raise it with me. You are free to complain in person or writing, to Professor Susan Weil, Director of SOLAR and my Director of Studies or if still not satisfied to the Dean of the Faculty of Health and Social Care.

**What about the code of professional conduct (ethics)?**

This study has been reviewed by the United Bristol Hospital Trust and the University West of England, Bristol Central Ethics Committee.

As health care practitioners we are bound by our Professional Code of Conduct. Part of our meetings will be to constantly ensure that any reflections and actions we take are ethical. We are likely to be discussing and debating some of the ethical tensions in practice. The inquiry group should support and challenge your practice. And as with all action research it is hoped that where appropriate, the research will enhance and challenge your practice and be educative for others too.

Issues of ethics and power and the use and abuse of these are also important aspects of any action research. These themes will be central to our inquiry involving on-going learning and discussion through debate and review.

**What happens at the end of this part of the study?**

This co-inquiry group forms the second part of the study with a further group to be recruited over the next year so that it may be sometime before the final thesis is
produced. However, at the end of this group an interim report of the findings will be produced together and everyone will retain a copy. As stated earlier, joint publications may be possible. When the thesis is complete you would be invited to a sharing event.

If there is anything you feel has been missed or any questions you may want to ask we can discuss this at the introductory meeting or if you require further clarification about the study please do not hesitate to contact me on any of the numbers below.
If you would like to take part in this inquiry I will ask you to complete a consent form at the introductory meeting. I look forward to working with you in a cooperative and collaborative way.
Thank you for taking the time to read this lengthy sheet.
Kind Regards,

Clare Hopkinson
Senior Lecturer in Nursing
University of the West of England
Glenside Campus, Blackberry Hill, Stapleton, Bristol BS16 1DD
Clare.Hopkinson@uwe.ac.uk
0117 328 8567
Mobile 079053229362
Version 5 5/6/04
Appendix 2

Faculty of Health and Social Care

First Strand Participant’s Consent Form to Join a Co-inquiry Group into the Tensions and Possibilities of Reflection in Practice

Strand No.
Study Code Number:

I understand this study uses a collaborative action research approach and I am familiar with what this means

Yes/No

I have attended an introductory meeting and read the information sheet

Yes/No

I have had an opportunity to discuss the study and an opportunity to ask questions

Yes/No

Have you received enough information about the inquiry?

Yes/No

I understand that I can withdraw from the study at any time without giving any reasons

Yes/No

Codes and Pseudonyms may be used to represent my comments and ideas in the study

Yes/No

I agree to take part in this study

Yes/No

I agree to the inquiry being tape-recorded?

Yes/No

I understand that the recordings and transcripts of meetings will remain confidential, will be shared with the group and will be accessible only by the researcher, her supervision team and the co-inquiry members

Yes/No

Participant Name...................................................
Participant’s Signature...........................................
Date..........................
Researcher Name ................................................
Researcher Signature............................................
Date.............

I can be contacted for the purposes of this study:
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My preferred times for meetings would be:
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Version2 28/06/04
Appendix 3

Whinging and Reflection

JON
March 2005

- **Physio team leader** – *Space was important to allow a place/environment to come together to allow sharing of experience, thoughts, emotions and whinging. Felt to be productive and necessary for a team to work together and support each other, a confidential environment encouraged the whinging to be aired and then reflected on through discussion.*

- **Nurse 1** – *Need to reflect with someone to help turn whinging or negativity into learning = positivity, possible optimism. But the emotional labour of this could be a tension to acknowledge and prevent follow through. A final trigger tipped the balance for this individual from coping to whinging to seeking support from a colleague who could listen and facilitate them through whinging back to coping. *Does this demonstrate a need for facilitator’s in practice?*

- **Nurse 2** – *Act of talking, communicating and reflecting on turning whinging into action. Whinging was a way of asking for direction/guidance. Individual found that through reflective response this enabled them to take ownership of their actions.*

- **Nurse 3** – *Currently experiencing big organisational changes, related to whinging as a consequence of stress, change, the unknown and pressure. Reflection they felt helped them to recognise what was feeding into the pressure and identify what they had control of and what they did not.*

- Whinging was related to reflection, but would the team have been able to use it constructively to develop their practice.
- Whinging viewed as negative past time but reflection a positive response.
- Whinging the trigger to seek assistance through reflection.
- Reflection was observed as a tool to assist those that were whinging.
- Facilitation of reflection required intervention.
- Whinging only part a reflective process.
Appendix 4

Interview Schedule for Strand 1 Co-inquiry

What attracted you to the research?

What do you think of the process of co-inquiry?

How has your practice changed? If so in what ways?

What do you think are the tensions and possibilities of reflecting in the workplace?

Does reflection make a difference to work practices? If so in what ways?

Ethics

Politics

Empowerment

What do you think about the storyboard?
Appendix 5

IMPACT EVALUATION: three responses

Course or program title: MATRON ACTION LEARNING SET:

What was your original learning need?
1. I had been volunteered for the group but found it useful to discuss issues with matrons form other areas.
2. A need to share problems and discuss any anxieties outside of the management structure. To understand a different way to approach issues and concerns. Networking support from others at a similar level with similar problems
3. Was very unsure what the format or remit of the group would be.

Why did you undertake this program?
1. As above
2. An opportunity for development for me as an individual rather than just for me as a Matron
3. Felt that it would be somewhere to explore own attitudes, learn from others and develop within matrons role. Had not participated in something like this previously.

Has the program changed

1. Your attitude or morale?
   1. I always found it uplifting and felt better for attending
   2. It has helped me to see things differently
   3. Yes. Feel that I am better able to say 'no' to situations, people. My main problem was feeling frustrated with the workload, demands on time, interruptions to work ie telephone, drop-in’s to office, felt the need to work long hours and was less productive. Now I have changed work practices slightly to make work more productive for me.

2. The service you deliver?
   1. Became more reflective
   2. Has made me consider my priorities differently and what my job is really about
   3. Yes, as above. Feel more efficient (not sure what others feel!) and get things done. Still have contact with staff but get some work done.

3. Quality? (the way you do things)
   1. Began to see the global picture rather than just my focus.
   2. Has made me consider my priorities differently and what my job is really about
   3. Yes, as above. Feel more efficient (not sure what others feel!) and get things done. Still have contact with staff but get some work done.

4. Was the program value for money you invested (time)?
   1. Yes, the facilitator was excellent but unfortunately I was unable to attend as
many as I would like due to other work commitments.

2. When I was able to attend yes it was. The problem was the timing clashed with another regular meeting which was often impossible to get out of.

3. Yes, although it didn’t feel like it everytime I went. Often felt stressed with workload and didn’t want to go. Was worth it at the end of a session.

5. Has the program made an impact on your own practice as matron?

1. A bit

2. Has helped to change my priorities and focus my thoughts although it’s still easy to become lost and lose the focus between sessions

3. Yes I think it has. Felt good to speak to matrons from other areas. Same stresses!

6. Other comments you have about this program

1. Wish I could have attended more of the sessions

2. The timing made it personally difficult for me to attend as many sessions as I would have liked and the low attendance was frustrating for all

3. Claire was very good – the programme was not that well supported which I think is a reflection of the workload of matrons within the Trust. Some matrons were participants in other groups and felt this would not benefit them greatly.
Appendix 6

FACILITATORS NETWORK
Wednesday 1st February Section from Notes from Meeting

<table>
<thead>
<tr>
<th>Removed earlier points to preserve confidentiality</th>
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3. Claire Hopkinson
UWE

How Poetry can help Facilitation

Using Poems Claire has written from student experiences working in the NHS, Claire has been able to help explore situations, unravel perceptions and build a common understanding for better team working.

Using these poems we worked in pairs answering 2 questions
What strikes you about this poem?
Was does it trigger for you?

Our findings
It drew a number of shared emotions out
e.g. Sadness, Anger, Sense of shame, Guilt, Positivism

Learning from each poem
- Challenging but feels a very safe way to get emotions out. It doesn’t challenge you personally
- Exploring situations
- Diversity of perceptions on same situation
- Makes you think about how your behaviour is being perceived
- Brings out pockets of practice Good & Bad
- How bogged down, Change Management can feel. It brought out frustration not resistance
- Lack of respect of one delivering change. Delivery of ‘person’ can affect how change done
- The emotional cost of caring for others
- How we need to support people and do ask for support when you need it
- The value of Leadership & being the Role Model
- Being aware of “Generation culture”
  Sue shared a model she uses working with Children to help them feel in control of their changing situation. It is known as the system of Traffic Lights and is given to children on admission to hospital
  Red – For areas that are non-negotiable
  Amber – Areas up for discussion
  Green – Areas you choose

Claire has had different success with asking groups to write their own
poems. Claire has used pros (sections from books) with success. Care – people can be put off by published academic works of poems

We also had a discussion on the **skills of engaging people with role play**.

- It is vital that people see what value it adds i.e. Why / Give clarity
- Make it anonymous. If situation is emotional it is key that you do not play yourself
- Let them observe and get them to share observations of a role play

- Removed final part to preserve confidentiality

---

**Sample Poem used**

**AGEISM by Claire Hopkinson  13/10/04**

Old lady 80 years or more
Alone and still with this open sore
She shifts about just a tiny bit
Her tied skin rubs sheets that don’t quite fit
The nurses' say she's not in pain
The student says look how she’s lain
Who makes the time to sit and listen?
Or notice the beads of sweat that glisten
Look at the Doctor, a tired man
Ask him what’s the care plan?
Just a bed blocker left to die
Frustration makes the student cry
Old lady in the hard ward bed
Her life story left unsaid
Her leg would open to the air
Hospital staff, do you really care?
Appendix 7

Vulnerability as strength

- main message.
- link to whining - railing - railing
- resistance to reflective practice as a way of learning
- defensive processes (Antigone) - lack of direct feedback - "yes but" game
- being anxious - dependency - arrive as underdogs

**Antidote**

- is vulnerability as a strength.
  - dealing with uncertainty
  - not being perfect
  - Be perfect driver + dependency.
- Mary Poppins: lifelines people from its stickiness
- control is an illusion.
- Problems - guidelines give illusion of control but weak emphasis can risk about more - Realm 1 is an illusion
- Direct communication.

**Triangle - TA:**

- Be a perfect driver
- Flawed people
- Being up

**Antidote**

- The power of knowing where you are going
- Take the power back
- Pool your resources
- You are benefiting

**Indirect communication:**

- Being told, Awareness Phase (little kid riding on)
- High comparison for
- Building

**Antidote**

- Learn, Calm, Create, Build
- Learning paths + self-awareness

Colliding Process:

- presents led to these ideas
Appendix 8

X NHS Trust

Reflection on Experience

Why Reflect

Reflection is a process in which the practitioner can think about and achieve a better understanding of their practice. It also encourages an articulation of the knowledge gained in and from practice and the knowledge that supports practice. It emphasizes the process of learning not just the outcomes translated into nursing actions. It generates a questioning and inquiry into practice that helps to stop practitioners becoming complacent about their work. An essential part of reflective practice is learning from both positive and negative practical professional experiences. There are different ways to reflect depending on individual practitioner preference. Reflection-on-action can be viewed as a retrospective activity, looking back and evaluating current skills, competencies, knowledge and professional practice (Schon 1983). Alternatively reflection in action can be seen as a more dynamic process of thinking about and coming to an internal knowledge of current professional practice during practice (Schon 1983).

In order to learn from all clinical incidents both personally, within the organisation and where it involves external agencies, we require you to complete a reflective account following the incident in which you were involved. This should be followed up with an action plan (attached) in order to ensure that we address the main issues and continue to learn and develop through these experiences. It may also lead to organisational policy or practice changes as a result. Please complete your reflective account and return together with the completed action plan to the Clinical Matron within the next 7 days. A feedback meeting will then be arranged to enable you to discuss your experience. You will find some guidance notes on the reverse of this document.

Description
1. Write a description of the incident:
2. What are the key issues within this description that I need to pay attention to?

Reflection
1. Was, what I was attempting to do within my sphere of responsibility, competence and authority?
   1. Why did I act as I did?
2. What were the consequences, real or potential of my actions for;
   − The patient
   − Myself - Others
3. What action did I take when I discovered that the incident had occurred?
4. How did I feel about the incident at the time?
5. How do I imagine others might be feeling and what leads me to suspect this?

Influencing Factors

25 May 2006
1. What internal and/or external factors influenced my decision-making and actions?
2. What source of knowledge did or should have influenced my decision-making and actions?

**Alternative Strategies**
1. How could I have dealt with this situation better?
2. What other choices did I have?
3. What would have been the consequences of these other choices?

**Learning**
1. How do I now feel about this experience?
2. What have I learnt as a direct result of this experience?
3. What effective action have I taken in order to address these issues?
   - **Complete action plan attached**
4. In what ways has my practice changed?
5. How can the organisation learn from this incident?

**Adapted from Johns (1994) and Gibbs (1988)**

**References**


Guidance Notes

1. Description of experience
This should consist of a brief factual account (no more than one size of A4) of the events. This should include:
- When it happened, an example might be 'I gave IV antibiotics to the wrong patient' - include date, time, shift, location.
- Key issues that resulted in this incident occurring — eg failure to follow policy / procedure, interruptions

2. Reflection
- Was I informed at local induction/orientation about the relevant activity, policy, equipment etc.?
- Is there a risk assessment, SSOW, operational procedure etc. associated with the activity? Were you familiar with it?
- If the incident required you to have completed any training in order to be competent, have you completed the training? If so, when? Have you attended an update? If so, when? Is this the first time you have been involved in a medication incident? If not give details, when, where, what, outcome of incident and lessons learnt.
- What led you to act as you did?
- Reflect on the actual and/or potential consequences to: Patient - effect of medication etc, Myself – personally and professionally