Women Clinical Nurses' Constructions of Collegiality: an Ethnomethodological Study

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I certify that the thesis entitled:

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is the result of my own research, except where otherwise acknowledged, and that this thesis in whole or in part has not been submitted for an award, including a higher degree, to any other university or institution.

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Signed ..................................................................................

Date....................................................................................
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Abstract

**Title:** Women Clinical Nurses' Constructions of Collegiality: An Ethnomethodological Study

This research is about a shared journey of being together. It involved thirteen women nurses (including myself) in a process approach to working with data collected through audio transcriptions of conversations during group get-togethers, field notes and journalling over twelve months. The project was conducted in a large acute care metropolitan hospital where the ward staff interests lie in a practice history of the medical specialty of gynaecology and women's health.

Prior to commencement ethical approval was gained from both the University and hospital ethics committees. Accessing the group was complicated by the political climate of the hospital, possibly exaggerated further by the health politics across the state of Victoria, at a time of major upheaval characterised by regionalism, rationalisation and debt servicing.

In order to ascertain women clinical nurses' constructions of collegiality I adopted an ethnomethodological approach informed by a critical feminist lens to enable the participants to engage in a process of openly ideological inquiry, in critiquing and transforming practice. I felt the choice of methodology had to be consistent with my own ideological position to enable me to be myself (as much as I could) during the project. I wanted to work with women to illuminate the ways in which dominant ideologies had come to be apprehended, inscribed, embodied and/or resisted in the everyday intersubjective realities of participants. The research itself became a site of resistance as the group became aware of how and in what ways their lives had become distorted, while at the same time it collaboratively transformed their individual and collective practice understandings, enabling them to see the self and other anew.

Set against the background of dominant discourses on collegiality, women's understandings of collegiality have remained a submerged discourse. Revealed in this work are complex inter-relationships that might be described by some as collegial, but for others relations amongst these women depict alternative meanings in a rich picture of the fabric of ward life. The participants understand these relations through a connectedness that has empathy as its starting point.

In keeping with my commitment to engage with these women I endeavoured to remain faithful to the dialogical approach to this inquiry. Moreover I have brought the voices of the women to the foreground, peeling away the rhizomatic interconnections in and between understandings. What this has meant in terms of the thesis is that the work has become artificially distanced for the purposes of academic requirements. Nevertheless it speaks to the understandings the participants have of their relationships; of the various locations of the visible and invisible voices; of the many landscapes and images, genealogies, subjectivities and multiple selves that inform the selves with(in) others and being-in-relation. Throughout the journey meanings are revealed, revisited and reconstructed. Many nuances comprise the subtexts illuminating the depths of various moral locations underpinning the ways these women engage with one another in practice. The process of the research weaves through multiple positions, conveying the centrality of shared goals, multiple identities, resistances and differences which contribute to a holding environment, a location in which women value one another in their being-in-relation and in which they stand separately yet together.
Preface

Before you read this thesis I want to mention several thoughts about why I have adopted some of the strategies in the writing of this work. The worlds of nursing are complex. One of the ways to try and grapple with these worlds is to attend to the aesthetic experience. I have endeavoured to portray dimensions of the participants' lives, often difficult to convey in language, by using different 'styles'. For example, you will note Gaye Bonham's original paintings appearing as photographs are scattered throughout the text. Like other photographs, they serve to enhance meaning. The music too has been chosen for particular areas, adding a different quality to the experience in the reading(s) of the text(s). You may not have the pieces to which I refer, but I am sure you will find other music that resonates for you at these moments. The music offers an enriching horizon in the shaping of ideas.

I have adopted two approaches to documenting citations. Where reference is made to quite specific ideas or points, I have identified the author's name, date and page(s). Where a year appears following the author's name without any page number, I am referring to the author's general thesis, position or argument.
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Chapter 1

Posing the question

As the reader of this text you are asked to keep in the back of your mind what this piece of work seeks to explore. It is a work of contradictions, interconnections, ebbs and flows in a group of nurses' everyday worlds of practice. It has no real starting point nor completion - it is and it might be. I want to share with you some of the many meanings underlying the notion of collegiality illuminated in the practice worlds of nurses in the culture of a hospital ward. In doing so, I have sought to expose many assumptions underpinning the social construction of collegiality and its expression through patterns, symbols, metaphors, rules and texts. In particular, I have sought to address the following questions:

- To what extent does a form of collegiality exist in clinical settings?
- What form(s) does it take?
- To what extent might the practice of nursing be improved through revised and enhanced notions of collegiality?
- To what extent does collegiality empower nurses to engage in caring practices?

Whether these questions are answered remains problematic given what has transpired and bearing in mind that, although these were the questions that I started out with, and were ones that were shared to some extent, they may not necessarily represent the interests of those with whom I engaged. Nevertheless they were posed as a starting point, or what I thought was one. What has emerged subsequently has been a profound experience, something I share with you as glimpses, windows into the worlds of women who most of all care, but do so always in-relation.
**Looking back**

As I pause to look back now it is easier to appreciate why this topic has been an important one for me. Often, I think, we fail to take stock of the contributions others make to our lives: in particular of those friends, students, families and partners with whom we share our passionate, frequently messy, often fraught journeys; journeys that can offer new insights, choices and possibilities to all of us individually as well as collectively. The insights in this work have been part of a larger journey, one in which I have been privileged to walk with others. I carry with me these stories, those in and of practice, of distance, privilege, walking boundaries, of being a stranger, then again, a trusted colleague and friend. Yet I am not the sole owner of these narratives for they are stories of us all; those of being and being in-relation, a knowing that is at once personal and passionate.

Over the years, the paths have been singular, shared, illuminating, painful, difficult, joyful and extremely rich but not without passion and not without struggle. It is not surprising then that I am interested in clinical nurses' constructions of collegiality, the focus of my research.

This project has in a very real sense, been a voyage for me; one involving my colleagues as well. The odyssey that we have shared not only arises from the questions themselves (for me it was there even before the questions sprang to mind) but it has also been embedded in the work I have done over some years as part of a larger political project. Many of the issues I want to address herein are those that I encounter in my everyday life. As the reader your will bring your own interpretations to bear as ideas resonate with your own experiences, creating further narratives along the way.

To help you appreciate why it is that I am interested in the notion of collegiality and how and in what ways a small number of women clinicians hold particular
constructions of collegiality, I want to first trace some of my background. This will enable you to better apprehend why it is that I hold certain values and pursue questions in particular ways.

Situating myself

One walks into the future carrying one's past, which inevitably has an impact on future possibilities and, of course, the choices one makes. As a child of the 50s and 60s I lived in several small communities yet moved between the bush, the plains and the sea. I attended a small boarding school set in the hill tops at the southernmost tip of the Great Divide, mountains that run almost the length of Eastern Australia. The beauty of this space enabled me to begin to recognise the importance of one's reciprocal connections, about the balance needed to live in our delicate environment as caretakers within our time, and the meanings of place in one another's lives. It was not always idyllic, nor was it easy, but the marks of my early life have left their own indelible legacy.

After school my career options were somewhat limited; or that is what I understood. The range of careers for women then included school teaching, secretarial work or nursing ... until one got married ...

I decided to 'do' nursing instead of teaching or being a secretary. In the early seventies I completed my hospital training, a time that offered me further insights into the socio-political and economic issues surrounding nursing and health care. I moved within and between patriarchies at home and school and then to another - the hospital! I began to recognise that my self as a person was one thing; there were other selves as well! My personal politics were beginning to develop as I began to question the ways in which women, and women nurses in particular were regarded.

While a somewhat benevolent culture pervaded hospitals, the invisibility of women nurses was notable. During those years I became more politically aware, not only of
the institutional life of which I was now firmly a part, but also of my position: that of a privileged, white, educated, angloethnic, middle class female, whose personal politics had begun to unfold. I began to recognise my own oppression as I walked the margins of several worlds.

My false consciousness of subservience was developing well; after all I moved from one community to another - the hospital! Over time the predominantly paternalistic ideologies embedded in the bureaucracies in which I worked led to quite intense feelings of fragmentation. I felt frustrated with the institutions for a variety of reasons. For instance, I disliked the structuring of relationships - who could relate to whom; the constant introduction of technological efficiencies which are (were) supposed to save nurses' 'time', meant less time spent on what I understood to be caring; and, the fact that certain voices were deemed more important than others all made me angry.

At the time I did not realise that my growing rage was telling me something that I was not listening to (Jaggar 1989). What I did not realise was that institutional strategies acted to distort one's reality, masking dominant interests. Rapid change and the need for hospitals to engage in capital accumulation marked the ideological shift of what had been 'charitable' institutions into the corporate business world. It was a move to a form of instrumental individualism which served to foster nurses' isolation while encouraging an alienated labour force maintaining nurses' impotence. Furthermore, part of Nursing's historical legacy and adherence to the philosophy of Science supported and sustained the existing cultural hegemony, a hegemony that has largely remained reified in the cultural practices, discourses and relationships of health care organisations. The legacy continues to contribute to a lack of recognition of the complex, often chaotic everyday worlds of nurse practitioners (Perry and Moss 1989, p. 35).

Further studies encouraged me to begin to problematise my own practice as nurse/educator/academic, confronting what were now becoming further contradictions
in my world. To what extent was I participating in the control of a banking model of
eduction, described by Freire (1972) as a top-down system, a hierarchy of knowledges
which served to silence students and render their experience irrelevant? Was I
engaging in an educational process which endorsed conformity by encouraging what
Greene (1988 p. 22) calls a 'passive consuming audience' with an emphasis on
behavioural and technical knowledge at the expense of critical and imaginative ways of
understanding situations (Greene 1988, p. 126)? Was I enacting a positivist approach,
ideologically driven through the classification and framing of educational experiences
(Bernstein 1975)? How and in what ways was I contributing to the status quo,
foisting a form of agency which I had begun to resist? In addition, I was struck by
the work of Shor (1987) who wrote fluently about the alienating experience of
education, particularly where the environment echoed a broader socio-cultural
harshness, one of impersonality, where expanses of grey concrete acted as sombre
reminders of uniformity and sameness, spaces robbed of their spirit of community,
politics, or their heritage rich in aesthetic artefacts.

The emerging question
As time went by I began to recognise more fully the dominance of patriarchal
ideologies embedded in the bureaucracies in which I worked. These ideologies,
through the structuring of the working world, were lived out in the divisions of labour
based upon the relative importance of tasks. Moreover, with the lines of authority
clearly drawn, it was of little surprise that nurses found themselves consistently
seduced by dominant interests. The homogenising effects of institutional culture acted
to alienate one’s self from others, meanwhile fragmenting care.

It was not until a number of years later that I experienced something different whilst
working with a group of women in a smaller community hospital. It was at this point
that I began to wonder what made this experience so different from previous posts.
Like Carmel Seibold (1990, p. 241) I had enjoyed working with others (including
Carmel) who ‘... encouraged, advised, inspired, intellectually stimulated and most of
all cared ...’ about one another. It was in this space that I began to recognise and reflect upon what it meant to participate with others, to be able to speak, to have your opinion valued and most of all to work with a group of women who really cared about/for/with each other (Cash 1993a, p. 71). I began to take seriously the work of scholars like Freire, Shor, Greene, Bunch, hooks, Lorde, Frye and others. Under their influence I came to grapple with issues of power enacted through curriculum and pedagogical processes thus foregrounding my interests in emancipatory strategies. My journey of transformations began in earnest as I sought to reshape my practice, changing my relationships with students in an attempt to enact a 'living of care' (Cash 1993a, p. 71).

I began to focus on my research interests. It became increasingly apparent that what I wanted to think about was collegiality, but to look at it in the context of nurses' everyday working worlds. I suspected that much of the information on collegiality, especially that appearing in the nursing literature, was drawn from management models and that the term itself was tied to the discursive practices associated with professionalism. Moreover, the fact that nursing had picked up the term suggested inherent political allegiances that at first sight stood at odds with values underpinning nursing. It was from this position and my own experiences that I began to seriously think about collegiality in practice.
Chapter 2

Literature review

Creating the context

As I have already outlined, my interest in collegiality stems from a period in my career during which I was privileged to work with a group of women nurses who were able to encourage, support, and value each other's contributions. This experience left a legacy of empowerment (Cash 1993a; Seibold 1990) and illuminated the possibilities of feminist praxis enabling an emancipatory approach to nursing in an institution that endorsed patriarchal ideologies. Since that time I have worked with other groups, particularly in a pedagogical sense, using an adaptation of a feminist process described by Wheeler and Chinn (1989) which had liberatory affects on participants' personal and working lives, and especially on their nursing care (Cash 1993a; Cash 1993b; Cash 1994; and Cash 1995). These processes have highlighted the recurring issue of the importance and empowering potential of personal relationships and networks - what may loosely be called 'collegiality'.

Broadly speaking, collegiality appears to have been paid scant attention in the nursing literature. Maybe it is because practice sites (hospitals in particular) have emphasised hierarchical roles, rule-governed behaviour, and patriarchal and paternalistic ways of enacting care derived from images of women including those of obedient, self-sacrificing mother or servant (Kalish and Kalish 1985, p. 108; Ashley 1980; Connors 1980). Generally, much of the work on collegiality stems from management literature which includes an array of debate ranging through issues of control; enhancing performance as an aspect of management strategy; issues of motivation where certain traits might be encouraged; or discussion on collegiality and its relationship to professionalism and authority (Campbell and Dowd 1991; Waters 1989; Roe 1987, p. 92; Crowley and Wollner 1987; Sawada 1982; Beyer 1981; and Beyer and Marshall 1981). Most of the studies reviewed were undertaken outside the nursing field.
primarily because very little research has been forthcoming on collegiality in nursing. This is not to suggest that nursing has given little attention to the importance of collegiality; rather, that the references made are citations in passing, leaving the question of problematising or critiquing nurses' constructions of collegiality unaddressed. Collegiality thus appears, in the main, to be an assumption of something present within a nursing environment, a rhetorical concept associated with discourses on professionalisation and management (Brewer 1996, pp. 23-25), or more recently, on tying collegiality to performance indicators (Cassidy 1998; Brett 1997; Bramble 1996). Many studies were situated in the fields of academe, teaching, social work/welfare, or the priesthood. The majority of investigations adopted empirico-analytical methods, giving a fairly narrow yet generalised view of collegiality. Some of the more recent literature (for example, Crellin 1999; Collyer and White 1997; Cordery 1995) appears to reflect what Smyth (1996 and 1992, p. 23) calls a 'resurrection' of ideas, where individuals are considered as objects having value purely in economically productive terms.

Now, with attention placed on efficiency and effectiveness, interest in collegiality seems increasingly to be focused upon co-operative strategies, partnerships and team work as fundamental themes articulating the ways in which individuals are to relate to one another at work. What this appears to amount to is a form of ideological control achieved in the main through the restructuring of health care agencies (Smyth 1992, p. 26), with a concomitant rise in forms of economic rationality that take as their starting point facts. Facts appear to be the legitimate knowledge, at least in the object sense. Harding (1993, p. 71) claims that objectivity, notably found in traditional science and manifested in health care bureaucracies, masks the value laden underpinnings on which knowledge claims rest. By masking the social construction of knowledge as well as its historical context, mystification of the subjective furthers the utility of objective truth claims while rendering the subjective invisible (Cash 1994, p. 77). The invisibility of the subjective nature of collegiality as it is lived out in the practice world of nurses remains unquestioned. Few studies appear to have been undertaken to explore the
meanings of collegiality to those working in organisations, let alone women's constructions of collegiality.

Problematising the extent to which politics, gender and the division of labour plays an important part in nurses' understandings of collegiality is central to this study. Practice realities form the nexus of the public/private images of nursing. What appears to be poorly understood is the dialectical relationship between the public/private spheres of practitioners as they are lived out in the public/private worlds of caring. In particular, the public space of patriarchal health care agencies masks the inequalities arising from what, on the surface, appears to be a gender neutral zone (Gardner 1989, pp. 54-55). This study has attempted to uncover and illuminate the '... unexpected social formations from the perspective of those involved ...' (Wade and Simon 1993, p. 81) offering a richness in meanings arising out of practitioners' lives.

In the main, studies have failed to expose the ways in which history, culture (in the broad sense as well as the local) and milieu play an important part in shaping the often contradictory nature of relationships between colleagues. Moreover, bureaucracies, in reflecting a gendered division of labour, parallel traditional feminine and masculine career structures augmenting existing organisational practices that can act to discriminate against women (Ruby 1998; Crompton and Le Feuvre 1992, p. 109). Wright (1995, p. 12), for instance, explains that, in the current economic climate, health organisations have become more rigid in their management practices, resulting in an adherence to competition, task orientation, objectivity and the commodification of health issues. Located in this particular climate, work traditionally associated with women, such as caring, has been either rendered invisible or 'technologised'. Thus, commodification of care in terms of the technical tasks becomes the output of nursing, devaluing and relegating issues such as mutuality, reciprocity or connectedness as something neither important nor significant.
It has therefore been important to illuminate the day-to-day realities of nurses' relationships with one another as they enact care to expose the pervasiveness of dominant ideologies. This does not, however, take into account the ways in which nurses' alliances are forged; the complex nature of competing claims within organisational sites; the struggle over culture in which the predominating view is a masculinist one; the fact that feminine notions of caring are on one hand part of the rhetoric of nurses' articulated values, and on the other hand, appear at odds with the corporatisation of health; and finally, that nurses themselves live out a life in which they find themselves compromising their values (Wright 1995) offering what has been recently termed 'survival care'. These tensions need to be placed both in their historical and their contemporary contexts in order to appreciate the ways in which the women nurses in this study apprehend their reality, and consider individually, as well as collaboratively, what possibilities exist for transforming their world. At the same time it becomes possible to grapple with the notion of collegiality and the intersection between dialectical relationships of collegiality and the ways in which nurses apprehend client care. It is these areas that appear to have been omitted from studies in collegiality especially in terms of women's understandings, but more particularly of women nurses' constructions in the patriarchal world of health care delivery.

Many studies reviewed reflected collegiality as a decontextualised 'construct', which fails to take into account the manner in which collegiality is continually shaped and recreated within the social world. Epistemologically, these studies appear to find their basis in a context free, empirically discrete object reality of causal relationships. As truth, these cause–effect relationships can then be used to predict and thus direct initiatives to control a social realm where interests and values are rendered impersonal and irrelevant or inappropriate (Cash 1993b, p. 86; Smyth 1991, p. 327; Denhardt 1981, p. 148; Fay 1975, p. 19).
What might collegiality mean and why is it important?

Thus, the importance and significance of this study lies in considering women nurses' constructions of collegiality as an alternative critique. One might ask, for instance, whether collegiality is a form of praxis that takes as its starting point the notions of participation, equity, and justice. How and in what ways do nurses enact their meanings of collegiality through their language and discourse, activities and practices and their social relationships within the organisation? What are the various meanings nurses ascribe to their enactment of collegial relationships? Whose interests does collegiality serve? Can collegiality act as a counter discourse to the form of technical rationality that gives lip service to caring? How and in what ways do the various constructions of collegiality effect nursing care? By exposing the notion of collegiality to mean something other than what has been traditionally considered as collegiality, will such alternative discourse(s) be implicated in changing patterns of care provision? To what extent will the process of involvement in the research transform the participants' understandings of their world, leading to change? How and in what ways might such change be enacted, and what meanings might arise from engaging in the research process? Such questions offer possibilities arising from engaging in a reflexive critique of practice; possibilities that generate different dimensions of collegiality that until now have remained elusive, taken for granted, or rendered invisible.

The implications of this project have been difficult to articulate, given the nature of the research process itself. Initially, I imagined that through the various processes encompassing inquiry, the research could have far-reaching affects. Given that it involved nurses in exploring the notion of collegiality as part of nursing's culture, or collegiality as a culture, I wondered if this research might act to improve the care that nurses offered to patients in the ward. In addition, I recognised that the research process itself, more than the outcome, would depend on the participants' willingness to become part of a group. Together the group's endeavours to unravel notions of collegiality, I thought, might arise from individual and collective experiences;
experiences dialectically situated within the context of practice having implications in/for care provision.

**Past studies—raising some**

Early studies attempted to define collegiality as 'comradeship' (Reres 1970), 'fellowship', (Cooley 1957, in Beyer 1981, p. 111) or 'interpersonal communication' (for example Fry 1975 in Beyer 1981, p. 111). Other studies have centred on traits or characteristics contained within the concept of collegiality. Beyer (1981, p. 111) in a cross-sectional mail survey of 222 female nurse educators concluded that there was considerable dissatisfaction with collegiality. Beyer's study appears to fall short, however, in revealing how, and in what ways, culture plays a part in maintaining contradictory and antagonistic relationships. Nevertheless, Beyer notes that, in the absence of supportive relationships based on communication and where respondents lacked involvement in decision making on curriculum or educational issues, collegial interactions rested upon a sense of distrust, lack of confidence or threat. This sentiment is echoed by Speedy (1990, p. 75) who claims that competition is another difficulty which appears to militate against the development of collegiality (Brett 1997).

Competition emerges as people find themselves increasingly isolated from each other through institutional regulations and rules promoting the division of labour and prescribed work practices. Through the hierarchy, responsibility becomes defused particularly by fragmenting, depersonalising and or selectively disseminating details so that many individuals find themselves in situations where they feel powerless. Often, members of organisations take for granted, and accept their situation without question (Roberts 1983). They consider their practice reality to be the way things are, or have always been, and thus that any change is inconceivable. While some feel powerless to do anything about an untenable situation they continue to comply in case sanctions or rewards are introduced (Ferguson 1984, p. 19). Penalties and affirmation thus serve several purposes: namely to ensure that the individual continues to follow the organisational line and at the same time, this kind of surveillance (Foucault 1977) acts
to maintain the power relationships in and between members of the organisation, enabling the silencing of counter hegemonic discourses and the masking of dominant ideologies. As one of many ideological strategies to support the status quo, competition acts to mask dominant discourses, thus legitimating institutional interests (Apple 1985, p. 14; Freire 1972, p. 58) particularly the political agendas of the institutional oligarchy (Apple 1985, p. 14; Ferguson 1984). As many health care organisations downsize nurses find themselves confronting the tensions of isolation, powerlessness and distrust. Bunch (1986, p. 149) offers the following comment:

> We must ask why, instead of coalescing more, women have to continually separate into distinct groups in order to be heard?... Whether on the basis of race, class, age, ethnic identity, sexual preference, or physical abilities, each group has had to find a separate space and identity in order to create conditions where their perspectives would be seen by others.

But it is not only a question of visibility; it is a question of nurses being heard and taken seriously as colleagues participating, as do other health care workers, in caring for clients. As Duffy (1995, p. 7) explains, the enactment of collegiality becomes extremely difficult for nurses who, while being responsible for client care, are subordinate to medical authority and subject to institutional regulations. Given these tensions, it is not surprising that nurses as a fragmented group enact and perpetuate horizontal violence.

Horizontal violence is a term broadly meaning the destructive ways peers act towards each other. Such action might include derogatory comments, scapegoating and blaming others (Roberts 1983) and arises from the inability of the oppressed group to confront and change their situation (Duffy 1995, p. 9). The matter is compounded by the dominant group exploiting and isolating individuals. It drives a wedge into the existing culture to diminish the valuing of nurses' understandings and their contributions in health care practice. However, it is not only those in leadership positions but nurses themselves who participate in horizontal violence (Duffy 1995). One possible insight is offered by Griffin (1982, pp. 172-173), who suggests that horizontal violence reflects rage. Griffin explains that behind anger, self-doubt and shame lurk. The more one is unable to express one's feelings, the more angry one
becomes, to the point of increasing shame and humiliation. Bartky (1988, pp. 76-79) argues that patriarchal constructions of an aesthetically feminine yet silent body of womanhood are reified through institutional discursive practices, practices that silence the voice contributing to the anger and disillusionment many nurses appear to feel.

Rage might be reflected in various ways. For instance, engaging in negative criticism of colleagues or self further sustains dominant ideologies that foster powerlessness (Cash 1993b and 1993c; Speedy 1987), lack of self-trust and self-esteem (Govier 1993, p. 110; Bartky 1988). Raising questions about the nature of relationships helps to surface the political sphere of the clinical environment frequently rendered apolitical through bureaucratic structures and processes.

Politicising the nature of the present climate in health care encourages one to reflect on Ashley's (1980, p. 3), claim that 'within patriarchy the power of structured misogyny keeps women in their role of glorified servants to men—keeps them oppressed in subjugated domestic roles living out the cult of true womanhood'. This, Ashley believes, increasingly disempowers nurses and reduces their ability to act politically. Ashley's notion of political action also reflects some of the contradictions located in various understandings of political agency. Greenleaf (1980), using Rich's (1975) work, argues that nurses' thinking is influenced by their social world, a world in which the pervasive perspective is male. An understanding of the dominant view in a more or less tacit sense, is part of the taken-for-grantedness of local political understandings coming to bear in any situation. Whether these perceptions are made explicit or not, they are understood in an intuitive sense so that practitioners manoeuvre around disenabling barriers in some quite contradictory ways (Frye 1992, p. 785). One could well ask whether such actions reflect forms of resistance associated with marginalised groups and, as such, constitute understandings constructed from 'life in the margins' (Hall, Stevens and Meleis 1994, p. 28). It should be noted, however, that even where alliances are forged by marginalised individuals they too will enact the same forms of oppression they experienced (Freire 1972; Duffy 1995, p. 14). Turner (1995, pp. 148-151), in a discussion on 'compliance and complaint at work', suggests
an alternative interpretation of nurses' practice reality. For instance, Turner explains that a sub-cultural text of obedience and complaint reflects a discourse of survival used primarily to work out tensions arising from the lack of autonomy in the health care environment. The 'vocabulary of complaint' serves a number of purposes, amongst other things representing a discourse of resistance that helps generate a sense of support amongst some colleagues, uniting them against those deemed as superiors (Turner 1995, p. 150). However, the outcome of such sub-cultural discourses is rarely the transformation of the environment.

It seems reasonable to suggest that the lack of strategic power and nurses' subordination reflects a deeper issue depicted in the lack of credibility and status accorded to women, especially in leadership positions (Ruby 1998; Nye and Forsyth 1991, p. 363). The situation is further compounded by what Turner (1995, p. 151) describes as a 'feminised labour' issue lived out through a questionable commitment to nursing, little occupational satisfaction, interrupted careers and career pathways which remain clearly untenable (despite industrial action). In these circumstances it becomes important to ask whether collegiality amongst nurses is a utopian concept.

Another study reported by Campbell and Dowd (1991) found that collegiality was an integral component in supporting research in the clinical environment. Again, the notion of collegiality contained various dimensions including respect for one another, understanding of others' views, how power was 'negotiated', involvement in the project and expertise in the area, and agreement on the common goal and associated philosophical views (Campbell and Dowd 1991, p. 44). Street (1998), Gandy and Jensen (1992, p. 7) and Roe (1987, p. 92) also report similar findings. However, these authors allude to equitable power relationships constituting an important aspect of collegiality. Billings (1993), reviewing an empirical study of collegiality undertaken by Halstead (undated), draws attention to the results of the study, highlighting that while students and faculty desired collegiality, there was a noticeable lacking of this 'value' (Billings' terms) in student–faculty interactions. It appears reasonable to
suggest that Halstead's study failed to critically examine the assumptions underpinning power, in particular, in the ways in which unequal social relationships came to be lived out through the classification and framing of knowledge (Bernstein 1975), desire, identity and consciousness, through the distribution of power (Bernstein and Solomon 1999, p. 270). The same might be suggested of Massy, Wilger and Colbeck's (1994, p. 18) work where they found that while collegiality existed even at a superficial level, any attempt made by faculty to reshape curriculum and pedagogical processes became thwarted by other academics. Similarly, Hansen (1991) in surveying over 500 registered nurses in two magnet hospitals, found collegiality to be important to effectiveness and efficiency. The issues surrounding power and its distribution however, were not problematised. Thus, power contained within an ideology of control clearly needs closer scrutiny.

Studies by Massy, Wilger and Colbeck (1994, p. 18), Roe (1987, p. 92) and Campbell (1985, p. 169) expressed, in particular, the need for collegiality that emerged from equitable power relationships in order to realise professional effectiveness. Collegiality, according to these authors as well as Hansen (1991), offers the medium through which effective team work can accomplish defined goals; in fact collegiality was identified as the hallmark of such work. The latter point is significant because one wonders whose goals and whose interests underpin the public or identified goals, an issue that highlights implicitly the competing nature of goals in institutional life. Even if one recognises the contradictions embedded in the politics of bureaucratic organisations, the notion of collegiality seems at odds with, and quite antagonistic to, the political sphere of team work (Moloney 1992, p. 166). These contradictions become apparent where, on one hand institutional culture supports the notion of team work in rhetorical terms yet, on the other hand, there is a constant attempt to sustain individualism, for example, by regularly rotating staff, or moving nurses from one ward to another on a shift by shift basis. As divisions of labour within nursing occur in part through prescribed activity, the designating medical specialist areas, and the social networks, each area has its characteristic discursive practices enabling the
enactment of care. Thus, when individuals are moved from one location to another they can be systematically excluded (Pettman 1991, pp. 188-189).

As a newcomer to the environment a nurse might be seen as an interloper without the relevant networks and connections necessary for the realisation of full participation and involvement in 'ward life'. Where nurses find themselves in this situation without the associated connections or alliances they are subject to being told what to do. They may engage in fragmented action leading to the alienation of the individual from her colleagues (Ramazanoglu 1989, p. 190). Thus, the way social relationships are structured amongst health care workers, and nurses in particular, reinforces the public political agendas while limiting participation in institutional matters (Benhabib 1992, p. 48). For many registered nurses, arriving in a new location makes them feel uneasy or different.

What is it about a new location that encourages nurses to feel they are not part of a team, alienated, or unwanted? In a study of a children's first dance party Rossiter (1994, pp. 8-9) found that the shaping of relationships, and understanding one's relationships with others, had a lot to do with the awareness of being watched undertaking a task. Knowing one is being watched or that there is a possibility of being observed engenders obedience, thus one acts in ways that support institutional norms to avoid the threat of rejection while hopefully being recognised and valued for one's contribution (Rossiter 1994, pp. 8-9; Cash 1994). The practitioner is thus caught in an awkward cycle, one that requires the nurse to demonstrate that they are competent according to implicitly agreed upon criteria. In order to demonstrate capability the registered nurse needs to have an opportunity to perform the deemed important tasks with appropriate skills considered by those with power to be of a satisfactory standard. Thus, the nurse is placed in an unenviable position of first having to 'prove' their capability, which is contingent upon having the opportunity to do so.
The nurse, as the outsider, allows the organisation through its structures and
discursive forms to manage difference, often through correctional approaches
(Ferguson 1984, p. 137). Labels and derogatory comments about practice facilitate
this process, resulting in the registered nurse becoming disenfranchised, devalued and
dependent. While nurses continue to engage in horizontal violence they are also
disempowering themselves, supporting the authority of others who, by virtue of their
status, are able to use the knowledge gained through disclosure as a power base
(Grosz 1990, p. 92). Labelling thus confirms the person as object other (Connors
1980) while implicitly excluding the subjective understandings that inform the nurse's
practice.

Rules governing institutional life form part of the overt symbols which control nurses'
activities while encouraging invisibility and silence (Ferguson 1984, pp. 68-69). As
rules dictate the way one acts in certain situations there is little room for choice.
Individual visibility helps to foster compliance with the rules and, over time, ways of
acting become reified and hegemonic, facilitating self-discipline and surveillance
(Bartky 1988, pp. 61-63). The notion of 'symbolic violence' (Bourdieu 1973) or the
ability to influence or manipulate suggests that understandings drawn from past
encounters are brought to bear in new relations of power which come to be understood
as the present reality. This new understanding represents a symbolic form of power
constructed as a synthesis of old and new meanings which, when shared with those
with whom the practitioner lives and works, comes to be understood as the existing
reality. Symbolic violence provides an opportunity to closely examine the
interconnections between intersubjectivity and existing reality (Bottomley 1991, p. 97)
and may offer some clarification about why it is that nurses seem to acquiesce.

Beyer's (1981) ideas are echoed by Speedy (1990, p. 74) who considers that
collegiality might be fostered through relationships which incorporate 'friendliness,
enjoyment, understanding, open communication and freedom from threat'. These
relationships, however, become difficult to foster in institutions dominated by
patriarchal ideologies (Speedy 1990, p. 75) where individualism prompted by competition encourages exploitation (Stearley 1994, p. 52; Lenz 1989, p. 82). In occupations where women far out-number men (such as in nursing) any major gains in working conditions or in acknowledging the importance of nursing's contribution to health care is in grave danger of being lost as women's voices are systematically silenced (Chandler 1995, p. 81). As Bryson and Wearing (1985, p. 361) ask, why is it that women continue to collude with male hegemony allowing patriarchy to discern their issues as those of the organisation?

As nursing attempts to grapple with professionalisation, the organisation and structure of nursing work has concomitantly seen a change in the direction of debate on collegiality, a direction towards quality improvement programs, quality assurance schemes, or performance targets - a legacy inherited from the business sector (Ruby 1998; White 1995, p. 231; Massy, Wilger and Colbeck 1994, p. 19). These trends are hardly surprising given the increasing number of (usually) male non-health (business) managers replacing positions traditionally held by nurses and doctors (White 1995, p. 231; Lumby 1995, p. 252; Adkins 1992, p. 209). It should be noted that in the studies specifically on collegiality, problematising the gendered division of labour has, in the main, not been addressed, or where it has, it has been considered tangentially.

Debate focusing on collegiality appears to emerge along several pathways. For example, the vast majority of information emanates from functionalism, role theory, attribution theories, traits or characteristics arising from behaviourist and social relations theories. In the main these theories are ahistoric, apolitical and endorse social elitism (Fowler 1990, p. 25). There is considerably less detail available in relation to the social construction of collegiality as an aspect of, and implicated in, management strategies and professionalisation. Exploring the latter, Apple (1985, p. 76) notes, and Giroux (1980, p. 332), explains, that 'work culture' mediates ideologies through both formal and informal organisational structures in quite subtle ways that render dominant interests invisible and apolitical whether in their explicit or rhetorical forms. To
understand the realm of work culture, and, indeed the ideologies embedded in working life, it is necessary to unravel the taken-for-granted ways of acting in practice. Through critiquing the contradictory spheres of action in which organisational members relate and actively shape the culture within the institution (Allen 1987), it becomes possible to expose those assumptions embedded within organisational life which are reshaping the notion of collegiality to mean skill, competence, staff development, quality assurance, and management or control (Smyth 1996; White 1995, p. 231; Smyth 1991, p. 328). The extent to which these assumptions are questioned appears to remain marginal at best, possibly because such analysis has failed to grapple with the ways in which power is imbued in, yet masked by, the complex dialectical arrangements in practice. As part of this analysis, it is important to reposition gender at the centre of nursing's complex world of structured dominant relationships (Ruby 1998; Davies 1992, p. 233).

Supporting the notion of professionalisation, Little's (1982, p. 333) ethnographic study of student teachers highlighted four types of collegial action seen to be crucial to professional development. Collegial actions included particularised talk which assisted in the fostering of a 'shared language' that not only supported the critique of each other's practice, but enabled the shared development of curriculum and pedagogical processes in which the staff were directly involved. Little also noted the importance of a school culture to the existence of collegial interactions. For instance, where the expectations of the staff included participation 'in critical practices of discussion, observation, shared planning, and learning required to satisfy the formal and informal obligations of the job - the greater the prospects that the interaction [would] influence teachers' practices and school success' (Little 1982, p. 335). Here it could be argued that peer review (acknowledged as a characteristic of professionalism), particularly some forms of it, comprises a prescription for staff development (Wainwright 1987) in which institutional agendas remain obscure. Moreover, where structural arrangements insist on, and press for, participation in a climate that is steeped in individual pursuit of goals, then 'norms' of collegiality become increasingly invisible due to the teachers
perceiving participation as a threat, with the coinciding introduction of sanctions (Ferguson 1987, p. 13; Little 1982, p. 335). The need for reciprocity in relationships between peers was seen to be crucial to a collegial atmosphere (Crowley and Wollner 1987, p. 60; Wainwright 1987, p. 19; Little 1982, p. 335). Reciprocity is best fostered, suggest Crowley and Wollner (1987, p. 60), through a common acknowledgment that, as professionals, nurses and other health workers have important contributions to make to health care, and that this contribution could start with a respect for, and understanding of, each other's roles. Such a position rests on assumptions derived from role prescription and gender ideologies (Davies 1992, p. 243) and associated inequalities (Martin 1994, p. 404), rather than illuminating organisational sites as places of cultural struggle.

Taking a different view of collegiality as somewhat analogous to conceptions of participation or community, Hyde (1986, p. 549) proposes a set of four dimensions which characterise 'collective practice'. Within the four dimensions '... subjective, relational, strategic, and structural ...' are elements that appear as traits. Elements such as 'positions', 'tactical steps', or 'relationships' could be seen as a drawback in the study given that there is no clear debate on the meaning of or assumptions underlying the elements or traits. The subjective understandings located in a reality that places import on objectivity or the appropriate behaviour in specific instances, separates history and meaning from context, renders values irrelevant, and serves to alienate and depersonalise the experience of caring (Lawler 1999, p. 142; Pitts 1985, p. 38).

Facts appear to remain legitimate knowledge, at least in the material or object sense. It has been claimed by Harding (1993, p. 71) that empirico-analytical objectivity, notably found in traditional science and evident in the health and management fields, masks the value-laden and embodied underpinnings on which the knowledge claims rest (Harding 1993, p. 73). Masking the social construction and historical roots of
knowledge enables the mystification of the subjective, which has acted to further the utility of objectivity (Cooper 1993, p. 30).

Mystification of the subjective is also achieved through rule-governed action fragmenting care and depersonalising relations with one another, particularly those of an intimate nature. Bureaucracies, in the pursuit of efficiency and effectiveness, impose through policy and rules, relationships that are impersonal and alienated reflecting interaction of the generalised other of formal association (Ferguson 1984, p. 12). Perpetrated under the auspices of policy guidelines, it is not surprising that isolation undermines the connectedness that experiences offer as a nexus in caring, the visibility of nurses' personal histories, women's experience the possibilities contained in being-in-relation with one's peers.

Policies and procedures that define and contain nursing work with the associated articulation of an abstracted description of what the job involves, create a differentiation between the public and private worlds of the practitioner (Davies 1992, p. 244). Such differentiation might be seen as part of the problematics arising from organisational structures and collegiality, where a number of contradictions are located in the intersection of normative institutional structures seen in bureaucratic organisations, and human agency depicted in egalitarian, autonomous, consensual understandings characteristic of professional collegial relationships (Waters 1989, p. 969; Kaufman 1977). Or, as Kaufman (1977, p. 418) explains, the very nature of bureaucratic institutions renders it impossible to enact normative and universal patterns of collegiality because the demands of both colleagues and institution are on one hand contradictory, but on the other endorse particular ways of acting which support the status quo.

Contradictions become further apparent when one focuses on functionalist arguments relating to notions of professionalism and the ability of organisations, through role prescription and implementation of sanctions, to bring about compliance. The latter is
particularly apparent when one considers how round-the-clock rostering of staff is achieved or how staff shortages are covered with the movement of nurses from one medical specialist ward to another. Kaufman (1977, p. 412), for instance, notes that structural accommodation is manifested through role adjustment rather than individual agency and the ability to make choices. Professionals located within organisations are bound to perform their work according to a code of conduct /ethics, a code which endorses normative ways of acting underpinned by detached objectivity and emotional distance which is best realised through role prescription. Nurses deviating from institutionally-specified behaviour may be subject to the imposition of sanctions brought about either by their colleagues or through the hierarchy. Drawing on Gouldner's (1970) discussion of Parsons' (1939) work on integration of norms and values, Kaufman (1977, p. 414) suggests that where discrepancies occur between prescribed group normative values and individual action, marginalisation of those individuals occurs. As Hall, Stevens and Meleis (1994, p. 26) note, those on the periphery are not only separated from the centre but they are also distanced from each other. By engaging in marginalisation, those at the centre endorse their creation of a singular value, an image to which the majority must appeal, and by which others may be stigmatised. The status quo is readily maintained with the shifting sands of reified and hegemonic understandings. Inasmuch as individuals are on the outside, they mirror the images generated by the mainstream views (Hall, Stevens, and Meleis 1994, p. 31) facilitating existing relationships. Despite the fact that dominant views require isolated practitioners to alter their behaviour or adjust to role variation allowing the organisation to pursue its goals, the isolation continues, and nurses feel not only alienated from each other, but from their clients as well (Benoit 1992, pp. 216-217).

Moreover, as Kaufman (1977, p. 416) asserts, the emphasis on the professional's adherence to structural imperatives adds little to uncovering the ways in which nurses come to understand the construction and shaping of one's social world(s). Indeed, the contradictions which become apparent appear as double edged when organisations are
examined through such a structural-functional lens, for they are internally inconsistent, at odds with the structural-functional notion of collegiality.

Kaufman (1977, p. 418) acknowledges that the conception of collegiality within the structural-functionalist tradition, while purporting informality and the absence of a demarcated hierarchy seen in bureaucracies, clearly sustains these arrangements through the exercising of alternative methods of control. For instance, peers establishing collegial relationships or collegial groups have an understanding of the requirements for 'membership'. The selection of individuals is therefore dependent upon prescribed characteristics and privileged forms of knowledge (Cassidy 1998, p. 47). Collegial power is further exerted by marginalisation, enabling a sustained group image while perpetuating alienation via the exclusion of would-be members (Kaufman 1977, pp. 411-412). This form of 'gate keeping' (Roberts 1996, p. 9-10; Mackie 1986) contributes to the symbolic colonisation of particular cultural texts at the expense of others (Brewer 1996, pp. 30-31; Bottomly 1991, p. 97; Bourdieu 1973, p. 487).

Legitimated discourse(s) with coinciding language and voices gives rise to the construction of certain meanings constituting such things as practices, modes of inquiry, or put differently, what counts as knowledge (Bernstein and Solomon 1999; Goldberger 1997; Ferguson 1994, p. 82). As Lather (1991, p. 87) suggests, it is not only what counts as knowledge but the politics embedded in the context and construction of meaning that need to be problematised. Western thought has framed reality as science or facts (Watson 1995b, p. 60). To this end, Western thought has fostered separations between that which is objectively known (facts/truth) and subjective understandings, generating dualistic thought. The historical legacy of valuing the bio-medical model at the expense of other ways of knowing (Carper 1978) has encouraged nurses to pursue technical lines which have obscured other knowledge interests (Lather 1991, p. 109). Thus, while nursing remains supported in the pursuit of knowledge constitutive interests along a technocratic front, scholarly debate will remain directed within a confined frame of reference rather than seeking alternative
frames or examining the metatheoretical question of the frame of reference itself (Ferguson 1994, p. 82). Inquiry located within the accepted limits of the dominant paradigm(s) encourages the silencing of the political nature of inquiry (Lather 1991, p. 105) and sustains certain interests. These interests are reflected in nurses' social relationships as they engage in the various dimensions of their work (Hall 1999, p. 92). Furthermore, where colleagues collaborate, common (perhaps legitimised) interests, background, trust and affiliations, while central to group norms (Campbell and Dowd 1991, p. 40), support exclusivity (Cassidy 1998, p. 47; Roberts 1996, p. 9-10; Mackie 1986).

Professional identity is also endorsed by such moral codes enabling the regulation of practice. Attempting to clarify nursing's moral endeavour as servitude depicted in advocacy or notions of caring, Fowler (1990, p. 28) identifies nursing's social ethic as one which relies upon linking nurses' adherence to the profession's moral norms with the community's adjustment to the moral standing the profession exhorts. Yet this, too, is framed in the interests of achieving conformity through rules rather than necessarily reflecting what Ray (1994, p. 107) describes as a moral community - 'viewed as the experience of shared meanings of thinking and acting, where moral virtues, values and principles guide interrelational behaviour toward responsible choice making for the good of the whole'.

Further tensions exist in communities where certain power relationships are legitimatated, rendering moral and political questions irrelevant. The nature of the technical rationality depicted in health organisations rests upon notions of accountability and subordination to achieve value-free organisational ends (Rizvi 1986, p. 26). As institutions attempt to retain some control, knowledge may be withheld from clients or those who are participating in the direct care with a client. Privatised knowledge therefore serves to facilitate power on one hand and, on the other, to subvert it. Nurses' moral agency could therefore be seen to be one of struggle amidst
the competing claims of the nurse's private understandings and those being promulgated through various organisational texts.

Thus, while bureaucracies sustain and perpetuate particular interests, collegiate relationships within (and outside) organisational settings can be clearly problematic. It becomes evident that the structural-functionalist view of organisations (or indeed derivations of the same school of thought) from which the notion of collegiality 'theoretically' stems, while widely accepted in health care contexts, generates a number of serious issues rooted within its ideology. These issues begin to surface in a closer examination of the culture of health care contexts, particularly in the contradictions illuminated through language, practices and social relationships. Each of these areas provides a text of meaning illuminating the intersections of various understandings that hitherto have appeared to be absent from mainstream debate, particularly in relation to the political agendas underpinning changes to health care.

The advent of the corporatisation of health care agencies over the last several years, has resulted and will continue to result in a concomitant loss in flexibility and autonomy (Beyers 1990, p. 469). Thus meaningful ways of relating are structured to enhance the political agendas of the institution, limiting participation in matters directly affecting practice (Benhabib 1992, p. 48; Smyth 1991, p. 330). As Collyer and White (1997), Paterson (1997), and Stearley (1994, p. 53) note, in an environment traditionally imbued with paternalistic and male dominated ideologies (commonly identified in medicine and management) organisational cultures will remain competitive and individualistic rather than adopt alternatives to be found in co-operative forms of engagement.

It is therefore not surprising that nurses' practice continues to be constrained by paternalistic influences. As nurses participate in shaping their realities within a competitive arena, they do so in ways that enable the co-existence of discontent and dissatisfaction. These feelings are frequently directed horizontally towards one
another. Using credentials, expertise, numbers, or time dedicated to that particular organisation, nurses seek to gain institutional recognition for their achievements in order to have some sense of authority (Copp 1994, p. 195).

Hyde (1986) offers insight to the debate. Her work draws on women's experience illuminating the epistemological foundations that rest upon a more inclusive view of rationality and agency in institutional life. However, despite the democratisation of institutions in which patriarchal authority remains entrenched, those without professional authority, particularly women (Falk Rafael 1999, p. 31; Nichols, Carter and Golden 1985) will continue to remain outside the scope of influence. While women lack the authority to encourage more egalitarian and inclusive views, their contributions in a patriarchal, paternalistic world will remain invisible (King 1995, p. 353; Nichols et al. 1985, p. 389; Ferguson 1984; Lodahl and Gordon 1973, p. 191).

If one examines management literature and unravels the interconnections between authority, power, and professionalisation the invisibility of women's understandings is striking. The notion of collegiality appears to reflect a male view of working relationships rather than women's understanding of work itself; in other words, the contextual richness of practical action (Chung 1990, p. 190). Institutional interests have masked women's understandings, an area which has recently been the subject of reflective critiques (for example, Baines, Evans and Neysmith 1992; Watson, 1990a; Ferguson 1984; Ashley 1980, Connors 1980).

Some authors have used reflective processes to enable a critique of institutional arrangements that have affected 'productivity' (Seibold 1990; Faase 1989; Little 1982). For example, in recounting her work experiences, Seibold (1990) claimed that collegiality when present contained the 'essence' of caring which was lived out 'through a group of co-workers who encouraged, advised, inspired, intellectually stimulated and, most of all cared' (Seibold 1990, p. 241). Having experienced collegiality, Seibold (1990, p. 243) considers that the mystery of collegiality could be located in its spiritual dimension, a pointer perhaps to unravelling the interconnections
within the moral, spiritual and epistemological dimensions of care. This might be one of the reasons why the notion of collegiality has been predominantly an unexplored idea within feminist critical social theory, and other interpretive, paradigmatic or postparadigmatic inquiries.

Other critiques of organisational life implicate the increasing tension between institutional ideologies, such as those incorporating privatisation, competition, and individualism, which work against the notion of collegiality (Boon 1998, p. 32; McTaggart 1989; Hargreaves and Dawe 1989, in Smyth 1991, p. 332; Seibold 1990; Faase 1989). Tensions appear to arise in social actors' language, practices, social relationships and organisation (Smyth 1991; Seibold 1990, Faase 1989) and may contribute to the increasing contradictions that systematically control organisational life through 'discipline' and 'surveillance' (Foucault 1977). It is suggested by some authors (Keatinge 1995; Cash 1993c; Benjamin 1988, p. 187; Ferguson 1984, p. 14; and Kaufman 1977, p. 424) that the contradictions inherent in bureaucratic arrangements coupled with professional neutrality/objectivity, act to disenfranchise nurses in the care they offer clients (Rowley 1995). This argument may also be relevant to the ongoing mystification of inequalities that exist within health care institutions (Glass 1997; Hyde 1986).

Recent texts, emerging corporate practices, professional, union, governmental, and legislative statements attest to a resurgence of collegial and/or participatory management strategies. These have received very little criticism, however, and as a managerial strategy, collegiality could be considered part of the rhetoric required for reshaping organisational processes in order to exert ideological control within the culture of the institution (Benhabib 1992, p. 48; Smyth 1991). In health care contexts, this directly influences care provision (Nolan and Hazelton 1995, pp. 113-136). Therefore, if the notion of improvement in nursing care is to be taken seriously, the culture of collegiality and its meaning to those involved, needs to be investigated.
Whilst collegiality may be viewed as part of the rhetoric of management, it may nevertheless contribute directly to the quality of care, particularly if it is located in a vision that reflects and informs the everyday world of the practitioner. Accounts of practitioners' everyday understandings of collegiality was, in my view, of prime importance in helping to create those forms of collegiality which might lead to improvements in the quality of nursing care within ward settings.

I wondered whether one of the ways in looking at collegiality in clinical contexts would be to begin by reflecting critically on discursive forms and texts thus re-framing the debates to enable close scrutiny of the political, social and economic agendas underpinning bureaucratic strategies. For instance, Ferguson (1994, p. 85) suggests that it is worth raising questions about how one speaks about the institution (the language used), rather than paying attention to one's comments about it. How one speaks about it will help in revealing meanings that shape understanding, thus surfacing taken-for-granted assumptions. At the same time, language discloses text, 'something that happens' (Ferguson 1994, p. 87), through which one can increasingly gain access into the meanings conveyed in practices. Reflection in and upon action thus becomes crucial as one confronts the emerging tensions though dialogue. Participative dialogue enables the disruption of the way things are, or what exists, creating space for the voices traditionally marginalised (Hall, 1999, p. 89; Glass 1998; Glass and Walter 1998; Glass 1997; Goldberger 1997, p. 257; Hall, Stevens and Meleis 1994, p. 31) to reveal their different understandings. One might well ask what enables such dialogue to occur given the hostile environments of health care organisations?

Notions of participative engagement in dialogue that seeks to adopt strategies founded on partnership, respect, transformative or emancipatory goals (Henderson 1995, p. 64) appear to offer the space in which collegiality might be fostered. Wheeler and Chinn (1989) convey the possibilities of participative engagement using a feminist process in their handbook titled 'Peace and Power'. The handbook offers a 'structure'
which may be used in different circumstances, enabling the transformation of relationships, and the empowerment of participants while offering a sense of community.

**In summary**

It appears that collegiality has its origins and definitions in the masculinist world of corporate organisations. Much of the literature (to which nursing is no exception) stresses the importance of collegial relationships in organisations and professional associations and its implication in productivity. Often such references are made only in passing, however. Studies on collegiality, in the main, stem from the positivist view to define collegiality and its various characteristics or traits. There appears to be very little information on the constructions and meanings contained within collegiality, particularly women's understanding of its meaning. Other tensions contained in organisational life such as the commodification of care, the questionable infatuation with professionalisation, the downsizing and restructuring of health care institutions, endorsed individualism, a gendered division of labour, and the invisibility of caring values all appear to influence the manner in which women nurses might think about collegiality and its import in nursing care.

It therefore seems that women's construction of collegiality within the nurse practitioner’s world is an under-researched field according to much of the literature available. This is somewhat predictable given the invisibility of women nurses' voices in the corporate world of health care. It was, I felt, a field warranting much attention, given the health care trajectory, a trajectory of changing patterns of care, managed services and masked power relationships. If collegiality comprises an aspect of benchmark quality control in health care then such indicators need to be unmasked, demystified and reconstructed in terms that have meaning for those involved, especially if nurses are implicated. Thus, if collegiality is to be taken as seriously as much of the literature suggests, it is clear that nurses' constructions of collegiality require not only further inquiry, but inquiry that stems from a radical critique of women nurses' ideas reflecting their major practice concerns.
It was obvious then that I needed a research methodology that was robust enough to support my commitments, tease out the meanings women nurse clinicians attributed to their relations in practice, and if possible to illuminate how and in what ways these 'collegial' relations were implicated in the care nurses offered clients in a ward environment. It meant also that I was seeking to find how such relationships were enacted through the various texts in one particular location, and given my practice background I thought it best to focus on an acute care environment. It became apparent that, to put it bluntly, I needed a methodology that would enable me to be me. The choice then was to some extent an easy one. What I wanted to do was to enter the world of the clinician, be one myself, work with the staff, and grapple with the world of practice. Because of my interests I chose ethnomethodology, for this approach seemed to me to be consistent with my critical feminist position. It was almost inevitable that the question would be politicised and I would find myself emersed in ongoing passions and struggles, passions and struggles that began in my past and ones that continue now as I seek to offer you what has transpired over the course of several years.
Chapter 3

Methodology

Clinical nurses' constructions of collegiality could be examined using various methodologies and methods. For instance, one could engage in an empirico-analytical approach, develop a questionnaire based upon past research and analyse the data using, for example, attribution or construct theories. Taking another tack, one could gaze at the clinical environment and depict collegial phenomena. Or one could employ ethnography and use an interview technique to tease out descriptions of what might be seen to be collegial relationships. But none of these approaches really fitted what I wanted to do nor did they sit well with my values and ideas in the context of this topic. What I really wanted was to get into the world of the clinician, be one myself, and grapple with the world of practice. I not only wanted to hear what clinical nurses said about collegiality but also to see the manner in which nurses' cultural practices illuminated accounts or situations which they implied or named as collegial.

Moreover, my desire was to engage in a research process with other nurses, a desire that reflects my intense interest in working with others upon collaborative projects, in building individual and collective understandings and grappling with multiple meanings. This desire also reflects my attempts to make a difference; a difference in one another's lives, in the various knowledges in practice and of course in the care nurses are able to offer others (including one another), about the things nurses do and about the things we (you and I) as nurses know or experience. My intentions therefore were multiple, highlighting, perhaps, the transformative intent underpinning this project.

Because of these factors I chose ethnomethodology, thinking it would enable participants to access various meanings in practice that might not have been visible using traditional approaches. Moreover, I hoped that, by using critical reflection to illuminate taken-for-granted understandings, it would encourage participants to problematise practice, theorising it and in doing so come to think about and act in their
worlds differently. Engagement of the participants in these sorts of strategies highlights the political nature of this research; political in the sense that the personal is political. As Klein (1994, p. 43) so eloquently put it, 'feminism and feminist research constitute a way of life - a politics and a philosophy - which is obviously much broader than "doing research" in the conventional definition. Once embarked upon, this way of "doing" research is very difficult to relinquish'. I was keen to use ethnomethodology underpinned by a critical feminist stance, positioning myself in multiple ways so that I would be better situated to capture multiple meanings.

During the course of this research I gathered accounts of collegiality from, and transformed through, participants' stories, self-critical and collective reflections, and field notes. I kept a journal which documented my journey, my thoughts in practice, commentaries on and about the day-to-day worlds which practitioners inhabit, stories of what happened, impressions, feelings and ideas. I have focused on the social: nurses' everyday experiences as they engage in their worlds, the ways in which their consciousness and subjectivities inform and shape the self, their relations, their understandings, meanings and action (Smith 1999, pp. 96-97). As part of the research, I have been especially interested in the occurrence of the invisible, juxtaposed, alternative or contradictory meanings; those that often disrupt the very locations in which one might choose to stand. These understandings have permeated various discourses, and the many practices in the ward and hospital more generally, but they are also embedded in the social relationships of the participants (Smith 1999, p. 121; Lather 1994, p. 40; Mullett 1988, pp. 114-5; and Sherwin 1988, p. 16). Engagement with the group provided the opportunity to access meanings as they were being lived, reflected upon, transformed, and theorised; made visible by the participants/readers of these texts, and for whom, one's situatedness enabled the confrontation of the dominant ideologies, enabling the emergence of new ways of acting (Wuest 1995, p. 134; Smith 1990, pp. 4-6; McKay 1989, p. 251). But before delving into these areas further I would like to address the methodology itself from particular vantage points.
Ethnomethodology

Ethnomethodology began with Garfinkel's work during the 1950s, which, according to Cuff, Payne, Francis, Hustler and Sharrock (1984, p. 152), has its origins in phenomenology, in particular the work of Husserl (1859-1938) and Schutz (1899-1959) as well as the action theory of Talcott Parsons. Husserl (1962) in 'Ideas: general introduction to pure phenomenology', discusses how everyday experiences (facts) are underpinned by essences which assist the actor in grouping the phenomena into intelligible bits to support understanding. Essence is, as it were, the core of experience, both fact and object present in form as universal, an essential in being and experiencing (Husserl 1962, pp. 45-7). Essences as the core of understanding enable the generation of knowledge about one's world through appropriating the lived experience. Essences are object truth(s) about the social world; truths shared in common with others through essences (Husserl 1962, p. 98).

Rather than examining the philosophical underpinnings of being, and the appropriation of facts as meaning, Schutz (1954, pp. 27-29) emphasised shared social intersubjectivity of one's everyday world(s) and its contributions to meanings for those involved (Cuff et al. 1984, p. 152). Through the process of socialisation actors come to understand meanings in their lives as givens. Being part of the world while understanding the lived experience reflects sense-making as practical knowledge or commonsense knowledge. The actor is thus able to group or categorise experience based in commonsense understandings drawn from knowledge of reality gained by living within it (Cuff et al. 1984, pp. 153-5). As Cuff et al. (1984, p. 167) suggest, Garfinkel's (1967) work captured the insights of Schutz's contribution and attempted to clarify the foundations of ethnomethodology as the study of the interaction of those engaged in the 'mundane' activities of everyday life.
Ethnomethodology, therefore, attempts to explore the commonsense understandings in one's everyday world. Heritage (1984, p. 4) defines it as

\[ \text{[t]he study of commonsense knowledge and the range of procedures and considerations by means of which the ordinary members of society make sense of, find their way about in, and act on the circumstances in which they find themselves.} \]

Emphasis is thus placed on the social construction of knowledge in action, inasmuch as the actor uses 'commonsense' understandings while engaging in everyday activities (Heritage 1984, p. 6).

Since commonsense understandings provide the 'modus operandi' in everyday circumstances, commonsense knowledge is considered 'practical', and is shaped within and extends from one's past and present realities (Cuff et al. 1984, p. 155). It is important to recognise that social situations do not occur in a vacuum: they are mediated by people themselves who carry specific speech genres that are also organised in texts (Smith 1999, p. 120). In other words, the contextuality of any social situation is peculiar to that situation and to the participants (Fine 1994, p. 29; Smith, 1974, p. 43). This dimension enables the actors to define and redefine the understandings generated from, and within any moment in that setting (Bowers 1992, p. 60). Whilst the material context of one's everyday world can be studied in the object sense, it becomes important to consider the various texts (action) as components of other texts (social relations) enabling the illumination of meanings within dialectical arrangements (Olesen 1994, p. 163; Smith 1990, p. 125). The medium through which these understandings become known is language, but they are shared further in the understood practices in which the participants mutually engage (Bowers 1992, p. 60). Here it is suggested that language is not the only medium in which meaning is carried, for clearly it can be found in symbolic practices and spaces held in common (Smith 1999, p. 128). Any action, therefore, reflects meanings located within the context. Thus, meanings are not only generated through language but also through practitioners' recognition of the meanings of their practices (Bittner 1965, p. 75). Over time, many practices become taken for granted, comprising part of the everyday repertoire. Geertz (1973), using the notion of 'thick description', clearly conveys the extent to which researchers need to continually
unravel the interconnections between the many nuances entailed in social situations and how action is interpreted. It is not a matter of simply describing the action or analysing the activity; rather it is peeling away layers upon layers of culturally embedded meanings. Janesick (1994, p. 216) suggests the use of thick description also enables thick interpretation, however thick description alone will add little to attempts to grapple with meaning.

Bowers (1992, p. 60) points out that meaning is also reflexive in the unison of past and present as participants engage collaboratively in the reshaping of understandings. To this extent meanings emerge in the first person as one speaks about one's everyday knowledges (Kemmis 1994, p. 33; Stanley and Wise 1990, p. 30). These points, in the eyes of those attempting to authenticate empirico-analytical research, constitute major concerns. Another question which offered some insight to the limits of the earlier work of scholars such as Husserl, Schutz, and Garfinkel was the notion of false consciousness, an issue raised as part of an interpretive critique. Cicourel (1965, p. 85) claims ethnomethodology attempts to unravel the connections between social action and how action reflects the ideological underpinnings of taken-for-granted rules on the one hand, and on the other hand, practitioners' theories as a dimension of the practitioner's body of knowledge, which constitute and give rise to, making sense of/in action.

Put another way, the action's intelligibility depends upon it being indexically linked to the context or upon being reflexively constituted (Coulter 1990, p. ix). Indexicality is the process by which meanings are 'tied' to their social context and specific practices, and these meanings are continuously changing and renegotiated as the context changes. This is why so many of the ideas emerging in this work have their own nuances and multiple meanings and connections. As Smith (1999, pp. 126-127) suggests these connections are available as iconic representations - objects mapped out in front of the person - requiring the reader of the text to recognise the object within a field of experiences. The reader therefore needs to make sense of these representations through
their own intersubjectivities. Sense making occurs as a dialogical moment, a point during which the reader as an active agent moves from the iconic representation to the material world, establishing points of recognition. It is a social process in which meaning is achieved contextually, in relation and reflexively. Reflexivity refers to the capacity that these meanings have to shape the context in which meanings occur and the practices within which participants engage. The notion of reflexivity enables an appreciation of one's knowledge and its locatedness in time and space, and the manner in which meanings might variously be shared, constructed, negotiated and overthrown. Moreover it establishes understanding as a social act grounded in the material world. Thus, both indexicality and reflexivity remain, in Coulter's (1990, p. ix) description, the hallmarks of ethnomethodology.

With respect to knowledge in practice, understandings generated through meaning presupposes interpretation of a context in which other social actors mutually engage. Thus knowledge of the history of the various actors and their social context becomes an important starting point in accessing multiple meanings. Because meanings vary in context, they may be apprehended and understood in terms of where one might stand. There were many times during the course of this research that my understanding of situations needed re-vision in part because of where I stood and the judgement made at any one time. Grundy (1987, p. 68) puts it this way: '[a]ction in the realm of human interaction (practical action) is dependent upon judgement, and the exercising of judgement is dependent upon the interpretation of the event, which in turn, is dependent upon the meeting of the fore-meanings or prejudices of the participants in the interaction'. Important implications arise from questions of right or good judgement (Grundy 1987, p. 184) concerns surrounding intersubjectivity and its various interpretations. It becomes possible to begin to see that interpretation of action will by its very nature reflect divergent understandings; some of these meanings may be held in common, whereas others will reflect differing ideas. However, when meanings are shared they giving rise to additional knowledges as a shared experience, an experience which constitutes the hermeneutical field of inquiry, for this approach centres on
making meanings explicit (Grundy 1987, p. 184; Allen, Benner and Diekelmann 1986, p. 37). The implications for authenticating meaning become patently obvious with a view of practical action that locates understandings in the discourses and practices of nurses as agents. What practitioners do, say they do, or feel they ought to do (Wolcott 1988, p. 204) highlight the import of some of the dimensions of agency yet may restrict scrutiny unless a more inclusive view of action is taken that involves a broader social critique (Moccia 1987, p. 284) incorporating a dialectical view. As meanings are socially constructed, practitioners' intersubjectivity, relatedness, ideologies and struggle form the sites in which culture is contested, supported and sustained, and where resistance acts as a counterpoint for emerging meanings and the construction of alternative possibilities for/in action.

**Critical ethnomethodology**

Jones (1989, p. 70) locates the meaning of critical ethnomethodology in the ways in which power relationships are mediated through social structures and how and why these relationships become lived out in everyday practices and understandings. Fay (1987, p. 23) puts the schema of critical social science this way:

> such a theory needs not only to be able to reveal how a particular social order functions, but also to show the ways it is fundamentally unsatisfactory to those who live in it, and to do both of these things in such a manner that it itself becomes the moving force helping to transform this order into something radically different.

The so-called origins of critical social theory stem from Marxist critique, in particular from the writings of what has now become known as the Frankfurt School and includes the work of scholars such as Marcuse, Adorno, Horkheimer, Fromm, Habermas and others. Critical theorists in particular reject the view that knowledge is neutral and value free and that understanding is socially constituted (Comstock 1982; Held 1980; Fay 1975). Scholars (such as those mentioned above) have offered what has been described as a 'negative' view (Kemmis 1994, p. 39; Luke 1992, p. 26; Fay 1987, p. 23) of the social world through ideological critique which, while providing important insights to the way in which culture creates, mediates, and sustains
meanings, also enables a vision of possibility in terms of action. Moreover, critical theory raises questions about the interests being served by dominant ideologies and the oppressive nature of these interests. Embedded in the critical tradition lies an emancipatory intention. Together, the Habermasian view of knowledge interests, Gramsci's (1971) notion of reification and hegemony, Freire's (1971, 1972, 1974) conception of 'concientization', and more recently Giroux's (1980) ideas on rationality enable considerable yet substantive critique (Luke 1992, p. 27) in terms of the politicization of social life. It is the inclusion of these critiques in particular that have enabled ethnomethodology to withstand the pitfalls of the past where attention to everyday phenomena and interaction remained the focus of the study, situations Holmes (1994, p. 364) describes as a failing to come to grips with social issues and 'pander[ing] to dissidents at the expense of intellectual rigour'.

While somewhat deterministic, several of the early contributions to critical theory such as Bowles (1971) and Gintis (1972) theses on correspondence theory, Bernstein's (1975) work on knowledge transmission and Bourdieu's (1973, p. 487) notions of habitus, cultural and symbolic capital, have added light to critiques of one's social worlds. Drawing on Bourdieu's (1973) conceptions of habitus, cultural and symbolic capital, Bottomley (1991, p. 97) claims that, within one's everyday world, power relations are both structured and symbolically formed, giving meaning to everyday practice. For instance, through symbolic capital dominant interests are conveyed in terms of object knowledge about reality which becomes legitimised in conceptions such as efficiency (Cash 1993a, p. 126). When one's understandings are derived from an object reality infused by power relationships actors come to see those relations through their group affiliations, fostering new meanings. Moreover, these new meanings of reality which are shared understandings are socially constructed as symbolic power (Bottomley 1991, p. 97). Thus the organisational participant engages in action that supports power within the organisation but at the same time may resist oppression. The dialectics of oppression and resistance become obvious in the taken-for-granted terrain
of practice. In essence then, critical social theory rests upon:

hope, liberation, and equity. Agency and (raised) consciousness
were reinstated on centre stage, albeit ... with structural
constraints acknowledged. Lived experience and the construction
of meaning and identity formation were re-authenticated, and new
goals for self empowerment and critical agency in a critical
democracy were set. (Luke 1992, pp. 26-27)

Identifying what possible strategies might be taken encourages a radical shift in
thinking about one's everyday world and thus situates the intent of critical approaches
(Fay 1987, p. 26). Moreover, critical traditions propose a manifold project that has
emphasised connections: complex connections mediated through practice in socially and
historically constituted texts comprising the everyday world of work, discursive
structures, social relations, intersubjectivities and power (Kemmis 1994, p. 34).
Through the unravelling of these texts light is shed on how material reality has become
distorted leading to the development of understanding that considers the self relationally
in the contexts of the everyday world(s) one shares with others in the social milieu.
Such knowledge reveals the intentions and commitments that individuals hold in
practice and at the same time through participation in teasing out these connections
individuals and groups can actively struggle to change their worlds for the better
(Kemmis 1994, p. 35). For Marshall (1988, p. 222) it is these emancipatory interests,
through the notion of praxis, that allow the reconnection of theory and experience in
one's understanding of the everyday world. In addition the notion of praxis also raises
some significant questions surrounding knowledge interests particularly with respect to
rationality (Code 1995; Lloyd 1979), and justice (hooks 1994; Collins 1989).

A number of problematics arise from the central project of critical social theory. For
instance, there are concerns that stem from equity and whether equity leads to
mediocrity. Concerns about building alliances and the extent to which individuals feel
coerced; the possible utopian view of idealism as well as the question of empowerment,
what it means, who is going to be empowered, and by whom, appear to be central to
the debate (Luke 1992, p. 30; Stanley and Wise 1990). Likewise, as the discourse
derives from predominantly male or androcentric scholarship, feminist critique enables
a more inclusive view (Fine 1994, p. 26; Chinn 1987, p. 127; Harding 1987, p. 6;
Fox-Keller 1985, p. 73) and one that not only seeks to challenge domination (power over) but also the premise of empowerment as well. While challenges to patriarchal power might be strategic emphases on building communities in which respect, diversity, sensitivity and participation remain as the cornerstones of engagement, what remain as central projects to feminism is the linking of these strategies to the possible transformations in the broader community (Bunch, Carrillo and Guinee 1985, p. 245). It is to feminist research that I now wish to turn.

**Feminist research**

Exactly how and why women understand the notion of collegiality has remained a submerged discourse perhaps, as Smith (1990, p. 1) put it succinctly, because women (and women nurses in particular) have been deprived of an authorial voice (Moccia 1987, p. 284) in a universalised view of knowledge based upon male subjectivity (Klein 1994, p. 41). It has been suggested that women's knowledge and experience stands at odds with the institutional structures associated with, and embedded in, bureaucracies - particularly in the contexts of large public institutions (Street 1995, p. 21; Jaquette 1992, p. 145; Ferguson 1984). Stanley and Wise (1990, pp. 22-25) make the case that a feminist approach to ethnomethodology not only helps to unearth questions arising out of the analytical research processes and theorising in the study of the material world of the researcher and the researched, but also takes into account the intersubjectivities of those involved in shared and distinctive experiences, whilst also being reflexive and self-reflexive in the light of ongoing experience. As its major epistemic project, this latter assertion grounds feminist theorising in the experience of the everyday world(s), a project that might be deemed relativistic given that women's experience could arguably be relative to one specific context or any one particular standpoint. It is an issue that has generated a lot of debate and one which could also be thought of as essentialising the experience of woman.

Reinharz (1992, p. 51) asserts that feminist ethnomethodology requires the data to foreground women's everyday worlds (Hekman 1997, p. 347) thus reflecting
women's points of view as they engage within the social world of practice, constructing and reshaping meanings. The experience of involvement is therefore not only a question of knowing what but also importantly knowing why and knowing for (Stanley and Wise 1990, p. 15). It is apparent then that in these knowings women are engaging in a form of praxis. Precisely because feminist research of this nature considers participants as 'co-researchers', they are ostensibly active agents in transforming practice as part of the processes involved in the research. Many feminist researchers, for example Henderson (1995), Janesick (1994), Olesen (1994), Smith (1990), and MacPherson (1988, pp. 19-20), argue that feminist research involves women in all phases of the research process, as active participants from working through issues such as design, data collection, and analysis to the writing of the final report. Given that this research comprises a formal qualification it becomes difficult to enact all of these requirements commonly listed as part of the feminist approach. Nevertheless certain provisions were put in place at the outset to try to involve the participants in the many decisions to be made during the course of the project. Some of these decisions reflected specific practices while others considered broader questions. Many of the issues that arose during the course of the research were relational, reflecting the experiences of the women involved, such experiences becoming the media for transformation. Such a position highlights the possibility for changing the traditional power relationships between the researcher and the researched (Fine 1994, p. 26; Olesen 1994, p. 163; Lentin 1993, p. 127) thus departing from mainstream dichotomies (Briskin 1989, p. 88).

This research has been conducted from what I want to loosely describe as a feminist standpoint - which means that in considering the practice reality it has attended to women's interests and values which have framed and underpinned the project (Lentin 1993, p. 124). Nielsen (1990, p. 10) suggests the notion of standpoint epistemology provides significant insights into dominant and subordinated positions in the social realm. The former offers partial knowledge whereas the latter embodies understandings in need of problematisation to discern a fuller picture of the epistemic
nature of understanding. However as Nielsen (1990, p. 25) notes, the difficulties inherent in this version of standpoint relate to the privileging of experience: that one group's knowledge is 'more real' than another's. Wolf (1996, p. 13) believes this viewpoint rests on the assumption that those dwelling in the margins have a less distorted picture of reality than those occupying the centre. The inherent difficulties in the privileging of some knowledges therefore becomes apparent, prompting a re-vision of these ideas which has given rise to thinking about the social situatedness of knowledge(s) and thus the position one occupies in the context of various knowledge claims (Wolf 1996, p. 14). Where one stands therefore will always reflect one's situatedness (Hekman 1997, p. 345). Thus positionality implies that there are many feminist standpoints, given the importance of different points of view, and such standpoints not only enable the emergence of difference, but avoid feminist cultural hegemony (Lentin 1993, p. 123) and the colonising effects of the homogeneity of one particular standpoint (Hekman 1997, pp. 359; Longino 1993, p. 205). These sentiments reflect the researcher's concern in/for the ways in which patriarchal health care institutions have systematically distorted the lives of women nurses. It is, therefore, women's accounts of collegiality that are the focus of the study, given the homogenising influence of a male perspective of collegiality that becomes read as the view of what collegiality means (Maguire 1987, p. 82). I wanted to move women's lives from the margin to the centre (Wolf 1996, p. 3). Yet this aim prompted comments such as 'men work in the organisation, they will feel excluded'; or 'you know doctors have to relate to nurses, won't that bias your results'; and even 'fancy working with just women ...' and so on (Journal entries, September and October 1996) - comments that are themselves considerably revealing of the male centredness of the culture (Lentin 1993, p. 123; MacPherson 1988, p. 19; Ferguson 1984). Moreover focussing on women nurses' experiences in their working worlds is not to deny that collegiality in clinical settings involves men too, but rather it is the women's understandings of collegiality that is central to this research.
Adopting a feminist perspective might suggest a particular posture as one engages in the conduct of research. The literature reveals some interesting tensions and a multiplicity of ideas about methodologies which are now beginning to emerge as researchers explore the varying approaches available (Hekman 1997; Klein 1994, p. 44; Olesen 1994, p. 163; Reinharz 1992; Stanley and Wise 1990, p. 33). There is, however, some agreement on what constitutes feminist research.

Feminist critique addresses women's understandings by placing value on women's experience/knowledge (MacPherson 1988, p. 19; Chinn and Wheeler 1985, p. 74) and systematically attempts to peel away the distortions created in a social world that perceives dominant, oppressive, patriarchal views as the only legitimate vision (DeMarco, Campbell and Wuest 1993, p. 29; Allen, Allman and Powers 1991; Weedon 1987, p. 6; Eisenstein 1984, pp. xviii-xix). Such a vision is omnipresent in one's social world, rooted in ideology, one's relations with others, practices and organisations. Dominant interests are lived out in relationships that render class, gender, sexuality, race, age, 'disability' or difference as invisible. Feminist scholarship attempts to confront the invisibility of women's experience/knowledge and the 'injustices based on gender' (Chinn and Wheeler 1985, p. 74) and I would add difference, in the case of this work. Hence, the politicization of practice and the generation of knowledge remains a central thematic in the feminist project (Wolf 1996, p. 14; Fine 1994, p. 23, Klein 1994, p. 43; Stanley and Wise 1990, p. 30) through the developing awareness of how and in what ways life has become distorted, and based upon this knowledge the teasing out of plausible future possibilities. It is therefore apparent that the research has a moral and political commitment, a commitment that for the most part has been both implied and explicit throughout the entirety of this work.

Themes in feminist research

Shields and Dervin (1993, p. 65), identify themes which may be drawn from the intent of feminist discourses and which have had a significant impact on this research project particularly. Feminist scholarship places emphasis on the following themes.
Valuing women's experience of everyday life through creating legitimacy for the undervalued aspects of personal understandings and the frequently unarticulated dimensions of contextual being (Shields and Dervin 1993, p. 66; Lentin 1993, p. 126); women's lives, the lived experience of women as it informs the reality of study.

Gender relations which reflect socially constructed meanings that serve particular ideologies. Thus women's experience reflects the tensions located within the cultural constructions of gender (Shields and Dervin 1993, p. 66; Lentin 1993, p. 126); it is important to expose the shared commonalities as it is equally important to highlight and value differences (Lather 1992, pp. 129-132). Through discourse analysis it is possible to intersect the historically constructed understandings of sex/gender categories as they are lived out in practice (Smith 1999, p. 127; Allen, Allman and Powers 1991, p. 56). Tensions do exist in the notion of difference, where difference becomes so individualised that the roots comprising such social constructions become lost to the experience itself (Briskin 1989, p. 91). This heralds concerns relating, amongst others, to hierarchies of experience, debate amidst the axioms of expertise, knowledge, rationality and experience or falling into binary categories or dualisms (Wolf 1996, p. 13; Olesen 1994, p. 163; Capo and Hantzis 1991, p. 250; Nielsen 1990, p. 25). The implications of these tensions lie at the heart of the notion of agency. In using a process of consciousness raising, the space that consciousness raising has to offer makes it possible to problematise issues arising out of deconstructing the ways women speak about their lives in the context of their social world and in particular gender representation (Capo and Hantzis 1991, p. 257). In addition having a space in which women can speak, engage with one another, be listened to and heard, enables the expression of participants' meanings in a manner supportive of each other (Street 1995, p. 21). It is in this space where the self can be re-embodied within the narrative rather than remaining outside, that highlights a crucial issue for women as embodied subjects with rather than on whom the researcher engages.
Gender sensitive reflexivity (Harding 1987) in which the researcher actively involves herself in the research process as a participant. The notion of reflexive sensitivity encompasses wide ranging issues such as the cultural constructions of subjectivity: for instance, emotion, fantasy, or feelings (Chodorow 1995, p. 521). Additionally, the long standing criticism of researcher bias in feminist research can be brought to bear in reflexively critiquing not only the position of the researcher (Olesen 1994, p. 165) but also the research process itself. These subjective understandings have both challenged the epistemological nature of the research process and enabled the illumination of hidden structures of domination (Olesen 1994, p. 165) which have been systematically resisted. Through the participatory nature of co-researchers as subjects, the women in the project shared their intersubjective understandings in ways that adopted a critical yet emancipatory stance (Shields and Dervin 1993, p. 66; Lentin 1993, p. 126) enabling the development and articulation of deeper and more penetrating understandings.

Emancipation or transformation which arises from consciousness raising, critically reflexive dialogue, and shared meanings. New understandings of the social realm illuminated through problematising practice offered the opportunity for participants to make choices on/in action in their everyday lives (Lentin 1993, p. 126).

Each of these themes is interwoven in some methodological principles for feminist research outlined by Cook and Fonow (1986, p. 72):

1. [T]he necessity of continuously and reflexively attending to the significance of gender and gender asymmetry as a basic feature of all social life including the conduct of research.

This principle, while reflecting the themes above, also stresses the position of the researcher and the role she might adopt. In some respects, this highlights the necessity to move away from neutrality and indifference (Mies 1983, p. 122) to a position in which the researcher situates herself amongst the research participants and participates in the project as well. It is this view in particular that has prompted the framework for
this research, a framework that allowed me to work through the multiple positions in which I found myself. Such movement enabled me to engage in the research in a manner that included my own understandings and, in the context of this research, to participate in practice along side the co-researchers in accessing understandings that constitute and mediate part of the taken-for-granted world of practice. At the same time it assisted in altering some of the power relationships embedded in traditional approaches to research (Campbell and Bunting 1991, p. 9) where participants are regarded as the objects on which research is done, to a way of relating in which nurses as subjects mutually join with the researcher who is also a participant (Mies 1983, p. 123). Thus participants' experience reflects contextual richness and relational underpinnings. It also highlights some of the debates which allude to concerns about privilege, and whether being on the inside will offer additional insights leading to a fuller understanding of that location (Wolf 1996, p. 13). This latter point raises the question of potentially essentialising the insiders' experience. However if one's position is understood as relational then multiple knowledges can emerge from the partiality of knowing (Wolf 1996, p. 14), a knowing arising from the various situations in which one finds oneself in practice.

2. [T]he centrality of consciousness raising as a specific methodological tool and as a general orientation or 'way of seeing' (Cook and Fonow 1986, p. 72).

Through a process of consciousness raising (involving self-reflexive critique) participants engaged in developing alternative insights and visions (Thompson 1987; Speedy 1987). Much of this work was undertaken in our times together as a group. In some instances it involved special moments of being with another participant or as a reflection. Frequently ideas were revisited and elaborated upon further to be gazed at again in a different context. These opportunities enabled the unfolding of contradictions, counterpoints and resonances adding to the richness and intricacies of the data. Klein (1994, p. 45) calls for a sense of humility in attending to women's voices; listening, hearing and learning from them, and where necessary revising assumptions and prejudices. MacKinnon (1989, p. 84) claims that consciousness raising enables the articulation and legitimisation of the invisible, the subjective
understandings, the concerns and struggles of oppression and gender, feelings and emotions (Chodorow 1995), all of which might otherwise remain unacknowledged. Premised on dialogue, consciousness raising politicises the personal and engages one in transformative action (MacKinnon 1989, p. 84; Lorde 1984, p. 43). Such transformations also enabled those engaged in research to conduct it in a way that was openly ideological (Lather 1986, p. 271) without which, the research might have stumbled into the pitfalls of authority and commodification over meaning (Lather 1994, p. 42; Olesen 1994, pp. 166-167; Lather 1991, p. 89; Heron 1981, p. 35).

3. [T]he need to challenge the norm of objectivity that assumes that the subject object of research can be separated from one another and that the personal and/or grounded experiences are unscientific (Cook and Fonow 1986, p. 72).

Objectivity, a canon of positivist research, assumes significant power relationships between the researcher and the researched. The conduct of positivist investigation depicts research on people as the objects or other, of the research. Moreover, objectivity distorts the situatedness and historicity of knowledge (Heron 1981, p. 35). Centring on conceptual oppositions such as the subject–object dichotomy detracts from the development of alternative possibilities to perceiving such binary opposites (Gatens 1991, p. 137). As Campbell and Bunting (1991, p. 10) claim, understandings are contextual and therefore knowledge as both object and subject needs to be understood in terms of a dialectical relationship. Moreover, by viewing dichotomies in terms of dialectical arrangements the invisible, the distorted or the mis-representations of reality(s) become increasingly evident (Lather 1994, p. 42; Olesen 1994, p. 167; Mies 1983, p. 125). For instance, knowledge cannot be separated from the material conditions in which it is produced nor can the producers of knowledge be excluded from the social and political forces that influence the creation of that knowledge. Thus research needs to reflect not only the understandings developed by the participants but also the production of meanings by the investigator as well (Olesen 1994, pp. 166-167; Stanley and Wise 1990, p. 23). Of course, the extent to which these meanings are either shared or different, reflects the authenticity of the participant(s), or indeed represents, and speaks to, the differences of women authors in establishing what they
see to be the important considerations for them in the project (Lather 1991, pp. 98-100; Stanley and Wise 1990, p. 23; Heron 1981, p. 35).

In acknowledging the historical locatedness of the participants I have felt it important to capture a number of insights that help to appreciate who these women are individually. I also wanted in general terms to offer some historical commentary on the development of nursing over the last century, for this heritage is carried by many nurses contemporarily as enculturated understandings.

4. Concern for the ethical implications of research and recognition of the exploitation of women as objects of knowledge ... (Cook and Fonow 1986, p. 72).

The traditional approaches to research have submerged and obscured ethical concerns in seeking to adhere to the scientific tradition and legitimacy. Clearly both methodologies and methods have been tied to audiences that engage in gate keeping (Opie 1992, pp. 55-57; Cook and Fonow 1986, p. 78). Hekman (1990, pp. 18-47), drawing on the work of Foucault (1971), clearly points to the controlling nature of language (articulated rationality) and its nexus with power. Lorde makes the following comment:

Those of us who stand outside that power often identify one way in which we are different, and we assume that to be the primary cause of oppression, forgetting other distortions around difference, some of which we ourselves may be practising. ... white women focus upon their oppression as women and ignore difference in race, sexual preference, class, and age. There is a pretence to homogeneity ... [u]nacknowledged class differences rob women of each others' energy and creative insight (1984, p. 116).

Communication that is both penetrating and revealing in its deconstructive and liberatory intent finds itself in a form of relatedness that engages participants in what Mies (1991, pp. 80-82) considers 'affectedness'. Affectedness and concern, Mies argues, encourages movement from authentic views of participant situatedness to participants informing their action. Locating action becomes paramount in reducing some of the ethical dilemmas: for example, exploitation and betrayal (Wolf 1996, pp. 23-25; Stacey 1991, p. 113; Patai 1991, p. 138) withholding knowledge (Cook and Fonow 1986, p. 78), disrupting, interrupting or intervening in participants’ lives (Seibold 1993). These dilemmas, and others like them are part of an evolving struggle that emerges as the research unfolds and contradictions become apparent (Lather 1991,
Additionally, these concerns highlight the moral underpinnings of feminist research.

5. [E]mphasis on the empowerment of women and transformation of patriarchal social institutions (Cook and Fonow, 1986, p. 73). Transformation is a central project of feminist research. Transformation involves raising questions about one's world in a manner that seeks to reveal and actively address the constraining, paradoxical, contradictory conditions of everyday life (Fine 1994, p. 30; Opie 1992, p. 59; Lorde 1984, p. 41; Griffin 1982, p. 167; Freire 1972, p. 96). Thus transformation includes both the naming and framing of oppression whilst strategically analysing and building alternatives for individual and collective action. Roman and Apple (1990, p. 62) put it this way:

... the commitment on the part of the researcher to allow her or his prior theoretic and political commitments to be informed and transformed by the lived experiences of the group she or he researchers ... [Research] that is dialogical and aims to build theory democratically encourages the research subjects' empowerment through systematic reflection upon their own situations and roles in reproducing or transforming existing power relationships.

The process of problematising practice through openly ideological inquiry (Lather 1986, p. 266), engages one in self disclosure, collaborative critique of ideologies embedded in practice, negotiation of meanings, taking into account multiple meanings, and construction of new approaches in fostering emancipatory interests. As Lather (1991, p. 3) claims, quoting Fox (1988), 'the heart of the idea of empowerment involves people coming into a sense of their own power, a new relationship with their contexts'. Moving from silence to finding one's voice in expressing one's story, one's interests or concerns through narrative, one is able grapple with new points of understanding and at the same time generate new courses for action (Fine 1994, pp. 26-28; Mishler 1986, p. 119).

These principles, while not seen as the hallmarks in total, comprise assumptions underpinning feminist research. Cook and Fonow (1986, p. 80) suggest at least two of these principles should be present if the scholarship in question is to be named as feminist. Likewise these principles should be transparent in the authentication of the research.
Authenticating the research

Sandelowski (1993) notes that one of the issues arising from using alternative paradigms in research is that of rigour, a concern that stems from traditional notions of validity. Traditional research and the generation of knowledge has exhorted value-free, controlled contexts, manipulated variables, objectified relationships and has taken a stand of disinterest in the realm of social inquiry, an area which is neither value-free, disinterested nor neutral (Meleis 1996, p. 19; Stanley 1990, p. 4; Chinn 1985, p. 45).

As Heron (1981, p. 34) suggests, inquiry that seeks to generate knowledge through participatory processes requires a commitment to participants' rights; moreover it attempts to support empowerment through the development of reciprocal relationships that are founded in trust, respect and acknowledgment of diversity (Meleis 1996, pp. 11-12). The participants have a right to be involved in decisions about that knowledge to which they have been party. This, Heron (1981) argues, includes honouring the knowledge developed individually and collectively, attending to the possible misuse of knowledge about those involved in relation to that knowledge, and participants having a sense of ownership of that knowledge that is supposed to be about them in order to prevent inappropriate use of that knowledge (Meleis 1996, p. 10; Fine 1994, p. 21; Lentin 1993, p. 132; Opie 1992, p. 56). It becomes clear that the research then has a moral and political commitment to the actors in terms of authentication of that knowledge in which individuals and groups have a stake.

The question of legitimacy remains a very vexed one, and one that has fuelled multiple debates. Very recently Emden and Sandelowski (1999, pp. 2-7; and 1998, p. 207) have raised some serious questions surrounding the rigour of what they describe as 'qualitative research', concerns focussing on validity and reliability as the criteria for 'good' research. These authors argue that criteria for good research are now in need of re-vision given the disintegration of grand narratives and the totalising effects generated from traditional sciences (Lather 1994, p. 37). Living in a postmodern world, Emden and Sandelowski (1999, p. 4) claim, requires a rethinking of a singular point of reference to judge the worth of research of this nature. Rather, postmodern genres
need to work creatively in being able to 'play' with multiple positions as they weave and intersect one another creating ambiguity, dissonance or uncertainty. Lather (1986) in her earlier work 'hi-jacked' and then reinterpreted the language of triangulation, creating a new edge in establishing authenticity.

Triangulation, according to Lather (1986, p. 270) and Reinharz (1992, p. 213), means including a variety of methods and theoretical debate to highlight 'counterpatterns as well as convergence if data are to be credible'. Lather's (1986, p. 271) earlier work suggested the use of forms of validity: dimensions including construct validity, face validity, and catalytic validity.

Construct validity, Lather (1986, p. 271) points out, draws on the participants' descriptions while engaging in systematically confronting their lived experiences through self and group reflexivity. It is important to avoid imposing ideas and to allow theoretical connections to emerge (Campbell and Bunting 1991, p. 13; Lather 1986, p. 271; Heron 1981, p. 31).

Face validity is inextricably linked to construct validity, attending to the extent that participants know something to be what it is, without hesitation. Lather (1986, p. 271) using Kidder's (1982) description refers to face validity as the 'click of recognition' or the 'yes, of course', the 'ah ha' in knowing. Here there is a danger of false consciousness; however what might be labelled as false consciousness may indeed reflect the problematic of truth claims. To achieve face validity participants' descriptions and analyses are returned to participants for checking (Thompson 1991, p. 39). Catalytic validity addresses the generation and fostering of a substantive reflexive critique of reality with the intent of transformation. Lather (1986, p. 272) uses Freire's (1972) term 'conscientization', a point that speaks to the praxis orientation of the process and provides insight into the direction catalytic validity takes.
More recently, Lather (1994) has argued for a reframing of these ideas. While continuing to use the notion of validity she asserts that counter authoritative discursive practices take into account the problematic of representation. In adopting this postmodern stance Lather re-addresses the notion of validity through the following model/system of 'frames'.

**Frame 1** - the depiction of what is as a 'simulacra': put simplistically, something that one understands as existing but which in fact does not exist at all. The representation of reality is thus a rhetorical form existing in the foreground and obscuring what might lie behind. By exposing that which is in the forefront (what one supposedly knows) the invisible becomes clearer - perhaps - (Lather 1994, pp. 40-42).

**Frame 2** - legitimation by paralogy, in which tensions are continually juxtaposed and where differences are fostered to expose contradictions, enabling the emergence of multiple voices (Lather 1994, pp. 42-44).

**Frame 3** - rigour/rhizomatic validity, where ideas reflect the questioning of the interconnections in and between understandings which together form a mass of disorderly intersections of multi-layered multi-dimensional meanings. This frame supports the engagement of participants in hearing their own voices (Lather 1994, pp. 44-46).

**Frame 4** - situated validity, reflects the space necessary to enable women's situatedness to be expressed. The situatedness of woman as the embodied personage, and as participant, arises from engaging in critical reflexivity, from which dimensions of being are in the multiple possibilities of becoming (Lather 1994, pp. 46-49).

Lather's 1986 and 1994 work on issues pertaining to validity highlight clearly some of the contemporary concerns relating to authenticity in feminist research. Olesen (1994, p. 165), for instance, stresses the importance of critical self reflexiveness as an aspect
of sensitive intersubjectivity in promoting a full account of the project, including the
researcher's situatedness. Like Olesen (1994, p. 167), Opie (1992, p. 59) believes that
major emphasis has to be placed on 'writing the voices'; that is, in the selections,
contradictions, emotiveness, control of interpretation, and at the same time, in exposing
and analysing one's own ideological position, something which Opie (1992, p. 66)
argues is taken for granted in Lather's work.

**Commentary on the methodology**

Given the complexity of this project and the time over which it has occurred I have
endeavoured to be 'true' to the enormity of information collected through field notes,
my journal, and also through the group meetings, transcripts, reviews of transcripts
and conversations. In working with the material over time I journalled as part of the
reflexive process, searched for and pondered attempting multiple ways of grappling
with the ideas.

Braidotti (1994, p. 59) uses Haraway's (1991) notion of figurations, which she
suggests refers to knowledge that is not caught up in imitating the discourses of (in this
instance) the medical model or patriarchy. Such a notion enables the teasing out of
multiple connections between the various thematic and methodological ideas. In
addition, precisely because ideas are inextricably interwoven in such ways that to
separate them would be to distort their meanings, these connections take on a different
style and are variously expressed. Braidotti (1994, p. 60) argues that the inadequacies
of 'man made language' has led to situations in which the expression of women's
understandings, the knowledge and experiences of their everyday world have been
marginalised and silenced. By teasing out connections and weaving them in the
context of multi-layered relationships -

that is to say not only cerebral, but related to experience, which
implies a strengthened connection between thought and life, a
renewed proximity of the thinking process to existential reality ...
connection is not dualistic or oppositional way of thinking but
rather one views discourse as a positive multilayered network of
power relations (Braidotti 1994, p. 60).
I wanted to find ways in which the participants' ideas and everyday knowledges could not only surface their subjectivities while ensuring that these subjectivities were adequately configured, as well as helping to support the rigour of the work. In establishing rigour in the context of feminist research of this nature, Braidotti (1994, p.76) suggests rigour might better be judged by the strength and emphasis in the interconnections between the political and theoretical concerns as well as the foregrounding of women's everyday experiences as legitimate claims to truths. Indeed, feminists need to re-configure the manner in which subjectivity has been structured and its relationship to otherness, and then work towards transcending existing boundaries in the negotiation of new configurations of women's identities (Braidotti 1994, p. 77). These ideas helped me to understand why it was that I was having difficulty in working with the data and to think more expansively, adopting the rhizomatic ideas suggested by Deleuze and Guattari (1987 and 1983).

**Rhizomes**

Deleuze and Guattari's (1983) notion of the rhizome was a way of making sense out of what I had in front of me. Using the rhizome to depict what went on and the ways in which I was wanting to work with the data has enabled me to honour the moral commitments inherent in this project. Specifically, I am referring to listening to the voices of the women, allowing participants' interpretations and reflexive thoughts in/of the social to stand and emerge, locating history within the lives of the women. I have paid attention to working with the women collaboratively, being involved in teasing out knowledges as legitimate, being sensitive to the various relations in which these women (including myself) individually and mutually engaged, working with myself, and walking with them as we have participated in the unravelling of understandings, coming to grips with meanings and possibilities in a process of ever expanding lines of connection as part of this rhizomatic experience.

In botanical terms a rhizome is a subterranean root-like system that spreads horizontally, producing flowering stems from the joints or nodes. It reproduces itself
from the roots stemming from the nodes. Bearded Iris and Lily of the Valley are examples of rhizomes. They are used here metaphorically. Rhizomes have several characteristics in common. At a glance they vary in shape, however they extend in chains connecting at any point and moving as if there were no beginning nor end. They are heterogeneous, suggesting diversity, yet they also share likeness, only inasmuch as they are arranged in certain ways, around something shared.

Deleuze and Guattari (1983, p. 13) cite language as an example of the rhizome, for it acts as the focal area around which signs are attributed to objects, yet these significations are themselves a metamorphosis. The manner in which significations occur is through media such as language, social practices and things like etiquette. When language, for example, is destabilised it can be analysed, broken down; yet these pieces of language comprise and are contingent upon other bits and pieces of the social world in establishing and maintaining connectedness through the rhizome. If the rhizome metaphor is applied to the context of this study, it can be seen that by positioning the self in various locations it becomes possible to see different versions of the same situation. Thus politics, one's biographical self and the relationships in the field as insider and outsider become part of the study (Wolf 1996, p. 34). Moreover it is also possible to consider the alternative ways participants make sense of their realities. Shifting positions acts to destabilise what at first seems given. At the same time it helps to peel back the layers upon layers of meanings that connect the social, the political, the commonsense understandings, practices, rituals, agency and relations. These examples cannot be plucked out on their own, they cannot be separated from one another (Deleuze and Guattari 1983, p. 11), they are part of the same thing. There is no unity, rather only lines, concepts that connect the multiple dimensions of the rhizome in its underground system. The lines or concepts, according to Deleuze and Guattari (1983, pp. 16-17), form planes which carry connections that begin or depart from any one place on that dimension and traverse to another plane connecting with another line. These planes are referred to as 'planes of consistency', in that they are linear and multiple forming plateaus.
Deleuze and Guattari (1987, p. 22) explain '[w]e call a plateau any multiplicity connected to other multiplicities by superficial underground stems in such a way as to extend a rhizome'. These plateaus or their likenesses form simulacra, acting as punctuation points; they might be ideas, experiences or thoughts and so forth, held together by connections, extensions of the rhizomes beneath the surface. The more planes there are the more connections there will be spreading one way and yet another in the development of a matrix. Multiplicities, the dimensions of the planes, are distinguished from the outside by creating abstract lines that serve to demarcate, or as Deleuze and Guattari (1983, pp. 16-17) write, deterritorialise the nature of the structure while segmenting it as well. Thus, a rhizome can rupture at any point and then proliferate along what they refer to as 'lines of flight', becoming different only to be reterritorialised as something else through signification. As the group engages with one another for example, the conversations take flight along particular lines. These lines are the planes of consistency for they become deterritorialised through various interpretations which take on a different form at each point. In becoming reterritorialised the form emerges yet again differently but it still constitutes part of the rhizome connecting at some point with another segment or line(s). It becomes possible then to develop maps, constructing connections within a field of connections with multiple entry and exit points, enabling a mapping of the subterranean. For this very reason I have experienced an immense struggle in trying to depict the body of this work. Consistently, there has been an ongoing issue of seeing the connections and avoiding repetition, seeing the lines and segmentations, developing, increasing, varying and expanding, always growing - becoming; there is no end point nor beginning, but there is always relationship (Deleuze and Guattari 1983, pp. 48-49).

One of the constraints in writing this thesis was the tension between my desire to incorporate large pieces of dialogue, a position in keeping with ethnomethodology and feminist principles in foregrounding women's voices and the strict requirement of academe to limit the length. The compromised position adopted (and a reluctant one)
was to include aspects of the dialogue most pertinent to the 'arguments' I was framing and to attach those in the form of appendices to which the reader is constantly referred. This no doubt fragments my original conception where aspects of the dialogue and the ways in which I engaged with them would have been seen in close relation.

What appears to you as the reader, hopefully, are multiplicities arranged in such a way as to collapse many of the traditional boundaries in research. I have endeavoured to stand in different places, wander through the field, stand in the middle, sometimes move, traverse and take flight. For Braidotti (1994, p. 60) rhizomatics in particular supports a wandering style enabling the exposition of the multilayered dimensions of participants' everyday worlds and their coinciding simulacrum. The approach pays attention to the complexity of everyday life, the networks of power, ideas, claims to various truths and also multiple desires. This is what Deleuze and Guattari (1987, p. 23; 1983, pp. 56-58) and Braidotti (1994, p. 60) refer to as being nomadic.

In very real ways I wanted to preserve the integrity of the work; to be sensitive to all the voices and the richness and complexity of the various locations in which I found myself. What I had been engaging in formed a series of transformations. Trying to depict these transformations has led to some tentative thoughts about the ideas. The extent to which these are frames or simulacra remains problematic, but these distinctions are false for the work is slippery, positions tenuous and in-between. In other cases I have found myself in two or more locations at once. These locations are not designed as arbitrary categories for they reflect different positionings at various times within the field. I want to speak of these as polyphony - writing undertaken in the reflexive voice, the actual voice(s), the metaphorical voice(s) the poetic, lyrical or 'dreaming' voice; and finally the subterranean voice - the voice of expansion.

**Voices in the rhizome**

... work in a sort of fluency. At first sight there is the voice of the author positioned outside. Then again as an insider with multiple voices, the woman in practice -
myself, the other selves - my other selves, the metaphorical 'I' and 'you' and so on. Practitioner's voices are also present, appearing through narrative (Journal entries in italic) and dialogue (written in bold comprising Appendices 1-10) and plain text (as part of the body of this work). Various voices interrupt the texts, weaving connections and ideas. Yet these interlace at many other points with other narratives and commentaries. Often the voices disrupt, create tension, fathom, critique and expand the ideas to create additional dimensions to the maps of the subterranean: new multiplicities - refigurations of what was - becoming and unfolding.

**Epiphanies**

And so it was one Friday afternoon I was sitting in my office when like a bolt of lightening it hit me. What I had been engaging in formed a process; 'YES!', I said to myself, it is a series of transformations underpinned by relational ethics! As I looked closely I began to reconsider these transformations as moments of realisation, epiphanies perhaps, the traversing of plateaus that were not necessarily recognised at the time but perceived later as part of my reflexive stance. The ideas flow on the board like this:

```
OUTSIDE-IN
    me - as the outsider looking in, getting started, otherness etc

INSIDE-OUT
    me as nurse - looking from the inside out
    staff insiders - looking from the inside out

INSIDE-INSIDE
    us - the staff

INSIDE-OUT
    us looking out

OUTSIDE-OUT
    me on the outside - finished? and gone?
```

Having sketched this process out it is easier perhaps to see some of the issues which might arise within and out of one's positionality. Indeed, it also foregrounds the various positions in the context of relationships - the rhizomatic environment traversing
a journey woven in and between various realities. Here were the lines segmenting and stratifying dimensions of the rhizome, lines of flight and multiplicities acting to deterritorialise, reterritorialise and vary, modify what was and what becomes (Deleuze and Guattari 1983, pp. 48-49) as we were all both the insider and the outsider at once, and yet separately. Were these notions of insider and outsider helpful, or rather, inherently contradictory?

**Outside-in: Some thoughts**

My own experience and that of many of my feminist colleagues is that each of us feels intensely passionate about what we are doing and for some, as Klein (1994, p. 43) comments, it is not just a matter of 'doing' research it is about a way of life. For many of us the questions or issues we are dealing with are political in nature, albeit political in the sense that the personal is political. This research for example, reflects my intense interest in working with others; about being together and building individual and collective understandings. It is about attempting to make a difference - in knowledge, in the care one offers others - about the things nurses do, and about the things nurses know or experience as nurses.

**Outside-in: Getting started**

Ethics approval was received from both Deakin University (see Appendix 11) and The Hospital to conduct the research. As a matter of courtesy I made an appointment with the Director of Nursing (DON) enlisting her support. At the meeting with the DON our discussion with regard to the research focussed around the many options for participant selection including why it was that I wanted only women in the study.

I also wrote to the DON to request 'permission' to practice in a supernumerary capacity at the hospital enclosing an authorised copy of my practising certificate plus a curriculum vitae which I understood would be forwarded to the hospital board for approval. My requests were granted but not without questions.
During the course of this work I have frequently been asked why I do not call the project a critical feminist study. My choice to avoid a label was because I felt that it would never get further than the proposal let alone gain approval in a large public hospital. This again perhaps highlights the politics of research in my community(ies), where knowledge of the culture can have major implications on the direction the research might take. Past experience has informed me (Cash 1993a, p. 72) that many nurses (and other groups as well) equate feminism with lesbian ideologies (Chinn and Wheeler 1985, p. 75). The picture of feminist for some is the 'man-hating dyke', the woman with hairy legs and armpits or indeed the 'butch lesbian' stereotype. These images are not without their own contradictions (Cheek and Rudge 1995, p. 312; Pettman 1992, p. 63) and tensions. It was with this sort of knowledge that I chose not to name the study as a feminist one.

What happened as I tried to access a group
At the outset of the study I had thought to include clients in the ward, those patients who were being cared for by participants. Patients' involvement, I felt, would add to the richness of data available and provide another dimension to the understandings and meanings in collegial relations and the impact this might have on nursing care. However, before the DON gave final approval she expressed concern for patients' vulnerability and preferred they were not involved. Thus, I chose to exclude conversations with patients from the project. I remain unsure whether this was a requirement from the hospital ethics committee.

I had also heard through an anonymous source that during the course of discussion at The Hospital ethics committee a number of other issues were raised. Apparently, the concerns centred around the perception that:

- the research was not research;
- the methodology was flawed, it was biased;
- the research excluded men;
• whether the nursing workforce could spend time undertaking this project; and,

• the project would start a revolution and the hospital could not afford this happening.

(Journal entry, March 1996)

I was unable to see the DON until May to clarify the questions she was asked to address by The Hospital ethics committee. When it happened, it was not a long discussion, merely one which was designed to clarify the points.

I was told by the DON to approach ward X. She had already had a conversation with the Charge Nurse and she (the Charge Nurse) was happy to support staff who might want to participate in the research. Moreover, she said 'we' (the participants) could use space in the hospital providing that the meetings were not held in staff time. I assured her that I would convey this to the potential participants. The DON's comments appeared to be grounded in concern for not weighing down the staff too much because they were already experiencing a high work load due to staffing cuts (consistent with the retracting healthcare dollar of the time). The DON commented it was a case of 'survival care', much as she did not like to admit it, but that was the reality in relation to caring for people nowadays. The concerns she expressed translated into quite clear directives about what was going to be acceptable to her in terms of the staff’s involvement. I wondered what the staff would make of hearing the DON make decisions on their behalf? Would it worry them? Would it matter that they had no control over what could or might transpire in their work situation? Was this an example of paternalism? And what of the ethics of this approach? (Journal entry, May 1996). Finally in June the letter of approval arrived from the hospital.

Over the ensuing months I made many trips to ward X, going to great lengths to get people interested and trying to get participants, but to no avail. The initial meeting was with the Charge Nurse to arrange times to talk to the staff and invite members to participate. According to the Charge Nurse she knew nothing about the project, nevertheless it was a fruitful discussion (or so I felt) with arranged times to access staff
members. Many stories arose during the chain of events over the course of the next few months. I found immense difficulty in recruiting staff. While they were co-operative on the surface, clearly there was more to many of the contradictions I was beginning to experience. To start with, the ward was mixed gendered - not what I had been led to believe. I would make appointments and these would be overlooked, often cancelled. Sometimes the person concerned would be off duty and then there were other instances such as inconsistent information about Christmas ward closures, and so on. I was concerned to continue the project over Christmas/New Year in order to amass a considerable amount of data. In addition, I did not have a teaching load then and therefore my time was considerably more flexible, so I was able to focus my energies into the location. I spoke to as many staff as I could locate, part-time, full-time, day and night nurses. Despite having the roster, it continued to remain a mystery - again my information contradicted what was happening. One day late in September I went to the ward to see the Charge Nurse as we had arranged. Suddenly my attention was drawn away from the person speaking. I snatched glimpses initially and then stared, only to find -

... a list of the staff, much as you would see on the roster. Running across the top two columns was yes/no. The top was headed ‘Who wants to be in Penny Cash’s research? Please tick - ‘Yes’ or ‘No’. Some people had already indicated ‘No’. In fact there were a number of Nos and quite a few staff who had yet to indicate their choice. There were no Yeses ...

Having carefully studied the list again I left the room thinking to myself - Interesting!!!

‘B’ stopped me as I walked out of the ward. She said to me: ‘Don’t be disappointed with the response; it’s typical, everyone is waiting to see who will tick yes before they decide to join your group! There’s a lot of backstabbing going on here so some will join but some won’t ... I want to join in but I’m not going to put a tick on the board ...’. It was at this point that I began to make sense of many other comments made both haphazardly and pointedly in some of my
discussions with the Charge Nurse and with the other staff members. As I drove home I began to put into context the DON's comments. I wondered about horizontal violence, why I had felt so awkward, why one of the casual staff members (J) from the first group had come up to me in the corridor after the second group meeting and said, ‘I did not want to say anything before but I'd really like to join the group’ and then comments by the Charge Nurse about staff being too busy, closure of the ward at Christmas etc. Looking back now it became a much clearer picture. B had stated the obvious. Was her outspoken/forthright approach an issue as well? Was J also marginalised? J, although new to the ward in relative terms (12 months) acknowledged that she was on the 'outer a little bit because she was bank and worked part time in this ward'. She mentioned she did not feel she 'could say very much but I'd make the effort to come in'. J spoke to me quietly, and no sooner had she made these remarks then she disappeared. I wondered if her quietness was also about her interpretation of herself in what was emerging as those who were in the inner circle and those on the outer.

(Journal entry, September 1996)

By early November 1996 I was feeling very disheartened. I returned to the DON and give her an up-date on the progress, something she had requested. Relaying the major difficulties in gaining the required number of participants I asked if I could approach another ward - one of the options we had discussed earlier, the surgical unit 13 North. I am not quite sure why the DON agreed but she did. She began to talk a little about the ward - it was a large surgical ward where the nurse in charge lived on a farm out of town which she shared with another staff member. Both had recently lost their last surviving parent, the staff member about six months ago and the Charge Nurse about eighteen months previously. Both had nursed their parents until they had died at home. I wondered why she was telling me this? What was she saying and why? In addition, the ward was well run, but it was 'fairly autocratic'. It almost sounded as if I would have some difficulties. 'Certainly, by all means try that ward' were her parting
comments, 'let me know how you get on'. I decided to go immediately up to the ward and see the Charge Nurse.

BRING ON THE REVOLUTION I THOUGHT TO MYSELF!

And this is how this research began ...
Chapter 4

Bracing the self: Poised?

As I reach the top of the sand dunes the wind embraces my body as if to hold it. Leaning into the wind to avoid falling my hair is pushed back as gusts brush past; the chill surrounds me but I am warm inside. My ears are exposed to the wilds of the wind as I turn my face towards it. Fresh? Cold? No - it is the powerful force that strikes my body as I set forth again. Momentarily poised, I catch my breath as the sea stretches out to meet the sky, the colours merging as if they were one, but are they?

It was Thursday 7th November 1996.

As the elevator moved up to the thirteenth floor I planned what I would say. I felt I had been given another opportunity, 'better not stuff this up' I said to myself, admitting perhaps for the first time that I had failed. Or was it that other pressures had been brought to bear?

I walked onto the ward and up to the 'sister’s station'. There was the Charge Nurse, Annette; I recognised her immediately. I asked if I could make an appointment to discuss whether it would be possible to talk to her about some research. She showed me into the office and said she had to fix something up and she’d be back in a few seconds. I looked around this very small office. There were no windows; a variety of manuals and surgical texts filled the shelves; a mobile phone on the desk was being charged; notices adorned one section of the wall on the board and although tidy it seemed a bit more personal than the office of the Charge Nurse I had seen previously. There were also pictures on the wall; women who I came to understand later were staff members. Then I caught sight of several photo albums. Annette walked in and closed the door behind her. 'What can I do you for?' she asked. I explained my project and
she listened intently. Following my brief outline, several questions were raised, predominantly about numbers and discussion time. Annette’s first response was 'I've always been interested in team work and it's something we do well here so we need to be involved. No one’s really studied it; it sounds great!'

At this stage I was not sure quite which way to take these comments (given my previous experience and perhaps my second-hand knowledge about this woman) but I worked on the assumption that it was genuine interest. We walked through the issues, such as all female staff, and Annette said 'we're basically a gynae. (gynaecological) ward although we do have some surgical patients; we only have female staff on this ward, no men'. I asked about staff numbers and Annette showed me the roster which she said Vivien managed, because 'she could work it out' and 'anything to do with rostering was her job'. She explained that the ward was made up of a core of full-time staff with permanent part-time nurses adding to the total number. Annette mentioned that some of the nurses had worked there for many years and that they might go off and have a baby but would return perhaps several years later after their children commenced school. I began to get a picture of who these woman were as Annette cited a number of staff members, for example Lyn, Jenny and Mary who had at various times blended and balanced their family and working lives. We talked about our pasts, sharing where we had been, what we had studied and so on. She mentioned that she had undertaken a degree in women’s studies while Vivien had done a course in humanities. Annette commented, 'It's a feminist study isn't it?' to which I responded in the affirmative; it was underpinned by feminism but I had decided not to call the research 'feminist'. The point, having been made, was left alone. I moved the discussion to the more pragmatic issues of method; specifically, who might be involved.

Annette and I discussed the duration of the project, ethical issues surrounding participation, how the data would or might be collected and numbers of participants of between eight and twelve staff members. She seemed keen to get the day staff to
contribute but I asked whether night staff might want to be included. Annette preferred that the study was undertaken with the day staff team. Pragmatically it was considerably easier to omit night staff from the study given they comprised a large majority of nurses working in a part-time capacity and it would be difficult to get them together.

I asked about working with the staff as a clinical nurse, and she said gently that would be possible but it would depend on how the staff felt. I could feel our time was just about up. As we stood up to leave Annette asked me when I wanted to start and I said as soon as possible. She talked to Vivien, then came back: 'How about coming in next Tuesday and you can meet the staff and start then?'. I mentioned the plain language statement and consent forms and Annette said she would talk to everyone about the project. As we walked to the entrance of the ward I said to Annette that the DON did not want the meeting held in staff time. 'We'll see about that'; I looked at her, startled. 'This is important work here - it's something that needs to be studied, and we can all benefit! We'll call it inservice education; you can't be studying this outside the ward 'cause it's the staff you're looking at in terms of team work! Don't worry about it, no one needs to know, it's inservice education - Okay?' She looked at me with a smile; her comments were at once both quizzical and assertive. 'Thanks Annette, I'll see you on Tuesday!' 'Good!' she exclaimed turning and pulling the door behind her. I stood waiting for the lift in a state of exhilaration.

**Returning**

I returned to the ward on the 12th November to speak with the staff about the research. I felt somewhat like a visitor to the ward. I was greeted by Annette with, 'We'll see what sort of authority you can exert', with regard to asking two patients to vacate the day room. It was an interesting yet a challenging welcome, a comment made with a wry smile! I found myself searching for an appropriate response. At the same time I reflected back to a previous conversation and what seemed to me to be a masked humble pride in 'her' staff. She had explained earlier of her interest in team work:
... we work well as a team; we couldn’t function without it ... I am grateful to the staff for their support, particularly when we moved to this ward - there were[ten] more beds and it took a lot of getting used to. I struggled in terms of the ward's size; it was so much bigger and more to remember; without them I wouldn’t have coped you know! ... We have got staff here who have been here for fourteen or more years ... I guess they wouldn’t stay if they didn’t like it. I hand pick all the staff ... we have a position here now and I am being pushed to get someone but it takes time.

(Journal entry, early November 1996)

There were dilemmas in speaking with Charge Nurses about the research. While following the practical concern in terms of appropriate ways of acting such an approach can influence participation. The power of the Charge Nurse had the potential to encourage participants to engage in diverse, subversive or supportive activities in response to such a request.

Sure enough Annette had spoken to the staff(!) and at 1430 hours about ten people walked into the room, pulled up chairs and continued to speak softly to one another as they waited. Shortly after everyone arrived I was invited to 'tell us what you want' (Journal entry, early November 1996). I asked what the staff understood by the research, to try and discern what information had already been imparted. It was clear that they had been informed and were willing to be involved. Nevertheless I reiterated issues surrounding confidentiality, anonymity and privacy.

**Being involved**

At this initial get-together to discuss the project I began by suggesting what participation might mean in terms of their involvement: for example, the project would run for a minimum of six months but would more than likely cover a twelve-month period; I wanted participants to keep a personal/professional journal, plus a collective
journal documenting practice insights shared during the meetings; and, that I desired to
work with participants as well. Moreover, I was keen that each person consider the
proposal outlined in the plain language statement (see Appendix 12) carefully before
signing a consent form (see Appendix 13) and that I would return in one week's time
to collect them. If I had eight participants at that point, we would commence the
project with the first of our meetings two weeks later.

Location of the meetings
The meetings were held in the day room rather than a meeting room situated outside the
main entrance to the ward. Perhaps the choice of venue was more to do with
convenience than finding a carefully discerned location on neutral territory. Somehow
organising the venue fell into place. I did, however, say to Annette the previous week
that the DON had stated I could use space in the hospital to hold meetings. There were
never any questions asked but I was informed later that most meetings concerning
ward issues were held there, while inservice, report and other more formal activities
were conducted in the meeting room just outside the perimeter of the ward. While the
day room is used for some gatherings I still wonder if the use of this room was
because it was considerably less conspicuous.

Data collection
During the briefing session, I explained that the research would involve weekly
meetings for approximately one hour and that these meetings would be audiotaped.
Throughout the course of these audiotaped meetings, individuals had the right to
request the cessation of audiotaping. Indeed, during the course of the project there
were four or five occasions when audiotaping was paused. These pauses were due to
intrusions, such as patients walking into the room, or where staff members not
participating in the group sought clarification on patient care. The audiotaping was
also stopped in two other instances; both surrounded a breach in the group 'rules'
when a short discussion about a particular member of staff ensued. Any mention of these instances in the transcripts or the report was requested to be omitted.

At this first meeting with the staff prior to receiving their signed consent forms, and then again once we commenced the study, I stressed that it was important for them to share only what they felt comfortable saying during the course of these meetings or with me in general because I would be taking field notes. During the course of my working time in the ward I also had discussions with various staff participants individually as well as in twos or threes. Some of these discussions took the form of an informal interview type situation where I took notes while we sat together in the cafeteria, and where possible I paraphrased to ensure the information I was documenting was captured correctly according to the meaning the participant was attributing to the details she was imparting. These times were marked by a reciprocal sharing of one another's worlds; listening and responding, yet getting clear about what was being said and trying to appreciate the other (Mies 1991, p. 69).

Conversations such as these acted to build rapport, hearing what was important to one another, while at the same time they helped to support a more 'friendship-like' relationship in the field (Wolf 1996, p. 20). Other conversations and indeed practices generally, were documented using a critical incident technique. Even though individual participants gave consent I remained cautious about some of the conversations I documented. With the informal interview type situation and in some instances where I used critical incident technique I asked those concerned, either prior to or following the engagement, if I could document and use their information. These instances comprised more personal accounts and therefore I deemed them very sensitive material and wanted to make sure the individual(s) concerned was comfortable having the data recorded.

There were, however, many other conversations, instances in practice, rituals and pieces from the everyday world which I recorded without gaining verbal consent
because they reveal dimensions of the unselfconscious practice world. Drawing
time to them as they happened during the course of the project may have created
distortions, altering practices and patterns in caring more so than would normally be
the case in my presence. Each of these strategies was important in encouraging the
participants to judge the level of their contributions and establish whether they felt
comfortable in being a part of the project. It was important to me that the group
understood their role as co-researchers, that collaboratively we would engage in openly
scrutinising practice understandings just as I would be doing with them during the
course of the sessions (Wheeler and Chinn 1989; Comstock 1982; Freire 1972, p.
64).

Tuesday was deemed the best day for meetings, given the ward activities and available
staff. Some women mentioned that they would not always be working on Tuesdays,
given the rostering, but where possible would come in to the hospital to be at the
meeting. They asked if this mattered. Having thought about the ongoing contributions
over such a long period I had felt that it was preferable that those involved attend every
session. Pragmatically, however, I realised that it would be impossible to sustain such
a long commitment given issues such as rostering, holidays and so on. Thus my
expectation was that if staff chose to become involved that they attended as often as
possible to help create and then sustain continuity within the group, support one
another, and in being together, facilitate the development of shared understandings.
Perhaps it was because the potential participants understood why I wanted ongoing
involvement that the group who started this work continued throughout the course of
the project. One woman became pregnant and left the group mid-1997, taking twelve
months maternity leave. Indeed, when they were able to do so (given family
commitments), several staff members attended meetings in off-duty periods. Perhaps
it is this measure of commitment, a commitment that speaks to the individual and
collective expression of faith in one anothers' collegial relationships, that underpins
this research!
I was keen to work with the same staff members for the duration of the project rather than have individuals come in down the track. New members joining a well established group can act to disrupt group processes. Nevertheless Mel joined the group towards the end of the project, necessitating a discussion with members beforehand. Decisions like this one formed part of the 'negotiated' approach. At the briefing session I also explained that if anyone wanted to withdraw at any time they could do so without penalty. Even though I offered this assurance I was never entirely clear that if a person elected or wanted to withdraw that they could do so without feeling they were letting down their colleagues. In addition I was concerned that if they did withdraw, they might be subject to prejudice. The dilemma is a difficult one yet one I did try to address in emphasising participants' rights. While no one did withdraw, the level of participation varied given participants' everyday commitments, the advent of holidays, pregnancies, illnesses and so on. Thus there were occasions when the full complement of thirteen participants (including myself) met while at other times meetings attracted six to ten participants.

**Audiotaping**

During the course of the briefing about the research, it was reiterated that meetings would be audiotaped and that the audiotapes would be transcribed and then the transcripts would be returned to individual members to read and make comments where they felt inclined to do so. I pointed out that this was an important step in authenticating the work. Initially I proposed to get the audiotapes transcribed ready for the meeting the following week. This proved an impossible task for the transcriber and for me as well given that I wanted to listen to the recording and make corrections before I circulated copies to individuals. It was an issue I raised as a difficulty with the group in week two. The participants felt it would be better to get transcripts back in bundles of weeks; this they felt would enable them to view the ideas consecutively and prevent the transcripts getting lost! As a result, I returned the transcripts to participants in bundles of three to five weeks periodically.
 Altogether twenty-one sessions were audiotaped. New audiotapes were used for each recording. Despite testing the equipment and ensuring correct audio levels were achieved, two meetings could not to be transcribed. These instances were consecutive meetings in weeks nine and ten. Interestingly, I had purchased a different brand of audiotape which appeared to be faulty.

Throughout each meeting I took notes; sometimes these were fuller than others. Details varied depending upon my contribution to the discussions. I found it difficult to concentrate on the flow of ideas if I wrote large amounts, hence key words, concepts, thoughts along the way, prompt questions I wanted to clarify, direct quotes regarding major points or revelations comprised my note taking. These were all recorded in exercise books set aside for this purpose, books the group had access to and which I encouraged them to use and also to view. On the odd occasion someone from the group recorded bits and pieces in these books as the meeting proceeded. In many respects I came to regard this note taking as my job as the researcher, something I would have done anyway, but I wanted to offer the group the opportunity to engage in this process as well if they desired to do so. I seemed to slip into this role. These exercise books took the place of the group journal, something the participants felt would be better than having a journal specifically for this purpose. In addition it would save them doing it, given nobody was keen to engage in the documentation process. It was also made very clear at the briefing session and then again later at our first group meeting to start the research that no one wanted to keep a personal/professional journal. I acknowledged this position and decided to abandon the co-researcher journalling dimension of data collection and instead reflect back on the previous discussions from the meeting before.

**Transcript identification**

Each transcript is referred to as consecutive weeks one to seventeen (indicated for example T:1, plus a page number where specific reference to a transcript is made) and then reviews one to four (R:1 for example). These classifications in terms of weeks are to some extent misleading. What happened was that the first seventeen weeks were
recorded consecutively whereas the review weeks happened during and following my involvement in working on the ward with staff participants. The notion of review was coined because this is exactly what happened, the group reviewed the ideas raised at earlier stages; those that were important to them. Participants elaborated upon them further, often revisiting the understandings again, connecting the meanings in different ways. The gaps in dates in the review weeks coincided with times when our meetings could not be held. I joined in other staff get-togethers, but these were all unrecorded events due to the nature of these meetings, which amongst other things, focussed on budgets, planning for changes to the ward in terms of rostering, day surgery creating increased through-put and implications for patient care, inservice education on the ward, re-structuring of the formal organisation and so on. In addition, while I was working on the ward sometimes our meetings had to be postponed because they coincided with emergency union meetings surrounding forthcoming industrial action over issues concerning the advent of health care networks and associated re-structuring.

Transcripts
All the group members received individual copies of the transcripts; recordings transcribed verbatim to ensure accurate representation of each voice. Some participants collected these from the meetings while those who were unable to attend were able to pick up their transcripts at the next meeting they attended. I found it necessary on one or two occasions to leave several sets of transcripts for participants with Annette, given the difficulties in trying to handout the information to them in person, difficulties surrounding work patterns and holidays. Each participant therefore had access to all transcripts whether they attended every meeting or not. I chose to ensure that everyone had copies to enable those who were not attending to keep abreast with the discussions the group were having. I asked the participants to read the transcripts, and in doing so, to offer comments about their voice in the margins and identify what, for them, formed the significant ideas in each session. A number of participants never returned copies of some of the meetings despite several requests. I chose not to chase up these
transcripts to avoid participants feeling uncomfortable. I remain unsure why they were never returned: embarrassment perhaps in seeing the speech patterns; perhaps they preferred not to read the material; or could it have been that they could not add anything further?

Reviewing the transcripts acted as a strategy to help verify the ideas but it also served as a prompting point, a punctuating moment during which participants could individually think about what was said, add any further comments, raise questions against the dialogue or identify sections of their own voices which they preferred to be omitted. I had asked participants to put their names on their returned transcripts in order to make any necessary adjustments. Interestingly when I began to work with the returned transcripts, initially participants wrote in the margins what for them constituted important areas. I had requested that everyone highlight these areas. As time went by this pattern began to change. Many raised questions against the dialogue whilst others wrote further comments that added light to the idea(s) or offered alternative interpretations. Occasionally remarks were inserted that indicated a conversation-type response, a question mark here or there which revealed doubt, uncertainty and now and then, realisation. These have been used in various ways. Often they help to pull out contradistinctions, and juxtapositions as well as enhancing or affirming the ideas presented.

Privacy, confidentiality and anonymity

As the audiotapes were to be transcribed I mentioned that the transcriber, an independent person not associated with the research would be privy to their first names only and that their identity would be held in confidence with the use of pseudonyms unless otherwise collectively requested and agreed upon. Because I was unable to gain consensus on this issue I have chosen to retain the use of pseudonyms, names that for the most part reflect women's names in currency in their age groups.
In addition, The Hospital's name has been omitted. You will note that it is referred to as 'The Hospital'. As well as names of patients, names of other hospital personnel have also been changed and pseudonyms adopted as part of the confidential nature of the project. Occasionally, I have retained the use of the person's role, in some instances assigned them a letter from the alphabet, or in others, both are used. The names adopted in this work are false except for my own name. I have avoided being precise about journal entry dates; however in terms of the physical dimensions of the ward itself and its location, I have remained reasonably accurate.

In order to support confidentiality and anonymity I have kept the audiotapes in a separate location from the transcripts. The key to pseudonyms, signed consent forms and other data have been held at my office or at home while in use. Following completion of the research, however, they will be forwarded to the School of Nursing at Deakin University to be stored appropriately in a facility set aside for this purpose and retained for five years. The transcripts will remain in a locked place and held by the researcher for the same period.

**Thoughts along the way**

As I sat in the briefing meeting my thoughts began to roam. I wondered to what extent the staff’s involvement was to be one of generosity towards the Charge Nurse; a form of tolerance; moving with the leadership to gain acceptance, or in a belief that if the Charge Nurse said it was a good thing then their faith in such a judgement was sufficient to encourage them to join in. There again it could have been genuine interest, personal growth and a desire to have another experience which may have motivated this earnest group keen to get an inkling of what might lie ahead. During this meeting I answered many questions about time, about commitment, and what might arise during the course of the project. Annette talked quite a bit, stressing that this research was different from what nursing normally encountered (referring to questionnaires and surveys) and that the experience would thus be different. But there were 'mild' concerns: 'Wouldn't it be a shame if all of a sudden there was some sort of rift?' (Annette, T:1, p. 6). Divisions that developed in the ward with those
participating and those that were not was an issue that was raised and reiterated on several occasions at later times. I mentioned that this was a very real concern but it would need to be addressed by all of us as 'researchers'. I wondered if I was abdicating my responsibilities in these moments. Others, including Annette, agreed that the ward would need to take steps both to prevent such divisions from happening but also, that if such a situation were to arise, then it would be handled with sensitivity. At this point I almost felt devoid of responsibility - they generated the issue (so they thought) - they would deal with it! The separateness of me the outsider, was now visible, laid bare through the conversation. At the same time it could also be understood as women taking ownership of their worlds, highlighting perhaps the difficult balance being sought to enable some staff to participate while others carried the work load of the ward during our time together. Here was a tension immediately recognised and one that bubbled away, only becoming serious well down the track.

In addition I was always acutely aware of the risk that some discussions or situations in practice may cause distress. In giving thought to what might be put in place if this became an issue, I made it clear at the briefing session that such possibilities might arise. This situation was discussed to some extent in the first meeting of the group and ground rules concerning the conduct of the group were established at that time. Other options for mediating or channelling these feelings included open access to the field notes concerning that particular person as well as individual contributions with the right to comment. I was continually careful to avoid using personal or private information unless I clarified with the person concerned that I could use the details imparted. In retrospect I now feel that I should have used the consent form like a working agreement, adding to it from time to time. There were some moments during the course of this research where I used my professional judgement to support participants, just as I would do in my day-to-day interactions with others. The support I refer to was mainly in the context of the field work when caring for patients alongside my colleagues, situations surrounding death, or in our day-to-day work together. Furthermore, there were times during our meetings when I found myself endorsing
others’ opinions, ideas or actions, affirming the participant's position as a legitimate view. While this did not happen frequently, it occurred on the odd occasion and related mostly to feelings. I took care not to embarrass, demean or judge individuals.

**Consent forms**

Because of other meetings, the staff could not remain for longer than half an hour on this occasion. Some had already signed their consent forms, having had the opportunity to read the plain language statement (I had left copies with Annette at the time of our first meeting) and were satisfied with the answers to questions they had. Others did so on the spot and several signed later and gave them to me at our first research meeting on the 26th November 1996.

**Our meetings**

We met for approximately an hour. Some days the session lasted fifty minutes, others lasted sixty-five to seventy minutes (especially the first couple) depending upon the group and what was being discussed. I acted as time keeper to make sure we finished promptly. This was important, given that some staff were due to leave the ward following their shift whilst others were continuing and needed to pick up patient care activities where others had left off. Meetings were held between 1430 and 1530 hours during the handover period between the morning and afternoon shifts. Tuesday was the negotiated day, one that suited the staff best and the day that I was subsequently able to set aside as the day I spent at the hospital. Fortunately my academic colleagues helped by making sure I could run my tutorials and lecture times around this requirement. For this generosity I will always be grateful!

**Format of these meetings**

Over many years I have worked with groups, particularly in the pedagogical sense, using a feminist process to conduct meetings, students' sessions, working groups and workshops. The approach I have adopted is a style similar to that outlined by Wheeler
and Chinn (1989) in their monograph 'Peace and Power: A Handbook of Feminist Process'. This style has evolved comprising the activities such as 'checking in' where individuals share their immediate concerns but then come to focus their energies onto the group's space and their commitment to participation. Creating the 'agenda' forms part of this checking in phase but moves the thoughts from what has gone before in previous meetings to focussing on emerging ideas for discussion, things that surface. This approach emerged as part of the natural being together of the group.

During the course of our meetings, I continued to reflect upon and support dialogue within the group. I began to question whether participants would be better able to make sense of their worlds through the telling and problematisation of their own stories. Storytelling thus became a powerful medium to raise awareness and in doing so to gain new insights (Mishler 1986, p. 119). Looking back now through the transcripts and fieldnotes so much of our time was spent engaging in stories of times past and present. Somehow these stories seemed to naturally evolve into seeing what happened anew and from this to enable the tellers to consider how things might be accomplished differently.

Trying to grasp the ways in which some knowledges are seen to be privileged or marginalised requires processes that will unravel how and in what ways one comes to know that certain social practices, language and social relationships are reified and hegemonic. Thus consciousness raising strategies formed the mainstay of our dialogue. Various protagonists such as MacKinnon (1989) advocate consciousness raising as methodology and/or method in feminist research. More recently Cheek and Rudge (1994) highlighted Willis' (1993) contention that reflexivity is a quintessential process in apprehending the context of one's past experiences and one's social situatedness. Henderson (1995, p. 63) suggests that while consciousness raising takes as its starting point the notion of (women's) oppression, consciousness raising serves to illuminate how and in what ways participants' lives have become distorted. Cheek and Rudge (1994, p. 60) explain that 'becoming aware' is paramount to the
development of knowledge and thus power, and in this sense the personal is embedded in the political and vice-versa. A key component to the transformative process is making visible those experiences, understandings, and meanings which have served to constrain us. The problematisation of individual and collective worlds through processes such as consciousness raising enables the valuing of individual and collective knowledges, thus serving to create a sense of legitimacy. Issues cropped up, for instance, around what the notion of a 'good nurse' might mean, or what individuals thought about the meanings located in advocacy, professionalisation or empathy and caring. Areas such as standards and coping were raised, each of these having connections to and with other ideas. As the group worked with the ideas they found their thoughts took on different dimensions and the conversations came to reveal in-depth epistemological and ontological concerns. Thus, women's everyday knowledges previously hidden, silenced or seen to be too subjective, become visible, articulated and political!

It is important to mention that the ward's reputation was well known in the nursing community. For this reason in particular, I originally made a conscious decision to adopt Wheeler and Chinn's (1989) framework described in their monograph 'Peace and Power: a handbook of feminist process' for the facilitation of group discussions. I had thought it would disrupt existing power relationships in a group forum. By disrupting the power relationships those who were 'voiceless' would be able to speak (an assumption I had made based upon my own experience and knowledge gained through living in my particular community). Perhaps a more fundamental intent contained within this model is its ability to shift the power relationships, enabling the development of shared meanings through dialogue that is open, uncoerced and 'where the way of speaking is an act of love, care and dignity' (Cash 1993a, p. 73). Symonds (1990, p. 48), for example, suggests that Wheeler and Chinn's (1989) framework is a 'connected model' for it offers participants the opportunity to transform their relationships. In addition, the process empowers those involved and gives the group a sense of community. But when we began our meetings I felt uncomfortable
about imposing such a structure. After all, I was invited into the group, a visitor, and this set up a different pretext interrupting my power as the researcher but supporting the group's power as co-researchers. It was in these moments that I began to really question issues of power and wondered if trying to achieve equitable relationships was a utopian vision. Instead, I realised that power was always going to be there, it was fluid, but the more critical question was how and in what ways power was used.

**Group rules?**

What emerged from the first meeting were some simple but quite profound guiding ideas or ground rules as we called them. The first was 'not interrupting anyone'; the second reflected the importance of confidentiality with regard to patients, and finally the group agreed 'not to talk about others in their absence' (T:1, p. 5). When problematised each of these rules offer some interesting comments about various understandings held by the group. The extent to which these understandings were reified and hegemonic remains contentious. For instance, take the first rule, 'not interrupting anyone'. Does this suggest that the staff talk over one another all the time, do staff members feel that their voice is irrelevant, or is it that they have so much to talk about that they are unable to get it all in before they move on to their next activity? There are a myriad interpretations but it was not until later on, as an insider, that I came to really appreciate that what they were saying related to the importance of time together.

At the beginning of our meetings we shared the immediacies of the day in what might be described as a 'jam session' (a version of 'checking in') before moving onto the issues with which we were working. At first the noise level was high, moderating as the participants settled into their seats and began to reflect. Quietness would then follow for a few seconds as co-researchers prepared themselves. While it was seen as a shared responsibility to generate the group agenda and identify and elaborate issues directly bearing on the co-researchers' understandings of collegiality as they arose in the meetings, often I found myself recapping from the previous time, which seemed to prompt others to identify the items for the agenda. Everyone had the opportunity to
speak, some talking more than others. Rarely were individuals interrupted nor were women spoken over by one another. Sometimes participants finished each others' sentences or anticipated what they would say, continuing the thoughts and moving the dialogue in all sorts of different directions. At first when this happened I felt some individuals were almost talking over others. Yet, as I came to understand the nuances in the ways the women communicated, this way of speaking had more to do with knowing each other so well that they intuitively understood or knew what one of their colleagues was thinking or going to say next.

**Documenting the field and working with staff**

Documenting practice using field notes formed an integral component of this research. Here again I used exercise books, note pads, and scrappy pieces of paper. Often I found myself looking for a quiet place to record details, what happened, what lead up to a situation, what the outcomes were and why, how people felt, how they looked, what they did, what they said, including the various responses, and of course how I felt. Frequently this was me gazing at myself in practice, in other instances it was not only me but others too, and then sometimes I was the bystander. Practising with others, looking after patients, having a patient load, being one of the staff and working as if I was a staff member even though I was supernumerary was a crucial dimension of my role as the participant researcher.

I found myself caring for patients, sometimes on my own, often with a participant(s) in the background with whom I would consult where necessary. I wanted to soak up the culture, be part of the ward, fit in and join in as much as I could. The extent to which this happened is debatable but to all intents and purposes I 'slipped' into the milieu finding myself once again falling into the known, my history and the present as if I had never left the ward. Just like anyone else I engaged in nursing practice; my one day a week for just over ten months.

During the course of the project I was unable to work with all participants. Rostering and my other commitments had a lot to do with the times I had available. One staff
member especially requested that I refrain from working with her, despite Annette's encouragement. With respect for this request I decided to honour her feelings.

**Commentary on voice**

There are some significant difficulties arising out of any feminist analysis of women participants' everyday experience, particularly where dominant discourses are subject to scrutiny. Investigations that purport feminist underpinnings carry with them the risk of inadequately representing the complexity of women's lives. The effect may be multifold, from marginalising some voices and rendering invisible aspects of women's worlds to challenging women's interests; in other cases voices may be appropriated into the research under the guise of another's interests (Opie 1992, p. 52) sometimes as a distorted picture of the participants' lives. These are very real risks and ones relating to how and in what ways the researcher's positioning acts to mask the very culture the researcher wishes to expose.

To help reduce these risks, Opie (1992, p. 58) suggests that preventing textual closure serves to enhance the multiplicity of possible interpretations available while at the same time enabling the problematisation of the authorial voice. Thus you will read different voices; commentaries that work to capture alternative understandings, cameos of practice and stories, all linking, traversing and moving meanings in a multiplicity of directions.

During the course of the meetings I attempted where possible to allow the flow of ideas, avoiding interruption. At the same time efforts were made to include all voices, not just some, although occasionally this proved a difficult task. Some members of the group spoke very little and I wondered why. Was it that they were naturally quiet women or was it something else? There were several authorial voices, those of the 'senior members of staff' (Annette, Vivien, Jenny, and Lyn in particular - deemed more experienced perhaps) who seemed to say more, and of course the authorial voice of author! The researcher, in particular, can position the researcher's voice in the
foreground, marginalising the voices of other participants. When participants' voices are shifted to the side, their interpretations become secondary, which then raises a series of questions about the power of the researcher.

Power can also be exercised over the choice of voice(s), and when the dialogue is directed along specific trajectories which can potentially generate distortions (Meleis 1996, p. 11; Wolf 1996, p. 19). What I have attempted to do is to focus on what the participants saw as the critical dimensions of their relations. Perhaps more importantly, however, are the contradictions that arise from marginalising the voices of the participants. The marginalised dialogue reveals difference, interpretations that might not necessarily be available otherwise. The visibility of voice then becomes problematic in the selection of dialogue and became problematic here because of what was able to be included due to the word limit.

I have paid attention to ideas as they have surfaced and how these relate to and yet are entwined in other thematised ideas; the ongoing embeddedness of what appeared to be ward power relationships; my situatedness and positionality initially as the academic outsider which questionably began to dissipate as time went by; and, finally the individual choice in electing to speak - some participants being hardly audible, often responding only to questions. I also wondered if the level of their contribution was their choice. Each of these issues has had significant bearing on much of the dialogue.

Successive meetings saw the emergence of more depth and circularity in what the group originally proposed as their individual and collective constructions of collegiality. Many of the ideas were held in common and it is worth asking whether these commonalities were carried prior to the research or whether they ensued as part of the development of the group's attempts to further feelings of trust and confidence in one another (Maguire 1987, p. 205). Exposing the ideological, hegemonic, and reified understandings of collegiality embedded in practice often stood in stark contrast to the rhetoric. Nevertheless, new understandings were illuminated through critique,
enabling further analysis of how and in what ways participants' practices, language and social relationships shaped and created their self understandings and the understandings accorded to their meanings of collegiality. In addition, these constructions, while named by participants, were not always commonly shared. Achieving any sort of balance between competing claims thus becomes questionable if, after all, this is what the researcher hopes to achieve. Rather, it is perhaps in the interest of diversity, in doing justice to marginalised voices that the moral underpinnings of this research might be exposed and thus realised. Bringing the different voices to the foreground thus focuses attention upon the plurality of women's experiences, illustrating the ideological underpinnings located in competing claims (Hall and Stevens 1991, p. 24) and in the ongoing struggles over meaning (Bartky 1995, p. 397).

The significance of these understandings often surfaced through the projected voice in the form of speech intensity, moments of silence which in some cases were lengthy, the frequency or repetition of a comment, the imbued emotion, differences in speech patterns (Opie 1992, p. 59; Mies 1991, pp. 80-82) or in the inherent contradictions in language, all of which served as focal points in teasing out new meanings and affectedness. Moments of hesitation may suggest points of reflexivity in which past understandings are brought to bear, imploding their influence in thoughtful deliberation over a particular point. At times one may have access to the meanings being expressed; however in other moments the meanings are slippery, evasive or illusory, and one is left to generate meanings within and from the text itself. The disruptive nature of this style acts to foil the possibility of the researcher appropriating meaning (Opie 1992, p. 59) and it is one I have used extensively.

Various positions or claims have been made about the control over and interpretation of the data and the extent to which participants should be involved (Opie 1992, p. 62). At least two issues may have compounded the difficulty. First, as the study was positioned ideologically at a point that delineates the various and separate worlds of the
practitioner in the work context, to spend time reading the transcripts and engaging with them in a critical way at home might have been viewed as work. Another explanation for participants' reluctance to engage more fully in the project could stem from the political decision not to name this study as a feminist one. This may have excluded the participants from a greater appreciation of what a feminist study might involve.

The question of choosing data for inclusion began with and revolved around the participants' willingness to engage in the selection of material. Despite highlighting the importance of individual and group participation in selecting what the participants thought was critical to their construction of collegiality, they believed that this was my job, a comment reiterated several times. No amount of persuasion would alter their opinion; even reviewing the transcripts was considered 'a favour', illuminating perhaps that, not only are different interests brought to bear throughout the research process, but also that all participants may approach the different phases of the research work in quite different ways and in this case it was in relation to the transcribed data (Opie 1992, p. 63). These particular issues highlight some of the relations of power within my project, ones that continued to be played out through 'power in positionality, power during the research process, and power in the post-fieldwork stage' (Wolf 1996, p. 19).

As I left the ward after the briefing session I started retracing what had happened. Was this an extraordinary situation, one in which I would find myself engaging in a world that was at odds with the prevailing bureaucratic imperatives? After all, this research was about nursing, indeed nursing research which had major implications for the staff on the ward. I found myself agreeing with the Charge Nurse. And this is how the weekly meetings began - we attended a 'staff development or inservice education' programme! This was the first of many resistant acts in which I was visibly a participant. Was it an act which blatantly challenged the authority of the those who claimed to be the custodians of staff interests, a text of dominant voices which
supported the status quo? Or was it the voice of (sexist) ideologies which sought to discriminate against women whose intricacies of family life forestalled commitments undertaken outside work time? Could this then be understood as a way to promote suspicion and mistrust amongst colleagues whilst contributing to nurses’ isolation, furthering the exploitation of women’s labour (hooks 1997, p. 488)? Was this act a form of resistance constituting part of a creative process in which meaningful attempts were being made to reduce the isolation between practitioners (Lugones 1992, p. 33)?

**Don’t you know they’re talking about a revolution?**

(Chapman 1982)

You can begin to see then, that my research has engaged me in a form of resistance. (I might add here, that when I started, I did not know the extent to which this topic was oppositional; I am now much wiser!) I was trying to set up a space in which a ‘bunch’ of women nurses could engage in a conversation on collegiality and what it meant to them in their practice. Was this revolutionary? Perhaps the rumour was revolutionary - nurses talking together about what they understood by collegiality, what was important to them in a collegial relationship(s), and was collegiality the appropriate word to represent what they believed to be ‘collegial’? Was the rhetoric on collegiality in the literature designed to promote separateness? Was collegiality something that nurses might hope for, but never achieve? Was the notion of collegiality reflective of particular interests endorsing a patriarchal construction of a ‘professional’ nurse, a construction designed to legitimise hierarchical ways of relating while masking others? Were there sites of resistance to such constructions? What do these resistant views look like and how and in what ways are these resistances enacted? Was the methodology chosen appropriate for what I was seeking to do, learn ... and then ... ?

**DON’T YOU KNOW THEY’RE TALKING ABOUT A REVOLUTION?**

It sounds like a whisper ... (Chapman 1982)
Chapter 5

Getting started

It was on the 26th November 1996 that I walked into the ward. I was shown into the day room. As I began to unpack my bag and get ready for the group, Annette voiced her thoughts on the number of ward staff willing to participate: 'I don't know how many we're going to get; I've talked to all the staff and so they know its on'.

Individuals began to arrive, initially several at once, then the odd one or two moved into the room. Sitting amongst the group as they chattered I felt like an outsider stepping into their space. Several women spoke to me as we waited, perhaps sensing my uneasiness and lack of familiarity. Annette signalled to go ahead so I began by inquiring if anyone wanted to ask any questions or clarify any points with regard to the research, contributions or involvement, before I switched on the audiotape. I was keen to make sure that each person had the opportunity to raise any further ethical concerns or address any general questions, having had an intervening period to think about their individual and collective involvement. It was therefore important that before I turned on the tape recorder any other information was made available to address issues arising from individual participants. Moreover I also wanted to revisit the methods for data collection with the group, having taken note of Annette's comments.

Reviewing the data collection techniques: shaping the work?

I was keen to get the opinions of participants on the manner in which the group would work in relation to the suggested strategies for data collection outlined in the plain language statement. The first of these strategies was the keeping of a personal/professional journal to document ideas and log descriptive, analytical and reflexive accounts of/in practice.
Keeping a personal/professional journal

It was made very clear at this first meeting (26th November 1996) that participants were not prepared to keep a journal, a point made earlier by Annette. Those who had already engaged in journalling as part of their studies mentioned that while it was an 'eye-opener', it took a lot of time. Certainly, if I wanted to keep a journal that was up to me! Immediately my thoughts turned to the notion of reflexivity and how I/we might get around the nature of reflexive inquiry as a component of the research. I began to realise how important it was to negotiate all these steps with the women as I tried to move away from what were originally intended as aspects of process, instead turning my attention to reconfiguring the initial design to something that the group could see as being possible for all of us to undertake.

Briefly I walked through some ideas about reflexive processes drawn from the work of authors such as Holly (1997 and 1987), Cash (1993a), Cox, Hickson and Taylor (1991), Hickson (1990), Smyth (1986) and Schön (1983). These writers, for example, suggest that by holding everyday reality up for scrutiny using description, analysis, confrontation and reconstruction in articulating the various epistemological understandings embedded in the practice world, nurses are then able to consider new possibilities in understanding and acting in their worlds.

However, given the group's clear wish not to engage in keeping a journal, I asked if the co-researchers would feel comfortable in revisiting the main ideas from the previous meeting. This would mean that time would be set aside at the beginning of each session for clarifying or working with the thoughts from the previous week in further depth. The participants nodded and there were many affirming comments. They pointed out that this would enable those absent from the group to be able to make a contribution at the following meeting. In addition, coming back to the main ideas from the previous week would enable those present when the idea was first raised to subsequently reflect, ask questions, work with additional interpretations and fathom how they felt. Pondering these comments I began to question whether my language
was so different from theirs; were the suggestions I was making being put into an alternative discourse more easily accessible to those in the room? Was the group trying to accommodate my requests while adjusting them to suit what was possible for them and each other?

**Keeping a group journal**

'Why was a group journal necessary?' I was asked. The aim of having a group journal was to document any main ideas the group might want to note or where, for example, a person might have an issue/concern/idea that they wanted to ask the group to explore. In addition I suggested the group journal might contain main themes, ground rules which the group chose to adopt and any other item the group wanted to address. In this way participants could track discussions, highlight areas for further work or reflect back on decisions made previously. Interestingly very little was documented in the group journal. The group's agreement on process and a small amount of material pertaining to commentary are the only visible items. While I offered to document material for others and invited the participants to do the same, the opportunity was rarely used. Instead the notes I took became what the group referred to as the 'group's' journal!

Inviting each person to share a little about themselves with one another seemed an appropriate way to begin the group's time together. I refer the reader to Appendix 1 'Painting the Self Portrait: Speaking on the Self' where all the participants (including myself) introduce ourselves. While the aim of the research was to involve women registered nurses only, Annette asked if Hennie, an enrolled nurse, could join the group. Annette mentioned that Hennie was extremely keen to participate, and given that she played a significant part in the social fabric of ward life (for example undertaking the organisation of dinners together, celebrations, weekends away at Tin Can Bay, and running the football pool) it seemed to Annette important for her to be included. I had no hesitation in affirming Annette's opinion, and so it was that Hennie came to participate.
On 19th August 1997, Mel joined the group in the first of the four-week review periods during which the group revisited many of the ideas arising from previous sessions. Undertaking a part-time graduate diploma in midwifery, Mel was not on the ward full-time at the commencement of this study. During her part-time studies she worked several shifts, mainly in a large intensive care unit at another city hospital and several shifts a fortnight in the ward as well. There had been suggestions of Mel's interest in participating in the group not only from Mel herself but also from other staff members. Just before our meeting commenced that afternoon, Mel was asked by one of the participants to join us in the day room. No one objected to Mel's involvement when I inquired; indeed, she was welcomed into the group with great warmth!

Inviting each person to speak about herself as an introduction was particularly important to me as the newcomer into their worlds. At some point I knew I needed to access auto/biographical details to help contextualise the various understandings and the context in which the group collectively engaged. The introductory process also provided an opportunity for individual women to speak about their lives as they understood them despite the impact, and thus influence, of my presence and newness in the environment (Cotterill and Letherby 1993, p. 74).

Speaking about myself and of course what was shared by others in the group generated a sense of openness to what transpired as months went by. I was very conscious of being the outsider - the academic who wanted to be part of the group. My language began to slip into the more pragmatic style of the practice world, something with which I was familiar. This too reveals my attempt right from the outset to identify with, and be part of, the group. It could have been that in gaining some reciprocal insights into who each of us was before getting started on the research topic itself, we gained credibility in one another's eyes.

While, in the main, these women had extended affiliations having practised alongside one another over many years, I was curious about the fluidity of their worlds. But,
just as I was keen to know who they were, I felt the group was equally keen to have an understanding of who I was, and why I was interested in them and in their relations with one another. Was this natural curiosity or was it something else to do with politics and institutional arrangements, education and the struggle over cultural terrain and meaning within and between nursing's various worlds?

In painting the self-portrait only a certain amount of detail was disclosed at this first meeting. Indeed, many of the deeper insightful thoughts emerged later. The extent to which such disclosures were forthcoming later on could well be associated with the degree to which all participants (including myself as the researcher) assumed relations of reciprocal trust (Harrison and Lyon 1993, p. 104). Interestingly, some of the more personal details surfaced as we worked together. In other instances information was revealed through interview, or indeed as corridor comments, those 'pearls of wisdom' often arising out of jest.

Painting 1: By Gaye Bonham

It was therefore not surprising that at the outset brief accounts of the self emerged. This may have been because each participant (other than myself) was aware of each other's histories and thus refrained from going into any great detail. Or was it possible
that each person felt uncomfortable sharing what they thought to be personal details to an unknown character such as myself? Perhaps another interpretation might be that these women participants were reflecting a form of false consciousness in which patriarchal ideologies had, over the years, served to render invisible and unimportant their individual and collective understandings. Minimisation of these women's experiences and knowledges might well be described as oppressive (Bartky 1995, p. 399), having arisen from prolonged discouragement and/or disenfranchisement of their lives. Even though my status in the group was that of a stranger, perhaps the disenfranchisement of participants' histories might well be appreciated in the limited details they contributed about themselves rather than what one might anticipate from those whose worlds are given credence. It is with these thoughts in mind that the autobiographical accounts reveal something of each woman as they came to be with one another in a different space, one that was atypical for staff on a day-to-day basis, and one that held an anticipatory air.

When women in particular begin to speak about their lives, sadly, their autobiographies often lack the detail and extent of their achievements as they depict the speaker's perception of their self in their world (Gergen 1991, p. 9). Frequently they underplay themselves, minimising the significance of their contribution and often at the same time avoiding reference to their personal power (Wolf 1996, p. 19; Etter-Lewis 1991, p. 48). Perhaps in response to this, as the researcher in gaining entrance to the field, I found myself deliberately and unconsciously engaging with participants in quite contradictory ways which led to various tensions and dilemmas arising out of the field work. For instance I may appear to conform to the dominant (patriarchal) values, something I assume is evident, playing down privilege but also trying to gain acceptance (Wolf 1996, pp. 8-9) while knowing intuitively that acceptance was contingent upon being able to engage meaningfully in practice with the staff. I found myself living out multiple subjectivities depending on my positionality. It is with this backdrop that one can better appreciate what transpired as each person revealed a little
of themselves, their backgrounds, and to some extent what informed their day-to-day 
lives.

The awareness of my position in the staff's territory prompted the relinquishing of 
some of my own power (highlighting its fluidity) and in so doing, placing trust in the 
participants that they would articulate what was important for them in terms of group 
process. What transpired at this first meeting was the evolution of a feminist approach 
developed by the group. Looking back now it is easier to recognise that, while the 
decision I took was initially a 'gut' reaction, it is also possible to see that my hesitancy 
also revolved around territoriality. Clearly, the question of my invitation to the staff to 
engage in the research with me was one thing; working with them in their space was 
another. Yet I was greeted by the group with a sense of openness, a willingness to 
feel the way and share understandings with one another; they generously gave me an 
opportunity, and I guess I gave them one too by inviting them to engage in this project 
with me. Perhaps the openness with which I was greeted could be construed in 
Gergen's (1991, p. 19) terms as part of the nineteenth-century legacy of romantic 
values located in a moral life. What distinguishes these values from others, Gergen 
suggests, is the view of self-in-relation epitomised by notions of commitment, 
passion, depth, creativity, feelings, needs or desires. In nursing these expressions of 
one's disposition in the contexts of everyday life remain in currency, a stark contrast to 
the rationalist standpoint which underpins much of present-day thinking in 
organisations (Ferguson 1994, p. 87; Gergen 1991, p. 6). The latter seeks to 
homogenise relations with others depicting these relations in terms of obligation, and 
in this case obligation through consent to engage in this research. It was reiterated by 
the individuals within the group that they had exercised their choice in becoming 
involved in the study. Thus, even though I had invited the staff to join in the research 
I was cognisant of myself as an outsider and therefore was sensitive to the location’s 
culture.

This sense of walking borders, so to speak, in an unknown territory enabled a sort of 
dual vision and an anticipation of being in someone else’s space and what treading
lightly (Cox 1996a) in this location might mean. I wonder now if my decision to abandon the feminist process I had intended to use could be likened to van Manen’s (1995, pp. 42-45) notion of pedagogical tactfulness, a ‘perceptiveness' or insight; an understanding that involves a dialectic of knowing and acting with a moral intention to do good. van Manen (1995, p. 43) also argues that tact is part of the intersubjective experiences between agents, something occurring instantaneously as if it is constituted by a holding back or being attentive to the other. Reflection is not part of this action; rather, pedagogical tactfulness is a knowing emerging with spontaneity in ever-changing day-to-day activities. Perhaps too, it was a moment of acknowledgment and respect for the other, realising that the journeys we were to embark upon were to do with walking alongside the other in their world(s) which was to become mine as well. The notion of invitation was complex and unfolding as I moved into the participants' private spaces and their landscape(s) and as they were also about to share in mine.

**Beginning conversations: Being together**

Before reading on, you are referred to Appendix 2 beginning conversations: being together which reveals further details of our first meeting on the 26th November 1996, including how the group began to work and some early concerns. At this first meeting I proceeded to ask the group how they might like to conduct our sessions, which gave rise to Annette's statement - 'I thought actually you'd tell [us] what you want to do; I thought you'd say what you wanted us to do; we're very compliant!' I was taken aback by this comment - compliant - what did this mean? Was Annette referring to the other participants' willingness to support the research? Was she indicating something of a more subtle nature in relation to the ward staff's hierarchical position within the larger organisation? Perhaps the comment was paradoxically signalling a sense of resistance to authority, a form of defiance to the dominance of those outside the ward while also acknowledging the embeddedness of 'power over' as part of the organisational culture (Starhawk 1990, p. 11).
I then made the suggestion that the group might want to consider establishing some 'ground rules' for the conduct of our 'get togethers' and discussion followed. The guiding ideas for group processes emerging from the first meeting (Appendix 2) were affirmed in the second session as:

- avoid interrupting one another;
- respecting individual rights (patients and staff members) to confidentiality; and
- regarding one another with respect: no name calling or talking about others in their absence (T:2, p. 2).

It is quite clear that these ideas not only reflected what the women thought were crucial in terms of their moral understandings with regard to one another, but also with regard to the patients. Moral agency can thus be understood not necessarily in terms of what is considered to be right or wrong (an unhelpful binary distinction) according to the dominant interests but rather as a form of agency that respects the contextuality of relationships (Held 1997, p. 636). This position stands at odds with the prevailing assumptions inherent in abstract dualistic utilitarian principles or where universal notions of good/bad have very little sway in terms of what women understand to be important to them situationally. As Held (1997, p. 643) suggests, perhaps women desire to create relationships that stem from a moral standpoint which presuppose the importance of concern for the development of connection and trust in-relation rather than focussing on universal views of right action and its related consequences.

Some time later, however, several issues arose surrounding several of these working rules. The first was in relation to a staff member who was not a participant in the group. Comments were made about the person's contributions to the ward. Mary expressed grave concerns about breaching what the group had formally agreed upon at the outset of the research. In another instance Annette shared her concern about whether it was her leadership or their genuine desire to be a participant that surrounded their involvement (see Appendix 2). This conversation arose from difficulties arising out of the tension between those who had elected to engage in the research and those who had chosen not to become part of the group.
Note that Jenny (T:1, p. 7) offers the first indication of faith in her colleagues. It is a belief in the strength and sustainability of connections between one another as they engage in an unknown process: one which departed from what they generally understood as research, to a process which invited their participation and where they hoped these connections would be affirmed.

Yet the question of Annette's power as the Charge Nurse seemed minimised by the group who appeared to take responsibility for their choice to participate rather than doing so in deference to Annette in her capacity as an authority figure. Despite Annette's open acknowledgment of her power, one wonders whether these decisions were informed through the need to conform to the dominant and ascribed ways of acting comprising a subtext permeating the ward culture. Was this then an example of the self surveillance operating within the ward, or was it something else - an opportunity to speak about the personal? Was it that the personal self remained somewhat invisible and were there intentions to foreground the private?

Annette: There are many ways that I'm good at my job but I find it very difficult to get the staff together and talk to them so I don't. I don't say to people you do a good job. How I'm successful I'll never know because they're the mistakes that you [make]; in management. Maybe I'll just bite the bullet and do it once a year or something ... we were joking one day and [one of the staff members] said, remember, you said, one Christmas I had said we've done a good job and everyone nearly fell over. The fact you [Penny] said we'd do this makes me feel good. I haven't got the confidence or the ability to look at their practice so you're filling a gap and that's why I suggested we do it ... I feel it's beneficial.

(T:1, p. 7)

Several issues struck me about these comments. Had I been presumptuous to think that my interests alone were driving the project and that these interests were foregrounded in my consciousness? My power to potentially exploit the participants
during the process or in the final writing up stage (Wolf 1996, p. 19) became immediately and all too obvious. Annette's unexpected honesty was striking. Even at this early stage she articulated her intention to use this forum to affirm and value the contributions of the women, in her words 'filling a gap' which she felt needed attention. Explicating the plurality of intentions inherent in this project highlights the point that feminist research frequently engages one in various forms of privilege, not the least of which calls upon the multiplicity of interests underpinning not only the research but also the various epistemologies that are embedded in these interests as well (Wolf 1996, p. 6). In addition Annette's intentions to affirm the individual contributions to ward life and the caring practices in which these women continue to engage, revealed a moral position that acknowledges and seeks to address the extent to which the participants' subordination (Friedman 1993, p. 549) to institutional arrangements remain hegemonic and reified. Even as Annette expressed her desire to see to it that the research served to value the experiences of the participants, I wondered what other intentions existed but remained at this point, anyway, submerged.

Nevertheless the group seemed eager to get underway and begin the work together.

**What are we trying to do?**

The discussion then turned to the task at hand as Jenny asked her question about defining collegiality and team work (see Appendix 2). This question was a critical one that has bearing on the theoretical constructions of 'collegiality' later on in the project.

Early comments on collegiality reveal an array of ideas that unfold and take on different dimensions in the various conversations through-out our times together. In some ways the participants are highlighting the meanings underpinning collegiality as they reflect on their experiences/knowledge(s) of and in, being part of a team. Prompted by the group, I began to think about the meaning of collegiality from the perspective of a team and what being part of a team meant. Were the participants alluding to their
affiliations within a group which constituted the team? Did they mean that within a
team or working as part of a team their relations were shaped around notions of trust?
As part of a team, were the contributions each person was making to a larger picture
reflective of something else, perhaps respect for one another that acknowledged their
mutual engagement as team members? What was meant by the notion of support and
could this refer to helping one another out in difficult or puzzling circumstances?
Could the mention of standards draw attention to participants' hegemonic and reified
depictions of the quality assurance requirements now pervasive in health care
institutions? And what of trust?

Lyn's final comment in Appendix 2 acknowledges how the bearing of individuals'
pasts had on the present and the ways in which histories might shape the future began
to reveal multiple subjectivities rooted in the appreciation of the private and the public
dimensions of the self. It is insightful that the comments made about trust feature so
early and to some extent I was left wondering about the impact that this project might
have on the issue of where I stood in relation to their trust. Indeed, by way of sub-
text, I was now well aware that my relations with this group of women were going to
be ones in which trust needed to be developed over time. In addition, the way forward
needed to be negotiated.

Time would tell ...
Chapter 6

Traversing Landscapes

I had walked this corridor many times - albeit in different contexts - yet it seemed so familiar. In some respects I marvelling at the sameness; you could almost predict what was positioned where ...

Glimpses of the ward constituted my sense of the environment; the rest I could make up somewhere within my imaginary. Maybe it was because I had worked in areas similar in design to this particular location that I felt as if I knew its dimensions. I seemed to have a grasp of the ward - its physical properties - the territories demarcated symbolically with areas of movement, some spaces seemingly occupied by nurses alone, others by patients, families and nurses as well.

Taking a closer look

Intersections, undercurrents and power

In keeping with the traditional allocation of wards to specialty fields aligned with medicine 13 North was no exception. When I started this project, patients undergoing gynaecological or women's health investigative procedures were admitted to the ward in preparation for their elected operative time. During the course of the research this approach changed to patients arriving post-operatively, a situation which was initiated by a working party of anaesthetists who wanted to increase through-put, thus reducing the waiting list time. Reducing the patient waiting list was part and parcel of the State's attempt to demonstrate to the people its effectiveness in dealing with health (hospital) issues. The anaesthetists' suggestion sparked considerable concern from the 13 North staff as well as from nurses in other areas of the hospital (Journal, late July 1997). The staff felt annoyed by the lack of meaningful consultation having little opportunity to be heard, or if they were, the group doubted whether their opinion held any credence. Their objections to this new arrangement focussed on three main areas.
First, the staff felt concerned about their lack of knowledge about the incoming (post-operative) patient. Second, there were concerns regarding peri-operative education whereby the participants could offer support for women undergoing gynaecological surgery, and this they believed would be hampered in major ways. Third, the nursing staff remained anxious about the establishment of a pre-operative unit, a unit designed purely to act as an assembly point from where surgical patients would be taken to theatre. They thought the new 'set up' was rather like a factory, each area (pre-operative unit, theatre and then the ward) doing specified tasks, with no-one really knowing very much about the patient at all (Journal entry end of July, 1997). These concerns prompted the staff to form a 'think tank' to pool ideas and develop ways to work upon the potential difficulties of the establishment of the pre-operative unit.

The staff also expressed other concerns about the changed admission protocol which saw patients admitted post-operatively. For instance they were worried about being unable to undertake a pre-operative assessment which would give nurses some guidelines or clues in assessing the post-operative condition of the client. There were comments about whether a patient's emotional status was the same post-operatively as it was in the pre-operative period, or whether a client's cognitive status was the same pre- and post-operatively. Also, the staff maintained that whilst the various tests were undertaken in the period prior the patient's admission, often these tests did not reflect the patient's condition immediately prior to surgery. Distortions in the biochemistry or for that matter their physical and emotional wellbeing may in fact have been quite different as outpatients from their health status on the day of surgery. Other issues that the staff reflected upon included early detection of pre-existing conditions such as diabetes mellitus or other health issues which may have had an impact on the patient's surgery and recovery period. In sum, the group were anxious about the lack of nursing care - discussing the changes and their reactions to them (see Appendix 2).

In response to these changes, the participants developed several strategies to help deal with the advent of the pre-operative unit. The staff decided to conduct pre-operative
education sessions for patients having elective surgery. These sessions were available on a weekly basis for women prior to surgery. The pre-admission protocol adopted by the hospital involved forwarding a letter to the patient notifying them of an admission date. As part of this package a woman having gynaecological surgery would also receive a letter inviting her to attend pre-operative education sessions available at the hospital. These sessions were conducted by the ward staff. Several members of staff became involved in pre-operative education giving both the women patients and the nurses an opportunity to meet meanwhile establishing rapport and ascertaining each other's expectations. This strategy in particular enabled the staff and patients to clarify commonly held understandings about experiences of hospitalisation and about the nursing care one might receive. Having spent time with the staff I wondered if the notion of establishing a connection with the patient and family was really at the heart of what the participants were talking about in their reference to being unable to assess the woman's pre-operative state. At the same time I also pondered the question of expectations - the importance of surfacing shared expectations between the nurse and patient early on (Middleton and Lumby 1999, p. 27) thus reducing the risk of disillusionment. In the absence of such shared ideas how and in what ways might the patient's and nurse's experiences reflect conceptions of caring that could have been at odds with one another. Moreover with the increased movement of patients into and out of the ward generating such a large volume of work (documentation and transferring people from one location to another) I began to reflect upon the transitory nature of relationships and whether it was possible to establish any kinds of meaningful understandings that could be shared between nurses and patients. Indeed, this prompted me to think seriously about the relationship between doctor and patient.

Given that patients were probably seen by their doctor/surgeon several times before theatre, it may have been reasonable to assume that a patient had already gained a sense of the medical expectations prior to surgery. The question then became one of understanding - knowledge about what the patient's care might involve and whether they had expectations that were different from, or at odds with, what one might
generally expect following gynaecological surgery. Indeed the area to do with nursing and nursing care could well be omitted or fall under the rubric of medical care. Thus nursing knowledge(s) and the legitimacy of understandings held by nurses in caring for women was rendered invisible. Such a scenario seemed to be prompted not only by the actions of nurses' medical colleagues, but also through the less obvious practices embedded in the institutional arrangements and the ideological tenets on which these arrangements were based.

The participants were cognisant of the medical dominance (T:14, p. 8). Even though recent changes such as the privatisation of allied specialties on the surface appeared to shift the focus of power from doctors to a focus on the patient (Annette, I: 2, p. 14), there was a degree of scepticism on the part of the participants about the intent of these changes. The group acknowledged their dubious position, a position they felt more than ever before was one well removed from the sphere of influence (R:2, p. 3). Although movement within the structural arrangements was evident, underneath the surface control had shifted to a more entrenched location within the hospital bureaucracy. Indeed, the distance between organisational conception and execution was becoming increasingly marked and nurses who, in the past, might have collaborated with their medical colleagues were now faced with a more isolated position. It was an invidious situation in which adjustments to practices needed to occur otherwise accusations surrounding the staff's failure to accommodate new initiatives would be made by those in power (Annette, I:2, p. 10; R:2, p. 5).

During the course of the research, there were at least four main gynaecological surgeons who predominantly admitted public patients to the ward. Prospects of a further number of surgeons joining the existing group (T:8, p. 12) were being rumoured, which would increase the theatre lists and increase the numbers of patients moving into and out of the ward. The participants commented on the average patient stay, which had changed over the last few years. In the past, the average of
approximately four to five days had been replaced by a duration of three days or less, depending on the type of surgery a patient required.

**The physical terrain - reflecting on spaciality**

The ward layout is not atypical of those wards built in the late 1970s. One’s first impression when alighting from the elevator is a large expanse of wall. This wall forms the external surface of a pharmacy satellite obscuring the two possible entrances to the ward. Neither entrance is readily visible; a short walk of ten to fifteen paces either to the left or right of the elevator reveals a pair of large, heavy grey impersonal looking fire doors. They are shut. There is no hint of what lies behind these doors. Those on the inside of the ward cannot see out into the foyer and those on the outside cannot see inward. These doors mark out the initial boundaries between the various public and private spaces of the ward in the context of the hospital terrain.

Once into the ward the floor plan becomes more obvious. Both entrances form corridors with the service areas in the middle of the ward. Entering the ward through the left-hand side of the pharmacy satellite a corridor is exposed running the full length of the ward to the day room (the location of our meetings). Several four-bed rooms are adjacent to this corridor which towards the end gives way to single rooms closer to the administrative area. As part of common practice the single rooms were usually set aside for sicker patients.

At first glance down the corridor the ward is shaped somewhat like an upside down 'L'; the rooms to the left and the service area containing a staff cloak room, pantry, equipment areas, clean and dirty utility rooms, the Charge Nurse's (Unit Manager's) office and finally the administrative area are on the right. The administrative area forms the most northerly point which, stretching through the middle to the right-hand side of the ward, gives the appearance of an island between the two parallel hallways which one can now observe are more like a 'U' with an extension at the base of the 'U'. Walking around the administrative area (referred to as the sister's or nurse's
station or more typically 'the desk' depending upon whom one talks to) the hallway runs parallel to the right hand corridor. However, an extension of the corridor continues from in front of the administrative area at right angles giving way to more four bed areas on the left with a smaller sequence of utility areas forming another island between the two eastern corridors. This corridor on the right contains a four bed room plus two single ones as well. The eastern section of the ward is frequently and humorously referred to as 'the back passage'! Those nurses working in 'the back passage' are often isolated from their counterparts in the other areas primarily because of the spatial appointments within the ward, a situation noted by Jenny as problematic (see Appendix 3).

Reflecting on the spatiality - through the windows

Almost all the rooms have quite magnificent panoramic views towards the north or north west. One can see for miles across the harbour as the water stretches out to meet the sky. The view is ever changing with the seasons. On a cold winter's day the colours are blue-grey, the picture wild as the wind buffets the boats and produces a damp breeze as the water swells in response to the wind. Spring colours range from
the soft greens of leaves and lawn, increasing with intensity as the spring moves to summer. In summer there are deep hues of blue; the heat seems to encourage a glistening appearance upon the water beckoning the onlooker to touch it. With the oncoming autumn the greens fade as deepening yellows and reds form a patchwork across the horizon. At various points trees, having been stripped of their foliage, reveal to all their own strength as stark vulnerability, punctuating the undulating landscape right to the water's edge where large ancient looking pines line the foreshore. At night, lights flicker across the bay, the green and red ones staking out the travelling corridors for those at sea, the shadows steadily creeping inwards to shore finally linking and creating a connection with the earth in the evolution of shapes and textures so familiar to the observer.

On a different scale, shapes and textures are marked out more clearly with fabric, steel and flesh. The colours, just like the textures and shapes, vary depending on the shades of the corporeal; it is a material world of fragmentation in which reflections of colours, moods, and realities find themselves intermingling amidst hues of blues, whites, creams, greys, blacks and fawns of the ward milieu. A sharper focus in the words of the authoritative text presumably brings greater clarity - but to whom?

What clarity existed was merely a figment of my imagination. I had come from another world to gaze somewhat vicariously at this one. In the past I had always arrived at this other world shedding the mantle of everydayness as I inhaled the fragrance of eucalyptus after rain or the smell of peppermint refreshing the spirit. Carved into the hill stood a world I had known so well for so long. It was a world I loved, one I believed in. Its soul was slipping away, I tried desperately to hold it, to hang on waiting for ... others? The movement was almost undetectable at first yet more obvious down the track - I did not realise it then; it was not until later on - much much later on. The colours were ochre-red - anger then sadness as spring gave way to autumn. Winter followed without rain; the soil parched, cracked and thirsty. Empty shells stood motionless except for the winds of change ...
Looking within

Several years ago the ward was located in another area of the hospital, in fact just around the corner in 13 West. Then, the ward was strictly a gynaecological unit with several operating consultants. The staff numbers were smaller and as the Charge Nurse notes (See Appendix 3) she inherited all the staff from the previous Charge Nurse - a situation which took many years to change, finally culminating in the formation of her present team of nurses, a team with whom she has considerable confidence.

Creating the team

Over the years, staff changes had occurred by a process of natural attrition. In most practice settings staff replacement and thus selection is undertaken by a panel. The composition of the panel may or may not have included the Charge Nurse. In the latter case, decisions were made in her/his absence.

How the staff came to work in the ward appeared to be a somewhat haphazard process occurring gradually over many years. In some instances nurses worked in another location (the hospital or another health care agency) prior to commencing on ward but had been sent to 13 North now and then, only to finally gain a position at a later date. Looking back at the biographical details (Appendix 2) you will also note that several staff members started on night shift, while some came to the ward following a refresher course or after their graduate year. In the two latter cases the nurse would have already been to the ward as part of a clinical rotation.

Because the Charge Nurse of this particular ward has such a vested interest in building the team in whom she holds great stock, her major interest has been to appoint those nurses whom she feels might contribute best in the context of the team. But it was not only her opinion on staffing matters that counted. It was not unusual that
conversations about 'appropriate women' were shared with the 'senior' staff prior to any appointment. Staff members' involvement in decisions about new appointments to the ward team have been a crucial step in ensuring the person commencing has the potential to contribute to the existing group in different ways. Perhaps most importantly the new appointee is understood to hold values about nursing that are concordant with those of the group. As the Charge Nurse suggested, it is vital to 'suss' people out even before a decision is made to interview. It is a process Annette claimed is often lengthy, but worthwhile.

Some staff were recruited from their graduate year, as Vonnie was, whereas others were asked to work on the ward as casual relief during periods when staff members were ill or when the patient acuity level was over and above what the staff would normally manage. Some of these nurses became staff members further down the track, having spent the odd shift here and there on the ward, often over several years. A few members of staff had completely different experiences of starting on the ward. After a long break having had children, Jenny undertook a refresher course as a means to return to nursing. She was recruited in a similar way. Some, wishing to re-establish their nursing career just as Jenny had done, took a different tack. They practised on night duty as Lyn and Diana did prior to recommencing day work. In other instances, requests to work on 13 North were lodged with nursing administration following short periods of being sent as relief staff. In this way Hennie and Mel joined the team. With the move from 13 West to 13 North there was an urgent need to get more permanent staff and as a result several nurses came on board virtually all at one time. Thus it was relocation to the larger area that seemed to mark the beginning of many other changes.

**Changing worlds**

You will have already begun to appreciate that most of the staff have worked with one another for years. In many respects it is an unusual situation given the general tendency for nurses to be a geographically mobile population, often working in acute
care locations for relatively short periods. In addition, many nurses have left the acute care area, often because of their frustrations in working within a bureaucracy that does little to enhance their commitment or value their contributions (Considine and Buchanan 1999; Schweitzer 1995). The fact that these women have continued to work in the same ward, albeit in a different physical location, with virtually the same staff is unusual if not exceptional in today’s nursing world. Moreover, because they have worked together for such a long time, each nurse carries with her stories of nursing as well as the collective history of the ward. Their understandings in practice have emerged as part and parcel of the cultural milieu in which they have lived and shaped their worlds. It is this in particular that places the participants in a unique position to reflect upon the past and use these knowledges to inform both present and future possibilities.

Throughout the project the participants referred to issues surrounding change, and these were often expressed in terms of the 13 West period or since the move to the newer ward 13 North. It was as if the movement to 13 North acted as line, point or signpost that set various historical moments apart from one another and against which others would be or were compared. Frequently, individuals traced changes from earlier times as students thirty or so years previously, to more recent moments such as the manner in which change came about currently. For the most part these references to change appeared sporadically. A participant might retrace a journey to illustrate a point, often commencing with their first experiences as a nursing student. This natural reflection back to an earlier period seemed to help situate the story, often imparting the moral disposition or intention being carried within the story, an intention that would be threaded through the narrative right to the end. Often these stories, while conveying a moral theme, revealed the political content of struggle surrounding the valuing of nursing’s contributions. For example some stories about change reflected the lack of meaningful consultation with the staff vis-à-vis their environment, the equipment they used or the protocols they enacted. Others had to do with control of participants’ practice and the many ways in which power was both exerted by the bureaucracy and
resisted by the staff; still others began to lay bear the impact that working in such an environment has had on individual and collective subjectivities and the way their contributions to caring for patients has been substantively affected.

I felt it was important to try and tease out with the participants what was perplexing about the changes they experienced. Thus, in one of the last four sessions we had together, several members of the group commented upon how they too had changed (Appendix 3, Mary, section 4) since moving from 13 West (the smaller physical location) to 13 North. For Annette it had been a question of carrying the 'scars' and 'feeling differently now about' her work than she had in the past (R:2, p. 3). This sentiment was echoed by Hennie, who affirmed Annette's comments; however Hennie added that the staff had changed, becoming a larger group, and with it there had been a coinciding loss of intimacy (R:2, p. 3).

**Relocating the ward**

The directive to relocate the gynaecological unit from the smaller site of 13 West to the much larger area of 13 North was a decision made by the hospital administration. The staff were told that the move was essential to create an area specifically to accommodate an ever-increasing demand for beds required by patients needing or receiving oncological treatment. Until this decision was made, clients requiring either palliation or chemotherapy were admitted to other medical wards; the hospital had no ward dedicated to the medical specialty. Even though there had been rumours circulating about the establishment of an oncology unit for some time, they were informed suddenly and the ward was moved within a week. During the course of this study there were further rumours surrounding the ward's location. A possible shift back to the original site was being touted, given the increasing need for 'oncology beds'. Prior to the move to 13 North, there was a notable absence of any consultation with any of the ward staff, a situation that left them all feeling ill prepared and one that has had far reaching consequences.
It was evident that there were feelings of loss surrounding the move from the smaller location (a twenty-four bed ward) to 13 North and the impact this had in the sudden need to recruit nurses to accommodate patient care requirements in the larger space. I wondered whether the experience of loss had more to do with the change of environment or the breaking of existing bonds amongst staff or whether it was a combination of both.

Reflecting on the various hospital permutations Annette felt that many had been imposed upon them (R:2, p.3) and the group 'had just sort of slowly adjusted' to these and subsequent changes, staff 'handl[ing] the stress differently' (Vonnie, R:2, p. 3). Lamenting the results of many of the recent innovations Annette said 'people who hold the purse strings have no idea; we face the relatives; we do the best job we can to help people get better' (I:1, p. 4).

For some, as for Annette, changes had brought about an alteration in how they felt about their worlds - these too were different now from the way they had been in the past, in part due to delegated organisational responsibilities, particularly in terms of the managerial dimensions of their work (R:2, p. 3). For the participants it was really a matter of day-to-day survival, Annette commented (R:2, p. 3). In comparison with the past, nursing practice had become a different ball game designed for younger practitioners (A:2, p. 8; Journal entry, early May 1997). Not only were there changes in ward practices associated with the relocation of the ward, such as those associated with the larger spaces, extended boundaries and more patients, but also there were more insidious effects. On the subject of loss of intimacy, Hennie also spoke about a different sense of the environment, one created and sustained by being with one another. It seemed as if there were new personal proximities ensuing from the design through spaces and boundaries. Was this part and parcel of the reconstruction of self and self-in-relation, the fluidity of images of the self corresponding to the corporeal agendas of others (Grosz 1994a, p. 181) which together have acted to disrupt the existing symbolic (moral) order(s) with the addition of staff (Weiss 1999, p. 86)? Yet as Hennie talked through her thoughts she began to recognise that it was not the
physical environment so much, but rather new demands that had interrupted the intimacy that staff had enjoyed with one another in the past (R:2, p. 4).

Mentioned time and time again were concerns about the budget which Annette now managed (R2: pp. 3 and 6; I:2, pp. 9-12). It was something she was given, just like many other strategies they had been told to implement. As Annette went on to explain, changes were easier to deal with if they had been initiated by those on the ward rather imposed by others within the bureaucratic hierarchy. The loss of what was, was palpable! It seemed as if the group had very little control over the ebb and flow of the larger political climate of health care of which they were an integral part. Clearly the participants regarded the latest protocols they were now experiencing as those that had implications not only on their capacity to enact care, but also as a politics which saw nursing without a legitimate voice and where the silencing of nursing knowledge was being sustained through the shifting sands of organisational language as well as particular practices which together served to mask ideological content (Annette, I:2, pp. 12-15; R:2, pp. 5-7).

**Emergences**

By the time I had begun the project the staffing profile had enlarged to accommodate the demands of the new locale. Many nurses practised on a part-time basis to balance family life and institutional work. In other instances women had taken the option of leaving temporarily while they had children, returning on a casual basis to fill in if someone was taking leave. To some extent this pattern was no different from what had occurred in the past. What was different however were the numbers of women employed which necessitated a re-vision of existing relationships. Thus, over the years, the team of the all women staff began to reflect a mixture of ages, experiential understandings as well as competency.

While part of the rhetoric surrounding the move to 13 North was justified by administrators in terms of the need for an oncological ward there were also some
corresponding debates about the increasing requirement for more gynaecological beds as well. The rhetoric could almost have served to appease concerns about the move to the new location. However, it soon became apparent that the ward's emphasis on caring for women was also undergoing adjustment. Even though 13 North continued to admit more women for gynaecological surgery, over time the numbers of pre- and post-operative women patients having general surgery increased also. In addition, the move from a single gendered ward with its focus on women began to be revised (somewhat by stealth), as male patients were now being admitted to the ward too. Some of these male patients had also had general surgery. In other instances men were admitted via intensive care or theatre usually because no beds were available in the wards associated with the patient's medical diagnosis.

Though it was never referred to openly, there remained a hidden loss of focus for nurses on the ward who had a long and sustaining interest in and commitment to women's health. It was noticeable from time to time in the participants' talk, particularly in reference to areas surrounding masculinity and male sexuality (Journal entry, mid-September 1997). No legitimacy seemed to be given to the group's practice understandings, their individual and collective knowledges about women and their bodies. It was almost a kind of arrogance on the part of the institutional management to assume that it did not matter where a patient was admitted nor with whom they were co-inhabiting during their period of hospitalisation. What made matters worse, mixed gender rooms were being promoted by administration. We were informed of this strategy by an administrative memo, a protocol that became enacted through the hospital's admitting office and accident and emergency department in the last four months of the project. Staff were horrified and enraged by this edict. On behalf of the staff, the Charge Nurse raised questions with administration about patients' privacy, questions which I understand were ignored altogether (Journal entry, late July 1997). Perhaps the administrators, acting in self interest, thought it more appropriate to focus on hospital through-put and subjugate concerns for privacy. Indeed it was not surprising that the concerns raised were regarded with disdain; after all the Charge
Nurse was speaking out of (her female) place (Waring 1996, p. 19)! Moreover, in asking women to adopt the ethos of patriarchy, yet remain committed to what they believe, is tantamount to asking them to be, as Janeway (1971, p. 87) suggests, visibly split - flexible rather than emphatic about decisions; accepting the self as inferior and with less ambition in comparison with their male counterparts; or adaptable to any situation confronting them. I got the impression that nurses anywhere should be able to care for any client, regardless of gender, without considering what a male or female patient might think about being situated in a mixed gendered room. I also speculated that management assumed that a patient on any ward would receive an acceptable (minimum) standard (sameness) of care irrespective of their condition. It was almost as if the experience of illness had been trivialised by those in control. Knowledges surrounding gender, specifically women's bodies, had become subjugated to ideologies of care that promoted women's disembodied selves as a universal object only to have inscribed upon them patriarchy's machinations of techno-medicine.

In particular, these new imperatives coming to bear on practice caused considerable angst for the staff. I noted from time to time the frustration of the nurse in charge of a shift as she attempted to get male patients transferred to appropriate wards to enable 13 North to admit women. This was just one of the ways the group resisted the mixing of genders in shared rooms. Another was to move patients from one spot to somewhere else in the ward, especially on (or before) the designated operating days, creating the number of beds required for incoming women post-operatively.

Throughout 1997, the hospital appeared keen to keep the bed occupancy levels as high as possible. It was not uncommon to have clients waiting in the corridors or in the day room for their bed to be ready for them. In addition the rapid turnover stemming from funding policies (casemix and DRGs [Crellin 1999, p. 16; Cordery 1995, pp. 370-371; Cornell and Ferguson 1995], which the hospital had agreed to use as funding predictors) encouraged the medical staff to discharge public patients earlier than they
might have done otherwise (Journal entry, mid-March 1997). In spite of the insistence of the nurses' union (The Australian Nurse's Federation) on discharge planning, frequently patients were encouraged to, or told they could go home without sufficient opportunities to access support from community based resources once discharged (Journal entry, first week in August 1997). During the early period of the research political pressure was being brought to bear by the Australian Nurse's Federation (ANF) on all hospitals in the State in an attempt to address patient–staff ratios, given the increasing acuity of patients and the obvious lack of discharge planning. Moreover there were growing numbers of patients being readmitted with difficulties associated with an early condition although their second admission saw their diagnostic category change (Journal, early August 1997). Yes, it was a revolving door for many people.

Issues surrounding economic rationalism within the health care field continued to escalate during the course of the project, culminating in the second half of 1997 with major industrial activities. Industrial bans were introduced as a starting point, shortly followed by closure of theatres except for emergency surgery, and culminating in strikes by various groups of hospital employees demanding wage increases and more appropriate staffing levels. Tensions were running very high and the feelings of many 13 North staff were no exception. However, instead of focussing on wage claims the participants' concerns continued to centre around issues to do with patient care. Bullying by medical staff over admitting patients plagued the senior staff members on the ward. The bans and strikes paled against the demands created by nurses' medical colleagues who failed to appreciate the untenable position in which nurses found themselves in trying to support one another yet ensure patients were receiving care (Journal entry, mid-August 1997). Cross words were not uncommon, nor were the phone calls requesting that a patient be admitted 'or else the patient would ...' (Journal entry, mid-August 1997).

Annette: You know what he just said to me?
Penny: I've got no idea!
Annette: What a cheek! - he just said it was up to me whether the patient was operated on. How dare he say that, it's
blackmail. He knows we have implemented bans restricting admissions to emergency surgery only, and now he is saying it's my fault! It's my fault if the patient can't have the surgery! What am I to do - that's absolutely ridiculous - it's not my fault! He's blaming me!

(Journal entry, mid-August 1997)

**Emergences: Authorities**

Despite the myriad changes coming to bear on the staff, the group themselves worked extensively to cope with what confronted them. Annette, for instance, talked from time to time about what was happening. Perhaps the most extensive conversation we had about change and her involvement in it was what I recorded in note form as part of the second interview I had with her during September 1997 (I:2). For the most part it was 'the staff who did the job of caring for patients', Annette (I:2, p. 6) affirmed, seeing her role as one that supported the group in their enactment of care, striving always to improve practice (I:2, p. 6). She noted that unless practice in the ward changed the group would be left behind. Alone Annette could do little to alter the course of events, yet with collaborative effort the staff could achieve things, together making a difference (Annette, I:2, pp. 5-6). It was this view that Annette thought others in the organisation did not understand nor appreciate. She reflected on the staff's endeavours proudly, despite the fact that she saw herself as struggling. Inside herself, she said, she felt devastated with what was happening, yet believed it was necessary to try and plan positively for the future and where possible pool ideas (Annette, I:2, p. 10). It took a while for her to realise this, she said, but when the 'penny dropped' it helped. Annette mentioned that it was important for her to remain strong - on top of things - which now required her to work differently. She recounted earlier moments in her career when she was extremely vulnerable. One of these times was not long after they moved to 13 North when she found herself unable to continue working as she always had.

It was a time when Annette had to relinquish much of her patient contact. This was perhaps her biggest regret. Her engagement with patients comprised the rewarding
dimension of her nursing career, it was what sustained her on a day-to-day basis. In 13 West Annette had always been knowledgable about all the patients, often working with the staff and taking a patient load. Now, however, given the size of the ward and the rapid through-put, remaining cognisant of all patients had become an impossibility.

Not long after they moved to 13 North Annette found she was unable to retain all the information. Initially Annette saw this as 'failing', she 'had never failed before'. 'Staff', she said, saw her 'in a weakened state'. She struggled, 'trying to hide it', but then something happened. The staff realised (perhaps for the first time) how vulnerable she was and they responded to support her - they 'stood up and got going'

Annette said. Perhaps this too was another turning point in Annette's career, a moment in which she recognised her own vulnerability; but a moment in which the staff responded to her - holding her close and enabling her to have the space to find other ways in which she could be the person she is in the enactment of her values as a nurse. This privilege, I think, is given to those who share commitments in common; where one regards another with affection; and where there is recognition and acceptance of one another's identity(ies). Located within a profound level of moral engagement, it is a way of being that emerges out of a sense of care and mutually reciprocated support for the enduring good of the other (Bowden 1997, p. 66). Now, rather than taking direct responsibility for patient care, as she had done in the past, Annette stands back a little, seeing herself extending her vision of care to the staff.

Annette believes that because the staff care for clients, care also needs to be extended to the team as well (Annette, I:2, p. 14). I wondered whether it was this vision that enabled the team to care for patients in the way they did. Caring for and about the staff was now what Annette understood to be her role within the ward. She had gained this particular insight during the depths of despair. Now, having transformed her own understandings of herself in practice, she was able to continue to enact her values albeit somewhat differently. I began to think about whether the 'failing' experience was about loss also - Annette finally emerging from it to re-vision things differently. I wondered what had prompted Annette to construct an alternative way of acting/being in the world that enabled her to remain consistent with her ontological understandings of
caring. To do otherwise may have resulted in her self-betrayal, living what Waring (1996, p. 35) describes as a tormented existence in the being of some one who she was not. Nevertheless coming to terms with who she was and what her contribution might be was an extremely painful process, something Annette openly acknowledged to me had resulted in her carrying the scars!

It is the intertwining of these complex moral phenomena that underpin acts of caring in the ward, the enactment of care that takes as its starting point one's everyday relations in the environment. It is a moral disposition, one located in various endeavours in working towards a sense of moral goodness; it is shared mutually in trying to support one another and, in turn, it is reciprocated as well. Through the sharing of one another's worlds, and in the grappling with each other's understandings and values, over time the bonds between participants had developed, enabling the emergence of trust, openness and love. It is these ethical virtues that Bowden (1997, p. 68) claims stand as some of the hallmarks of friendship, virtues embedded in Aristotle's (Nicomachean Ethics, 1170b, pp. 10-13 in Bowden 1997, p. 68) notion of *philia*, a form of mutual regard or affirmation. I wondered now and again about these relations, about the impact of power and whether the hierarchy within the ward, while initially evident, became less visible with my increasing knowledge about the participants and my locatedness within the context of group relations. Had I too become encultured into the immediate environment, my perspective moving inconspicuously from that of an outsider to that of an insider? How and in what ways had time served to fade awareness of one another's power to permit seeing things anew? Had these relations of power simply faded against those I was experiencing in my other life - the academic world - for clearly I felt the latter to be overwhelming. Did participants appreciate me as a person with my own identity rather than seeing me aligned with particular individuals and interests? Were my colleagues in the University seeing me in the same light as they always had or was there a difference here as well? My footing seemed to be tenuous, my sight blurred - where was I? Was I standing somewhere particular, or in different worlds at once? Was my location so important to my identity?
Had the bonds between myself and my participant colleagues developed to a point where they too were unrecognisable from those at the beginning? Perhaps, while understandings of one another may have changed over the course of the project, various dimensions of language and certain practices remained entrenched. They formed what one might well describe as taken-for-granted understandings in the everyday world of nursing. Looking back now on my first impressions I could see with the clarity of the outsider the ward hierarchy and understood implicitly how it worked - or so I thought. What I saw, I think, was the symbolic: artefacts of a bygone era, as my consciousness was flooded with assumptions drawn from my heritage (Gergen, 1991). A plethora of myths too found their way into my imagination; icons more glorious than the real, pretentious representations in a corporeal world that knows no limit to power in a material reality.

Despite the imposed changes there were aspects of some of the hospital directives that were accompanied by a degree of choice. For example, the corporate style uniforms of navy slacks and white blouses for registered nurses were introduced in the late 1980s. All the nursing staff had the choice of continuing to wear white dresses or adopting the new look. Some nurses choose to remain with white. I initially interpreted this preference as an assertion of authority, given that those opting for white were amongst the senior staff members on the ward. Later on I saw that staff in other wards had selected white as well in preference to the corporate appearance, regardless of their hierarchical position. Nevertheless I suspect that, to some extent wearing white retained a sense of symbolic authority in keeping with past icons. Yet, I contemplated the question of choice and whether indeed choice was really about conformity, and whether the adoption of the newer style presupposed a sense of liberation while at the same time continuing to exploit women's bodies as material objects (Morgan 1991, pp. 333-336). The colonising effects of this exploitation seemed to be part of the coercive tactics designed to at best mimic the perfections of patriarchy, and at worst endorse the misogynist attitudes and values of the organisation. The rhetoric about nurses being
able to make choices certainly raised questions about their 'legitimate' authority, especially in the context of their bodies. To what extent was this disposition far more embedded in everyday life than one might expect? This interesting tension of authority was not only visible in appearance but was embodied in many other ward practices, including everyday language, as well.

**Emergences: Languages and practices?**

One afternoon I asked Lyn and Jenny about why it was some staff, usually those visiting the ward (particularly doctors), still referred to the Charge Nurse or the nurse in charge as Sister? They responded by saying that not everyone did, but those who used the term Sister continued to prefer old patterns of acting (Journal entry, early March 1997). I noted on several occasions that some nurses within the hospital hierarchy used 'Sister' consistently, particularly in reference to the Charge Nurse. On one occasion I was told to clarify my role with 'Sister' - a directive to which I was unable to respond. There was no opportunity to reply to this order except in front of a large group, a scenario I felt to be inappropriate. I found myself without a voice and enraged! Several of the participants had observed the encounter. They too were embarrassed! We talked the situation over, concluding that what had transpired reflected an attempt to humiliate me in front of those commencing at the hospital. Rather than succumbing to the intent of the remark together we placed it elsewhere, resisting it as part of the ongoing struggle within the cultural milieu. We laughed about what had happened; we laughed about my anger and their embarrassment, laughed ... until we recognised with sadness the oppressiveness of the organisation and how we were engaging with it (T:17, p. 4; Journal entry, mid-March 1997).

I remained curious about the notion of 'Sister'. Vivien explained that with the advent of university nursing students the 'senior' ward staff had initially tried to hang on to the term. They would refer to one another and to the Charge Nurse as Sister 'so-and-so' but it was to little or no avail. Observing the students using first names, many staff followed suit. For some time first names were discouraged, particularly by others (in powerful positions) in the ward as a mark of deference and respect, but this like many
other things diminished as traditional territorial boundaries became more fluid (Journal entry, early March 1997). The use of first names, therefore, had become commonplace, with the odd exception of medical colleagues who retained the expression of 'Sister', illuminating perhaps, their requirement for her complicity. Maybe by being compliant it was possible to have some sort of meaningful connection in unequal relations of power (Jack 1991, p. 44).

Another expression used by several of the 'younger' members of staff in reference to Annette was 'the boss'. When I enquired about the language they were using I was told without hesitation that 'the boss' was used as a mark of respect (R:2, p. 12). When confronted with this comment my immediate reaction was 'are you serious?'. Looking back, however, I recognise that those referring to Annette as 'the boss' regarded her with a deep sense of respect, acknowledging her as the crone. Perhaps Annette’s ways of acting had become accepted as different from what was regarded as ‘the norm’ and in this difference there was also a sense of impunity, given the support of her colleagues (Janeway 1971, p. 123). It was almost as if they were reclaiming something they had lost, perhaps something that had been marginalised. Was 'the boss' like the terms 'dyke' or 'black', being held up with pride? Was it contesting the public spaces of the hospital, making others feel uncomfortable about their own unequal relations of power (Leck 1994, p. 86; Ferguson 1987, p. 8.)?

Words such as 'senior' or 'more experienced', while on the surface appearing to reflect a hierarchy in the ward, were terms participants also used to describe actors who were prepared to lend support to nurses less familiar with ward practices. I contemplated these terms in the context of staff relations. Not all those considered 'senior' took on the in-charge role, neither did those who were regarded to be 'experienced' members of staff. Those nurses referred to now as Clinical Nurse Specialists (CNS) did act as the person in charge of a shift, but then again this was not always the case. The title of Clinical Nurse Specialist, I gathered, had replaced titles such as Deputy or Associate Charge Nurse(s). Several women occupying these posts
in the ward, plus one or two others, were often acting in charge of a shift. Vivien, Jenny, Lyn, and Mary, for example, were amongst those who undertook this role. Even though the titles had changed some of the traditional arrangements surrounding nominated or designated authority on the surface continued to exist. In spite of the presumed authorial voice of the person in charge there were now new patterns of working that accompanied the relocation to 13 North. These patterns saw an appreciation of the legitimate understandings of practitioners enacted in the everyday activities, the person in charge working in a more facilitatory capacity than had occurred in the past.

Even though the notions of 'senior' and 'experienced' retained administrative currency and meaning in hierarchal circles, the terms were understood differently in the ward. What began to emerge was that those deemed as 'experienced' or 'senior' were those staff members acknowledged for their particular contributions to ward life. Whether these contributions were educational in nature, for example conducting the pre-operative education or supporting first-year graduates; research-oriented, for instance conducting an empirical study on the incidence of women with urinary tract infections post-hysterectomy; regularly organising social activities for the ward staff; or allied with the individual's knowledges and interests associated with practice, they were all deemed to be critical to improvement in care. I was to learn later that these activities corresponded with the woman's acknowledged gifts. I remained curious about what constituted the hierarchical arrangements in the ward.

Were there other interpretations that I was not privy to, ones that remained silently embedded, perhaps entrenched in the social worlds of the actors and their interdependencies in their relations more generally (Flax 1990, p. 226)? Was I trying to find explanations for particularities that were beyond articulation or reason, and in doing so falling prey to trying to justify why some things were the way they were? Alternatively, without justification, were my accounts dubious in relation to rigour? Perhaps these questions highlight the transitory nature of understandings emerging
from the differing perspectives of those involved. Each person, while offering
insights into the various ward practices, the language(s) used and discourses surfaced
in conversations, inhabits the intercorporeal worlds of the participants together,
contributing to a partiality of meaning richly laden with artefacts, alternative
understandings and multiple interpretations. Nevertheless, in the context of the
participants' worlds, the move to 13 North was monumental for many of the staff.
The relocation of the ward remains as a huge moment of consequence in the lives of
nurses on the ward.

All of these changes, in one way or another, had a significant impact during the course
of this study. The participants engaged with these changes in their own ways yet
continued to work with patients in a manner that supports their understandings within
nursing. Far from being rooted in the past, the participants seem to have been able to
manoeuvre themselves into thinking about how and in what ways they might best
work in an increasingly complex landscape. They sought ways of acting that disrupts
the regulated public space, making visible some of the private dimensions of the
intersections of nurses' work with patients. Moreover, through collectively resisting
many of the institutional directives, the group fostered and sustained their relations of
caring in the context of one another.
Chapter 7
Genealogies - in Control

Corporatising the body of both the patient and the nurse acts to facilitate the strategies by which the organisation maintains control (Parker 1999, p. 18) over what is commonly referred to as health care. There are insidious ways in which power is exerted that seep through the cultural terrain of the environment. Yet, it is lived out in the everyday world of the participants who, within the larger group, form the ward staff and who, in the context of their social world, both shape, and create their culture(s). On the surface the participants engage in this culture with relative ease insomuch as they work within the 'system'. Also superficially the obvious regulatory practices of the organisation are visible revealing the territorialities that, in a crude sense, define the various dimensions of the labouring processes in the everyday life of the ward.

Organising care

The organisation of care is accomplished through various activities, practices and social relationships forming the fabric of the division of labour. A hierarchy existed in both real and pragmatic terms. I was reasonably aware of this as soon as I walked into the environment, but to the uninitiated it may not have been so obvious. For example I was able to recognise who was in charge by briefly noticing who was at the desk.

Leadership

As the Charge Nurse or Unit Manager, Annette has the overall designated authority for the way in which the ward runs and provides nursing care for patients. Much of her time is spent at the desk in the 'Sister's station' answering the telephone, making calls attending to requests (orders?) by doctors, paramedical or nursing staff. She acts as go-between, liaising with nurses as they articulate the need for a doctor to attend their patient, or getting forms such as writing up further intravenous or drug orders and so
on completed. Annette believes that positioning herself thus enables the ward to run smoothly. She acts as a 'traffic director', contacting doctors and paramedical staff to avoid them being rung on multiple occasions by various nurses, usually for a different set of reasons. The knowledge thus accumulated adds to Annette's control in ward activities. Her engagement with the medical staff is always quick, to the point and very much matter-of-fact. Hospital staff move in and out of the area, doctors come and go; doctors, in particular, invade her office and use available space for writing their reports, reading results and prescribing the next course of medical treatment. She listens, sometimes she indicates to the person concerned that they need to talk to the nurse, or in other circumstances she locates the nurse and recounts the conversation. As medical consultants arrive to see patients they are usually escorted by Annette to the patient's room where the nurse caring for that person can often be located. If the nurse is there Annette may either return to her other tasks or remain to hear what is being said to the patient. It is a decision that appears to depend upon what she feels might happen during the course of the doctor's visit. In any event discussion remains brief, Annette appearing to distance herself from her professional counterparts. As she says, the 'eight to ten period is when everything breaks loose; I get frustrated when everyone wants things ... with all the doctors turning up at once' (I:2, p. 4).

The same pattern is revealed in Annette's interactions with others from outside the ward. To some extent one might assume that this way of relating serves to separate the nurses from the medical staff, the paramedical groups, patients' families and the administrative workers. Her interactions are a set of practices that contain within them the complexity of meanings derived from many years of experience as a woman/nurse. As I have already mentioned, I 'interviewed' Annette on two separate occasions. Both of these interviews were more like discussions as we shared a cup of tea or coffee in a quiet spot in the cafeteria. During the course of the first interview we talked together about leadership generally, and hers and mine in particular. I asked many questions about her experiences, and how and why she adopted the approaches she did. During this time together the importance of history became apparent yet again. Annette
recounted her earlier years as a serious person who learnt by others' example, but at the same time she used the 'negative experiences' as an opportunity to learn. We talked about what it was like in our early careers with 'no formal training' other than what was available in hospital schools of nursing at the time. Our learning of nursing had been very much part and parcel of the positivist paradigm focussing upon biomedical discourses of illness. We laughed about being late for doctors' lectures, falling asleep after nights: commonplace patterns of the period. In spite of this shared heritage, our paths to new understandings had been somewhat different. Yet, what was it that had prompted Annette's reflexivity, or indeed my own? What enabled her to imagine another world of caring? Why was I keen to see an alternative world too, one in which nurses' contributions to caring were valued, acknowledged and deemed legitimate? Why did it matter that one made a difference ... ?

On each shift, a nurse deemed as one of the senior staff 'manages' the desk. This nurse, like Annette, also acts in a liaising capacity with members of the hospital community. It is as if this person is the central cog in a wheel. She is the one who organises the workload, adjusts activities and to whom the staff turn in the event of reportable instances. In this sense the person in charge acts as an authoritative figure (for those who assume there needs to be one) although the staff adopt a rather pragmatic view of this role, seeing it as necessary to ensuring the ward activities run smoothly. However, the position is much more involved than would immediately seem apparent.

Looking around, I saw that the pace was hectic - steps purposeful, often hurried.

**Legitimate knowledges and authority?**

'I never used to think of nursing being a race - but now that's what it has become - literally!' (Jenny, margin commentary T:7, p. 4)
It was 0645 as I wandered into the ward to find Vonnie already in the cloak room. We greeted one another like old friends - 'how are you?'; 'I haven't seen you for ages!'. There was a real warmth in our greeting, genuine delight in seeing each other again after a break of several weeks whilst Vonnie was on holidays. As we began to talk about Vonnie's break Pam arrived, her expression of welcome revealing her joy in seeing Vonnie returning to the ward ... Having put away our gear, Pam, Vonnie and I prepared to 'walk the floor' checking the patients, their intravenous infusions, and looking for things out of the ordinary. Vonnie began to explain the ritual to me when Pam said - 'she knows' and adding to her comment 'we've done it before haven't we Penny!' We all laughed!

'Right, let's go' said Vonnie as we crept forward into the semi-light to check patients' I.V. additives.

'KCl 2 grams? Mics per minute?' asks Vonnie; 'yep' responds Pam.

'Normal Saline eight hour flask due at ten hundred hours' I read to Pam and so we moved on.

'No IVs in there' (a four bed area).

'No! ... No! ... No!' Vonnie indicated, leading us to the next room, and then the next and the next.

'This is pretty good' exclaims Vonnie.

'Yeh, they are all on the other side', Pam points out.

'There is only a few over there though' I suggested, having already overheard the night staff talking to Annette ...

Report started on time ... I wrote and listened. One of the staff was relaying an incident that happened the previous evening, a situation in which two men in room one were arguing over a TV Week magazine. The staff member recounted just how nasty the situation became, with one fellow about eighteen using abusive language and the other male threatening to have the accused male and his family beaten up. The staff member requested that the young man
refrain from using such offensive language in front of everyone and this request only exacerbated [the situation], his anger becoming more abusive and threatening the staff member as well. Another patient in the room became angry and the staff member appealed to his Christian background to stop. Apparently it got very noisy and potentially nasty; the staff member masked her concerns for the patients and herself with laughter.

At morning tea the story about the two quarrelling men continues, and various suggestions surface as to how one might act if the situation were to arise again. The talk then turns to discussion about another patient and the same staff member comments that the patient knows who the 'best' nurse is - Vonnie! Annette smiled. In a joking manner she admonished the staff member for her naughtiness. I am watching this scene with great interest and the intensity of my concentration in taking it in must have sparked Annette to say as an aside to me that the staff member eggs people on. Distracted by this aside I miss the connection to a commentary about the minimal number of sick days ward staff take during the course of a year. Moreover, where possible, the group try and cover for one another to avoid casual staff being sent to the ward. Lyn mentions that Annette has in excess of three thousand sick days which have accumulated over the course of her 'service' to the institution. We all marvel at this feat but Annette points out that very few staff take 'a sickie'. Annette then says to the staff member 'you wouldn't take a day off, would you?'; 'No Boss!' said the staff member; 'That'ed be right, only take a mental health day when I'm not on!'. 'Yes' said the staff member.

These genial exchanges of good humour are enhanced by laughter but I wonder to what extent these comments are designed to surface staff's awareness of their practices and at the same time exhort expectations.
Standards and evidence?

Here in this Australian hospital, as elsewhere, the quest for cost efficiency has pervaded health care organisations to a point where efficiencies have become understood to mean less staff, increased workload, a reduced patient stay in hospital despite increases in patient acuity, restructuring of health care organisations and a concomitant change in roles (T:7, pp. 10-114; T: 8, p. 10; T:17, pp. 2-3 ). The corporatisation of health has encouraged organisations to develop what could be argued as minimum standards of care, which to all intents and purposes are measured using several approaches which objectify a patient’s care by reducing it to the physicality of the problem whilst rendering invisible those less tangible social concerns faced by patients on a day-to-day basis (Varcoe 1998, p. 1; Frank 1997, pp. 131-135). The standards of care outlined, for example, in the hospital mission statement are really about articulating to the community what the hospital hopes to achieve. Moreover these statements are linked to hospital accreditation. Accreditation is considered by the hospital management to be important in establishing a sense of confidence that the hospital measures up to the same level as other health care providers, using technologies of care delivery systems as a basis for comparative analysis (Sullivan and Decker 1997, p.106). Ongoing quality assurance forms an integral part of the process, evidence of care constituting the trajectory for resource allocation and distribution (Kerridge, Lowe and Henry 1998, p. 1153). The accrediting group assess the organisation against given criteria and grade it accordingly. The upgrading or downgrading of the organisation as a whole has funding implications, paving the way for a competitive environment across the health care sector.

The method of funding has undergone various transition periods with the restructuring of health care into regional groupings. Each grouping now tenders for the provision of services. The large public hospitals are no exception, forming the biggest conglomerate group in each region, projecting their vested interests although they
would have the public understand that their position is value-free. Prior to this arrangement of large corporate groupings, funding was based on a successive array of formulas. Now, within the context of fiscal constraint (Considine and Buchanan 1999, p. i; Hicks and Hennessey 1999, p. 27), the emphasis on reform has reflected a political crisis of accumulating debt, requiring the introduction of management technologies in order to further restrict nurses' labour in particular (Varcoe 1998, p. 1-2), without any recognition of their unpaid labour as well (Considine and Buchanan 1999, pp. 4-5).

**Recent approaches to controlling nurses' work**

One of the most recent approaches to controlling nurse's work has been to implement strategies that increase patient throughput, which in turn affects funding. Just as larger corporate enterprises have adopted the rhetoric of economic expansionism by looking to productivity through efficiencies of scale, so too are these same pressures being exerted on the health care sector. Over the last twenty or so years, large hospitals have used different methods to quantify funding depositions, looking to accelerate productivity - which in very real terms has meant a shorter period of hospitalisation for the public patient. Some hospitals like this one have adopted patient index systems; for example, casemix formulas. However this hospital's funding has been attached to a patient's diagnostic related group (DRG). These DRG categories serve to explicate the predicted average patient stay in hospital for each particular medical condition. Funding is thus tied to each category. If a patient stays in hospital for any longer than the number of days specified for that condition, the hospital has to fund the gap between the specified days and the time of discharge. It is therefore in the interests of the organisation to discharge patients as soon as possible to avoid incurring additional costs. Where gaps occur due to protracted hospital stays, the hospital is required to fund the difference while it is able to retain monies in the event that a person is discharged earlier than anticipated and sometimes gets readmitted under a different diagnostic category. Often the patient's readmission is related to a complication related to early discharge, which is referred to as part of the revolving door syndrome (Journal
entry, mid-August 1997). Early discharges and rapid patient turnover has meant that the staff experience less patient contact and in what time there is they find difficulty in enacting the care they believe should be appropriate in terms of their standards (T:6, p. 8).

Time, or the lack of it, constituted a major dilemma for the staff. The busyness of the ward over the last months of the research had a particular impact on the ways in which care was organised. Despite the credo of ‘providing the care the patient wants’ (T:6, pp. 7-8) there remained considerable contestation about the meanings that this had amongst the staff. While Annette acknowledged that the ward was busy she took the line, as did others, that attending to a patient’s physical needs such as washing was assumed by the nurse to be important to the patient when this was not necessarily the case at all. For some nurses, letting go of tasks such as washing the patient was seen to be tantamount to cutting corners as Lyn suggested (T:8, p. 8), corners that may not even exist. Thus for Lyn letting go of those rituals without consultation with the patient may result in a drop in standards. There remained an ongoing tension between feeling the need to undertake traditional tasks in care and letting them go. In letting go the tasks and engaging the client in making decisions about the care that they felt they needed there was a shift in focus on what constituted care (T:6, p. 8). Such transformations, while stemming from bureaucratic directives, enabled the staff to rethink what caring for the ill person might be about and then try to support others towards this endeavour. As the participants suggested, it was as much their role to aspire to high standards as it was to ‘protect those standards as well as supervising and ensuring the patients do get looked after’ (Annette, T:7, p. 10).

Throughout the research mention of busyness and the lack of time to enact the care the staff believed to be important was an ongoing struggle and one which often saw nurse’s voices marginalised if not silenced. A poignant example of this silencing arose when the anaesthetists formed a working party to consider ways in which they could increase the throughput and reduce the patient stay in hospital. In general the group
felt it represented the medical staff's disregard and lack of respect for their opinions and knowledges. Indeed, they believed that where consultation was required their involvement was really tokenism rather than meaningful engagement.

Cognisant of the demands placed upon them participants worked consistently at trying to appreciate the changes in the hospital. Often these changes were thought about as something that enhanced the interests of patients, for example, in a reduced hospital stay, which in turn prevented the empire building of ancillary departments (Annette, I:1, p. 4). These alterations were something that the staff felt they had to 'go along with' (Annette, R:2, p. 6). Yet this was always with limitations expressed in terms of 'just surviving from day to day ... [with] imposed changes from above' (Annette, R:2, p. 3) necessitating new and different demands.

Recent innovations reflected various political agendas within the hospital organisation which in turn generated various dilemmas located within the ideological tenets underpinning the organisational demands for evidence in the efficient running of the hospital. The evidence that counted, or what was considered to be legitimate by organisational elites (Colyer and Kamath 1999, p. 191), related to patterns of increased productivity (Curley 1998, p. 70). It appeared to be augmented by the relentless quest for the corporatisation of health and the coinciding objectification of patient care commodifying the body. These ideologies stand at odds with the ethical position of many health care workers (nurses particularly) who locate themselves differently as part of an ongoing struggle to act as client advocates in care provision. Considine and Buchanan (1999, p. 2) reflect upon the current crisis as one in which the present culture has drawn upon nurses 'goodwill ... filling the gaps left by funding cuts' a resource which is almost exhausted.

Nevertheless, the pressures of these struggles have been on-going throughout the life of this project. Changes separating the administrative structures of the hospital into four divisions has had an impact on the ward and Annette in particular. Whereas in the past she was able to share her concerns with a supervisory nurse, the supervisor was
now joint head of the surgical division and her visits to the ward had reduced considerably. Moreover, their meetings had lost their patient focus and where Annette was once able to air her 'problems' she now felt unable to do so given the supervisor's infrequent visits (I:2, p. 3). Annette noted with regret that her role too had undergone revision and now incorporated running the ward budget. Annette 'never wanted the economic side of things ... I learnt bedside care and it's not the time to take people away from the bedside'. She reflected with sadness on the decline in fiscal resources with 'less and less money every year' (I:1, p. 2).

Perhaps the biggest bone of contention was that, in trying to make the budget work, she had no control over many things that happened on the ward such as 'the medical staff taking the dressing down [which] increases the costs of consumables; [or] people using intrasite and colloid agents without knowing how to use them' (I:1, p. 2). She acknowledged that the power remained in the hands of administration, yet in the absence of power, Charge Nurses were still held responsible for the budget they were given, something Annette viewed as extremely questionable given the interdependency of medical, allied health and nursing activities (I:1, p. 2; T:7, p. 11). Despite this, the Charge Nurse felt that if anyone could 'make the budgets work nurses can and will!' (I:1, p. 3). She maintained a great sense of confidence in her colleagues to help keep within the budget. For example she expected that through peer pressure a low sick leave record would be maintained and this in turn would assist keeping the budget within its forecasted range. When people are 'off', Annette noted, 'nobody helps us; we don't expect it ... we try and avoid replacement staff', a situation she anticipated would continue where ever possible (I:1, p. 2). It seemed as if the staff understood the importance of supporting one another by carrying the load when their colleagues were unable to be there and these expectations were also reciprocated (T:15, p. 1). Because staffing is the main ward expenditure measures were taken to ensure that the staffing mix was managed through careful rostering (T:7, p.12) albeit in the context of certain days being busier than others, given the gynaecological surgeons' lists.
Bodies and Rostering

Rostering is just one of the administrative activities that has been handed on from the Charge Nurse to the senior members of staff. In this instance Vivien takes care of the roster just like a number of other activities the senior group have volunteered to undertake. Some wards in the hospital have participated in self rostering, a practice designed to re-shape the power relations in the ward. In this ward however self rostering has been resisted by the staff; perhaps the staff believe that their requests (T:5, p. 2) have always been fairly accommodated and they trust that Vivien will continue to act in an equitable manner. Another interpretation might also be found in suggesting that the staff do not want to take on responsibility for ensuring that the criteria for 'sound' rostering would be followed, and that self interest and individualism would dominate, doing little to enhance the feelings of goodwill amongst the group. If self rostering were introduced it would serve to colonise individuals, as has been the case over some Christmas rostering in the past (T:5, p. 2). Thus, Vivien constructs the roster, working out the rotating shifts and creating the various ward teams. These teams have arisen out of personal choice and/or requests for particular shifts or days, and where possible takes into account the 'other' lives of staff members. Annette says that Vivien has 'a good handle on it and can stop and think who is on what shifts' (I:1, p. 2; T:5, pp. 1-3).

One of the important features of the roster is that there is an appropriate balance of the staff's experiential understandings on any one shift. If staff members want to change their roster they understand that this is possible providing that they swap with someone with similar experience in order to ensure the balance of staff is retained.

... again the discussion focuses on the ease with which one can change their roster. Everyone knows who one can approach if they want to change a shift; they also know who not to approach because they won't swap. So you always try and 'approach someone you know will change unless you are desperate, then you approach them anyway - and they say no! You just accept that, that's all! ... There's no negotiation, no
argument, that's it ...' There seemed as if there was just a hint of undercurrent with regards to the co-operative spirit of one or two staff members ...

(Journal entry, early April 1997)

During the course of the research, meetings were held to discuss how the staff might work with further budget cuts. The first of these meetings occurred during August 1997.

'You're coming to our meeting aren't you Penny?' I was asked by one of the staff. It seemed assumed that I would be involved but nevertheless I was asked to come in for the meeting given that it was held on a day I would normally be at the University. Annette felt that seeing it was the first meeting to discuss ward practices in context with the budget she thought I might want to contribute to the discussions. She mentioned in passing that it had taken her a long time to realise 'that more heads were better than one'! I wondered if she thought of me as a staff member now or if it was more to do with wanting my support ...

(Journal entry, mid-July 1997)

It was the first time she had taken this tack and it was based on the success of our meetings together considering her role as the Charge Nurse was to support those giving the bedside care, 'staff have enough to cope with without worrying about the budget!'. It was if Annette wanted to 'protect' them from the difficulties ahead.

... During the course of this meeting Annette relayed the latest statistical information gleaned from the most recent meetings she had attended with the administrative division of the hospital who kept track of the data and made decisions on budgets. In May, for example, the established staff numbers were an Effective Full Time (EFT) complement of 38.04 nurses whereas the reality reflected 37.65 EFT constituting some small amount of savings. Currently the average patient
stay was 3.2 days with a bed occupancy of 89.8%. Five (5) nursing hours were available for each patient per day. Annette commented that she understood from administration that based on these figures the bed occupancy levels would need to rise or that they would need to reduce staff by three (3) or four (4) EFT. These sobering thoughts were greeted with silence. Questions were then posed - how to better use the staff to ensure continuity of care? How or in what ways might the roster be re-thought to achieve better coverage? There was also a need to evaluate the way the 'X' shift was working. The 'X' shift (1000-1830 hours), a shift only worked on Tuesdays, had been introduced several weeks earlier to try to accommodate the large number of patients going to and returning from theatre on Tuesdays. Tuesday was in the main the major operating day for the specialty. At the meeting I asked about this change in response to the ward's staffing needs and was told that administration was unaware that the ward had decided to introduce the 'X' shift. After all, it was in the trial phase only and the administration did not need to know about it just yet! I smiled to myself - another dimension to the resistance? Those staff members volunteering to work these hours had thoroughly enjoyed doing so. As Lyn pointed out, she was able to get other things done at home. Another staff member said she could sleep in and still another was able to go out for dinner in the evening.

Other initiatives with regard to staying within the allocated budget were posed by various staff members. In each instance the suggestions were noted. Those that preferred to work four days rather than five might be willing to reduce their existing hours; making better use of the personal care attendants (PCAs) and involving them more in ward activities; and, avoiding getting stuck in the old ways and thinking about how things might be done differently. As the meeting came to an end Annette mentioned that 'our focus can and must change; we have to look at it [care] in a different way'. It was a plea
from the heart to move into the future but not to lose sight of
the patient and continuity in care.

(Journal entry, end July 1997)

The struggle over the cultural terrain within the hospital was marked. Dominant interests that sought to commodify care using strategies such as DRGs seemed to be endorsing the politics of capital accumulation and debt servicing, neglecting the very real human interests which dominant ideologies claim to support. Moreover the trajectory reflects a more global view in which the emphasis is placed upon consumerism, commodification and homogeneity in a streamlined service (Parker 1999, p. 18) to support economically sustainable if not profit-making ends. Thus the language used, plus the political rhetoric of efficient and effective care of those who 'rule' from a distance, mask the values articulated by those who directly engage in care at the patient's side. This struggle appears in a variety of forms and for the ward group in particular, many of the organisational strategies can be understood as technologies of surveillance designed to increase patient throughput. Strategies were often referred to as bureaucratic dictates, 'threats' and 'challenges' to be 'overcome' (T:7, p. 12).

Tracking and tracing bodies

For nursing staff on the ward, this has meant major changes. From the time of admission each patient has a patient care plan, a legal form documenting nursing contributions to the patient's care. Patient care plans can be audited for quality assurance purposes providing details in an analysis of nursing care costs in line with DRGs. The hospital administration has seen to it that particular nursing care plans relate to the specific medical speciality and thus the DRG. If, for example, a client is admitted to the hospital for bowel surgery the care plan used by nursing staff will normally echo the surgical procedure outlining in general terms the pre- and post-operative care. In addition, patient acuity or complexity scales depicting the technical aspects of care have been used extensively serving to provide another element in triangulating the cost of nursing 'input'. The strategy used by most hospitals has been the PACE system, a crude objective measure that has its underpinnings in time and
motion studies and is thus reflective of tasks in care. Complexity scales highlight, for example, the extent to which a patient can perform their activities of daily living; whether they require more technical care because they are receiving fluid infusions whether administered via pumps or gravity flow; or if they have multiple or single drain tubes with or without suction; wounds necessitating periodic dressings or the administration of pharmacological agents at regular intervals. Each activity is given a numerical value, the more dependent a person and the more technical demands required in the care of the patient, the larger the point score. Moreover, there is the added notation for ongoing assessment of the client's physical parameters, routine observations or any other specific clinical judgements needing to be recorded at particular times. Specific information such as this is available on both individual care plans and also exists as a precised version in a codified way on a whiteboard displayed in the Sisters' (nurses') station.

To all who enter through the main doors of the ward and walk down the corridor to the nurses' station to enquire about a patient, the board is a visual reminder of who is where and what they require, albeit only to those who understand the mystified information on the board. Thus a patient's nursing care requirements are codified numerically—the higher the number the more hours of nursing care they need.

Until recently, the practice has been that a nurse supervisor would come to the ward and collect the updated data which would then be collated by other administrative staff to establish throughput. The data is also used to gain details from which one might predict adequate staffing levels for the forthcoming shifts. If additional staff were needed then a nurse could be sent from an area in the hospital deemed to be relatively quiet. Alternatively a bank nurse (casual employee) might be called in to increase the staff numbers. The PACE board thus doubles as a directory as well as a site on which data is displayed. The information contained on the board reveals to the public, the patient acuity levels on the ward.
The extent to which this approach to costing has become less fashionable remains in question. Nevertheless, some wards continue to use the PACE board approach perhaps as something that had become a ritualised institutional practice. Other wards used the board for different purposes. In many respects the board stands as an artefact containing discursive practices of care, names which are then reproduced and become lived out as the entities (Parker 1997, p. 21; Butler 1993, p. 13) the particular activities in practice.

During my period in 13 North the board was not used for detailing acuity levels. I remained intrigued about this situation and assumed that the staff were engaging in resisting the quantification of care using such crude measures. Maybe they perceived that it failed to do justice to the care they believed they enacted. Alternatively it might have had something to do with patient confidentiality, given that the board was so exposed to public scrutiny. I was not privy to an explanation early on, but it was later that I came to appreciate the seriousness placed upon confidentiality as well as the resistance quantifying care generated. Clearly, the whiteboard with all its PACE delineation worked as a directory, in metaphorical terms like a chess board, rather than what it was originally designed to do. I noticed it was used as a reference on the many occasions when patients were juggled from one area to another, depending upon the demand for male or female areas, that is, beds. As a reference, the board provided a visible picture of who was where, the name of the consultant under whom each patient was admitted plus the number of days since the patient's admission or operation. In many respects the board was one of the most obvious signs of the medical staff's ownership over patients' bodies; so too were the name cards at the head of the patient's bed.

Even though the patient's condition or reason for admission was not indicated on the board, the name of the consultant placed against the name of the patient was sufficient to attune the staff to what medical treatment the patient was receiving. Moreover, these notations also worked as other cues, prompts or guides that related to the more
generalised and predictable picture of progression following a patient's surgical procedure. In this sense then, the board worked as a symbolic representation of the legitimate work involved in being a 'good' nurse (Street 1992, p. 22). Information of other kinds not appearing on the board were understood by the staff as part of the taken-for-granted understandings in practice.

Sometimes additional data would be written on the board. These remarks ranged from short reminders to the staff and other personnel that certain details were required to enable ongoing care; additional intravenous orders or a new drug sheet were not uncommon citations. However, information surrounding nursing care rarely if ever featured. When it did, it was as if the details were in line with the public's perception or knowledge of what surgery, generally speaking, entailed. An example of this sort of information was fasting pre-operatively. It was almost as if the 'legitimate' knowledge featured on the board whereas the knowledge deemed to be 'other' was invisible.

Clearly, nurses 'carried' knowledge relating to the nursing care of their patients. Forums such as handover (report) served to inform nursing staff not only about the care that a client was receiving, but also reflected the nuances that arise in the contexts of caring acts in being with the patient. Rather than documenting practice using evidence based upon the universalised view of a patient's requirements so often seen in standardised care plans, or in the decision-making trails considered to be crucial to robust evidence-based practice (Hicks and Hennessy 1999, p. 28), knowledges concerning patient care were conveyed via the oral tradition. Here too, acts of resistance (Street, 1992 p. 19) began to surface as staff recounted dimensions of caring that would not feature on any care plan.

Handover was a rather complicated process inasmuch as the person on in charge for the morning shift would receive handover from the nurse on in charge over night. This handover to the person rostered on as the nurse in charge of the day shift would
occur well before seven, the usual commencement time for the morning staff. The general handover to the morning staff by the staff member on in charge for that day would then occur at seven. Afternoons worked in a similar fashion to what had taken place in the morning.

Patient care was discussed, reflected upon, alternatives suggested or options considered at handover. In other cases issues might be raised and the group would spend time talking through the various ideas surfaced. This seemed to be one of the major opportunities for sharing understandings contributing to knowledge development (Benner 1984, p. 10). Sometimes memos, letters, reports from meetings or general information might be shared with the group. The importance of this period to the staff was apparent with the threat of loosing the staff changeover period. Loss of these periods was considered by the group to be a major threat affecting not only the continuity of patient care but also, as Annette commented, the support which held the group itself together (T:7, p. 12); a time in which they could 'be' with one another. A call by administration to abolish this 'luxury' was ever present (T:7, p. 11).

**Distributing bodies**

Without doubt the allocation of patients to particular nurses on any shift was, in itself, an art form. It not only involved an aesthetic appreciation of each person as an individual (T:6, p. 10) but also the combination of people on any one shift. Another important aspect was that the group shared a sense of confidence in those with whom one was working (T:11, p. 13). The person on in charge of the shift would make decisions about which nurse would care for which patient(s). Ideally the overall aim in allocating patients to particular nurses was to achieve a fair and equitable work load distribution with patients in close proximity so that the nurse would not have to walk too far from one of her patients to the next. What was deemed fair and equitable by the person in charge was dependent upon several factors such as who was rostered on that shift; the staff member's experience; and their category, for example whether they were an enrolled nurse, a first-year graduate, a casual nurse working on the ward, or one of the regular staff members. The number of patients to which one was allocated plus the
patients' perceived needs for care would be considered against one's category to
discern whether the work load was in fact feasible and fair. On the odd occasion one
or two staff members might not recognise the intricacies in the arrangements, believing
their load to be unjust, and in other circumstances staff are left thinking they have to be
'superwomen' to manage the day successfully; yet they did so, often to their surprise
(T:6, p. 7).

The criteria for allocating patients included giving each nurse one sicker patient plus
others who were not as ill (T:6, p. 10). Even though these were perhaps the ultimate
goals, other considerations came into play. Often staff thought about their allocated
patients as a challenge, an opportunity to learn more, or to develop skills in working
with priorities (T:6, p. 10). The challenge of this experience occurred in an
environment of support, something that participants such as Vonnie and Pam (T:6, p.
10) felt enabled them to grow and gain confidence in their practice.

Despite these aims, when it came down to the realities of everyday life, decisions were
based upon a number of other things as well. Nurses with more experience were
frequently allocated sicker patients (T:6, p. 10) primarily because, in the main, they
were able to respond to the situation more readily than others with less experience
(T:11, p.12). Put another way, the nurse with expertise is usually able to cope with
the complexity of illness, work out the priorities and be able to spend time with the
patient, in general terms 'provid[e] the care the patient wants' (Annette, T:6, p. 8).
She was able to draw on her vast array of knowledges (Benner 1984; Carper 1978;
Polanyi 1962) understandings and meanings that had arisen in the context of herself
and her various worlds, those of woman/nurse. In addition, nurses with less
experience had a tendency to hang on to the tasks, which meant they were unable to
focus upon the interiority of the patient (Benner 1984, pp. 1-12). What was critical to
caring and the goals of the staff was the more relaxed approach of the experienced
person who would pay attention, listen and be empathetic to the whereabouts of the
patient within their life's journey (T: 15, pp. 3-4).
One of the fundamental points about allocating the staff to the patient was to make sure that the right nurse was assigned to the right patient to ensure a 'good' standard of care (T:6, p. 10). Night staff for instance rarely, if ever, became involved in allocating patients for day staff and vice versa. Where they had done so in the past the staff found that the day or night began and ended in chaos! This was because night staff (or in the context of night staff, the day group) lacked knowledge about those who worked during the day or night (T:6, p. 10).

When I inquired further about how it was that certain individuals had a tendency to care for particular patients, I was informed that decisions revolved around an appreciation of the nurse for the person she was/is and her practice understandings, plus the skills each person brings to their enactment of care (T:6, pp. 10-13). There was a sense of confidence in their colleagues as they engaged in caring for the patients they were allocated. In having these various understandings of one another the participants were able to recognise moments when individuals needed assistance with their patient load. If, for instance, Mel's hair started to stand up (just like mine did on one or two occasions) it was obvious that she was becoming worried. Several staff, such as Vonnie, became quieter or withdrawn where as others got noisier. Some nurses walked faster or adopted a different gait as the pace in the ward escalated to crisis point. Yet, overall the participants felt as if they managed these situations together, Diana noting that nurses had such a large capacity to accommodate difficult times because 'nurses [had] plenty of gears' (T:6, p. 14). In response to having to accelerate the pace of activity, sometimes the noise level would be excessive. This was particularly evident in an emergency situation; for example, a recent incident where one of Pam's patients developed a burst abdomen and Annette found herself 'doing a rant and rave' up and down the corridor (T:6, p. 14). Individuals' responses or special cues were well known to one another but not always recognised by the self. Staff detecting other staff members' moments of crisis or busyness would do so in ways that took into account what they knew to be helpful to that particular person. These
understandings revolved around a complex set of meanings in what the group apprehended as the sharing of responsibilities, expectations and subjectivities (T:3, p. 13) that underpinned participants' everyday knowledges in practice (T:2, p. 15; T: 6, p. 13).

Indeed, it was only during the course of our discussions that the participants began to think about and articulate the ways in which they themselves dealt with difficult situations or emergencies (T:6, pp. 14-15). Pam mentioned that her response was to walk 'quicker and would tell others' while I said I would 'explode a little bit'. Annette said she would 'rant and rave' saying that bad days were 'mongrel sort of days, but we're all going to survive the day regardless of what we see or what we do ... ultimately you'll finish and go home at the end of the day!' (T:6, p. 15).

This new awareness of the self was not necessarily greeted with shock or disbelief but rather an acceptance that this is me and this is who I am. Annette's acknowledgment that it was not only difficult to recognise the way in which one 'comes across to others' but also that such understandings were elusive, was affirmed by the group. She, like others, while trying to be aware of the self for the most part, found that the self in the context of others was difficult to recognise (T:6, p. 13; V:I, p. 1).

Some of these insights reflected commonly held understandings about one another which the group seemed to know almost intuitively, especially when things were not as they should be, situations that would then prompt support from a colleague (T:6, pp. 13-14). Sometimes one's colleague might feel the way sensitively by listening. In other circumstances it might be by undertaking some physical activity such as assistance with bed making, helping a patient shower, or administering some intravenous drugs. On other occasions responding to a colleague may involve being with or there for another participant in times of difficulty, whether it had to do with one's life world outside the hospital or issues to do with work. More so than ever
before, it seemed the staff, were very concerned that changes within the organisation were impacting significantly on their ability to care for patients (T:7, p. 12).

Many of these changes were reflected in the all pervasive influence of dominant ideologies embedded in practice which the group began to tease out. Issues such as feeling one had to cope, otherwise one had failed; participating in the completion of what might be deemed as unnecessary rituals; sticking to tasks when clearly other priorities were more important; or, while obviously viewed as unacceptable, being subjected to verbal or physical abuse from others in order to manipulate a situation (definitely not nurses on the ward, I was told!) (T:6, pp. 9-10) which acted to perpetuate and sustain dominant values within the hospital organisation.

Some of the participants felt it necessary to 'give permission' to 'ease off' to those with less experience, encouraging the staff member to relinquish the tasks in care in order to focus on other dimensions in nursing their clients. Despite the fact that this was often conveyed to the staff, those with less experience plus one or two others continued to act in the ritualistic ways of the past (T:6, p. 11). In trying to grapple with this scenario the participants began to see that perhaps other staff members were trying to mirror their expectations in keeping up the standards. What was implied here was that new members of staff made certain assumptions about the standards and ward culture more generally and that this related to myths surrounding the ward's strictness and adherence to protocol. Lyn, for example, was wary about suggesting to people that they should 'drop their standards' or 'cut corners' (T:6, p. 8). Annette clarified the point by saying the intention was to think about care differently. The idea was to focus on the patient rather than what the staff thought should happen (T:6, p. 8). It was becoming clearer that a false understanding was apparent; less experienced staff enacting the expectations they had come to apprehend as part of the truth claims related to the ward and/or what they perceived to be the standard of care operating in the ward. It highlighted for the participants the relation of the 'inexperienced' nurse and the patient to be one in which the nurse assumed power over the client, neglecting to take
into account what the client wanted, might feel or desire (T:6, pp. 7-8). Even though the patient was the focus and the intentions were altruistic, clearly there were some competing claims with regard to ideals. It was acknowledged that because people were different their value stance would vary thus prompting their engagement to be what they thought of as the 'right care' for that patient (T:6, pp. 6-8). What was 'right' for the patient might therefore differ according to the various backgrounds of those who worked in the environment and the extent to which these nurses took for granted the dominant ideologies located in the organisation(s).

**Working the difference**

All ward staff members had their own particular interests, differing backgrounds and a multiplicity of ideas, and these appeared to be recognised and acknowledged in terms of the ways in which the work load was arranged. Lyn comments in the margin of the transcript (T:6, p. 3) just how important it is to know what the staff's capacities are or as Vonnie suggested (also in the margin of the transcript on the same page), knowing each other is vital in terms of allocating patients. Understanding of others appeared to be critical in generating a sense of calmness in accomplishing the ward work on any one shift (T: 6, p. 10).

Valuing the multiplicity of understandings brought to bear in practice served to inform one another as well as the care the participants offered clients, whether this was an individual contribution or indeed something that was shaped collectively. For instance some staff members had knowledge of a nursing specialty, having undertaken postgraduate courses in, for example, intensive or coronary care nursing, thus having specific understandings related to people who were critically ill. Several staff members had undertaken generic postgraduate courses and thus were able to critique their activities. Others had young children and this endowed them with an appreciation of the dilemmas facing women with children when they become hospitalised. Then there were staff members, other understandings of their everyday world outside the hospital, perhaps meanings generated in relation to the past or even to the present and these, too,
were used. It was these experiential knowledges that were foregrounded in allocating patients to the staff.

Even though some staff members might have had more patients than others, it was recognised by the group that situations such as this one arose from the perceived care requirements of individual patients and how and in what ways the needs of patients might be brought together in the context of the various gifts staff offered in their enactment of care (T:6, pp. 6-8). Those who worked in the charge person's role acknowledged that it was an extremely difficult task to get the mix right—the right nurses for the right patients (T:6, p. 10). '[Y]ou have to balance the staff's background and experience, provide them with a challenge but not over extend them too much ...' Vivien informed me one afternoon (Journal entry, mid-January 1997).

Frequently the notion of staff–patient mix was used. I was interested in the notion of 'mix': the right nurse for the right patient and what 'right' meant. The term 'right' reflected a commonly held understanding of what a particular nurse might be able to offer a particular patient. Individual nurses' talents were therefore used extensively, not only in the context of patient care but also to support the staff more generally. On occasions, patients were allocated to staff because they needed to expand their understandings, yet this would only happen with appropriate support or coaching (T:7, p. 11; T:8, p. 9; I:V, 2, p. 3) from other staff members on that particular shift. Thus individuals' understandings were valued and respected (T:5, p. 12; T:8, p. 7). As Vonnie suggested, 'you admire their work—you could not do better yourself (I:V, 2, p. 3).

The politics of patient allocation was certainly elusive, slippery and difficult to pin down. Sometimes I wondered if they reflected a form of exclusion, some staff members looking after certain patients and not others. I often thought about the interests being served as well, but over time, I began to realise that the expressed intentions with regard to the allocation criteria were in the main enacted.
Looking back, I began to reflect on the patients with whom I became involved. I was puzzled about what I understood to be my knowledges in practice and how these differed marginally, sometimes substantially, from what I thought my colleagues apprehended to be my gifts. Sometimes, too, I wondered if these judgements had been misplaced. I knew, as they did, my dexterity and adeptness in some areas was lacking. Yet, it seemed that my own willingness to work with and trust others and perhaps have trust placed in me by my colleagues and patients was, all in all, a profoundly humbling experience!

(Journal entry, October, 1997)

Sometimes there would be specific reasons for encouraging a nurse to care for the patients she had been allocated (I:V, 1, p. 2). I wondered why the staff usually regarded the allocation of patients as unproblematic and whether it had something to do with the high regard in which the senior staff were held (I:V, 1, p. 4). In addition I pondered whether the group's acceptance of their patient load was a reflection of their respect for the senior staff that, while enhancing the status quo, was not necessarily a reified and hegemonic understanding of the authority of those 'in charge'. In other locations, the way in which patient distribution works does not always revolve around the acknowledgment of, and respect for one another, as it appears to occur in 13 North. Rather, in other wards and in other hospitals, patient allocation is used to promote horizontal violence, one of the many tactics that perpetuate misogynist views as part of the taken-for-granted understandings in practice (for example, Glass 1997, p. 176; Duffy 1995, p. 12; Cash 1990, pp. 93-94; Roberts 1983, p. 27) a situation which has helped to sustain nurses' oppression.

Clearly, allocating patients to the staff was a jigsaw puzzle and one that seemed to reflect some interesting details which were revealed more fully once I had begun to practise on the ward. At first I thought that continuity of care would be a critical factor, and to some extent it was. Sometimes a patient would be in hospital for a
protracted period of time and the same nurses might be involved in her/his care for the
duration of the patient's stay. I enquired whether staff felt that they could ask for some
relief by being allocated to other patients rather than the same ones or one, day in and
day out, in the case of a patient's lengthy hospitalisation. There was no doubt in the
minds of the participants—they felt they could request a change. However Mary
mentioned that asking for other patients should never arise. Those doing the allocation
of patients, Mary said, anticipated staff's need to step back from one particular patient
from time to time and care for other patients instead. In this way the load was shared
around (T:6, p. 12).

I also enquired whether staff members felt they could say if they preferred not to look
after a particular person. I was assured that this did occur but hopefully that changes
to the staff's load would happen before they requested it (T:6, p. 11). Annette said she
anticipated that the person allocating the patients to the staff members would realise that
a change was necessary before a staff member mentioned their concerns. It was
obvious that in instances where a patient's stay was protracted several staff would be
involved with their care. Donna commented that no two days were ever the same and
because each day was different one needed to think about alternatives. Caring for any
one patient over time was a challenge and nurses needed to reflect on their practice to
tease out an array of options in enacting care (T:6, p.12). However there were
moments when such challenges were unsustainable; moments that necessitated the
sharing of care amongst other staff members who would become involved, but this
involvement too was based upon one's special contributions to care. In these
circumstances the staff member would be consulted with regard to their continued
participation and a decision reached mutually (Journal entry, early March 1997).

Caring documentaries?
In line with hospital policies patient care was documented in the notes using a
technique referred to as documenting by exception. This meant that only if something
out of the ordinary happened to the patient would the nurse write the details in the
patient's history. Also in line with the hospital policy, patient care plans were used. At some stage prior to commencement of this research, proforma patient care plans were developed in line with specific conditions which represented (and signified) the profile of a typical patient with particular medical problems. These care plans, as I mentioned earlier, were structured to be constant with DRGs. The care plans formed part of the official documentation which, at the time of discharge, would be enclosed with the rest of the patient's history and at a later date could be used as part of a retrospective audit trail for quality assurance purposes.

I was familiar with the similar care plans used by other wards in the hospital. When I came to fill this one out I realised that it was quite different from what I was used to. I went and found Lyn and asked if I had the correct forms which the ward clerk had gathered in preparation for Mrs W's admission. I specifically pulled out the care plan and asked about it. Lyn mentioned that they had been 'issued with various forms but the staff did not like them' because they were 'too directive and overlooked individual differences and needs'. Was this also an exercise on how well one could fill in documents having no bearing on care a patient might receive? Lyn went on to explain that all the forms were now packed away somewhere and they had 'dug out an old form' which the staff felt worked so much better. Lyn giggled as she explained that admin. had not realised yet and wondered what would happen when they did.

Here again was yet another dimension of the group's ongoing resistance to the organisational imperatives, decisions that flowed speechlessly through the 'pens' of isolated individuals to wards such as this one.

(Journal entry, mid-May 1997)

Documenting clinical pathways through the use of care plans constituted a discursive practice through which the administrative gaze could examine and quantify interventions. As Lawler (1999, p. 142) and Gibson and Heartfield (1996, p. 192)
suggest, the tacit understandings implicit in practice are rendered invisible by the
discourses of scientific rationality. These discourses presently represented and
articulated, for example, in care plans overlook the subjective and intuitive aspects of
care, the latter areas being deemed less legitimate or of little (economic) significance in
comparison to the behavioural focus of the current 'market place' (Parker 1999, p.
21). In real terms this has meant that much of nursing's labour was/is unable to be
captured economically (Gibson and Heartfield 1996, p. 192); nevertheless, what is
documented appears to satisfy modernist claims for uniformity and predictable ends

Are you special and can I trust you?
Unlike many Charge Nurses around the hospital, the 13 North Charge Nurse had been
involved in staff selection for many years. It was clear that each member of staff spent
time on the ward before they became 'one of the team'. During this pre-team period a
nurse would be closely observed; as Vonnie mentioned, 'you have to have basically
the same standard ... it takes a certain kind of person ... no one trusts a new person at
first; it is a pattern I've noticed ... I earned their trust and they responded by trusting
me—it's a key!' (I:2, pp. 1-2). This sense of reciprocity only happens if and when
one meets the expectations or the demands that the other members of the group place
upon themselves. These expectations reflect the manner in which a nurse enacts care.
In addition it is not only the question of enactment or being able to do the job in terms
of a person's competence, but also in one's ability to engage meaningfully and with
empathy with the client. Annette notes (I: 2, pp. 4-6) that one of the important
considerations in selecting staff is that they will be able to contribute to the team; that
is, that a new staff member will have something special to bring to bear in relation to
the rest of the staff and through this joint effort, the team is able to achieve. This latter
point in particular was something Annette felt was not well understood by other wards.

In the context of these comments it was not surprising that Annette mentioned to me at
the outset of the research that my working with the staff was up to them (Journal entry,
November 1996). Building rapport was quintessential to the first stages of a relationship with the group. Developing mutual respect and trust would follow; a time when I would be privy to a more inclusive view of the ward's culture. I mused that if the participants felt they could trust me and there was mutual respect it would be then, and only then, that I would be invited by the participants to practise alongside them. This was indeed what happened (Journal entry, early February 1997), Vivien noting 'I feel as if we know you a bit better now, [we're] more relaxed with you' (T:11, pp. 13-14). I was also aware that in becoming involved in the work of the ward I was now considered part of the team and this would evolve with deepening understandings of the self and others, whereby the sharing of one's worlds fostered new awareness, trust and respect. Thus it was that over time I became a member of the team, a status I only recognised when I was offered a position (Journal entry, May 1997), but something that had probably occurred much earlier. I felt this was an honour! What it meant was that in being part of the team what I had to offer patients was affirmed by my colleagues. Moreover, the care I was able to offer patients was acknowledged as being of a high standard. But looking more closely perhaps the significance of this lay in the support I received in the enactment of my profession, that my colleagues valued my contributions; they affirmed me enabling me to walk my talk, to be, to feel and to engage meaningfully.

**Performing**

Performance appraisals also acted as a more overt approach to the 'monitoring of standards' (surveillance) throughout the hospital, 13 North being no exception. Depending on whether the staff member was full-time, part-time, engaging in a clinical rotation, such as the graduate nurses did, or a permanent person on the ward, performance appraisals were conducted at regular intervals. Appraisals served as one of the ways the hospital remained accountable for the work within the organisation. At a ward level, however, the appraisals constituted moments when the Charge Nurse would take the staff member into her office and discuss the nurse's performance with her. These were times of discomfort for all concerned. Jenny commented on what happened, saying that instead of the Charge Nurse filling out the forms (a traditional
approach adopted in other places), Annette would engage in a consultative process with other staff members (usually the senior group) to gauge their opinion of the performance of that particular staff member (Journal entry, April 1997). Then the nurse would be asked to see Annette in her office and Annette would invite the nurse to complete the form there and then. Invariably the staff member would understate her achievements, Annette working at adjusting the nurse's perception of herself whilst affirming her practice (T:17, p. 9). Rarely did Annette feel that she had to 'reprimand' a person at the time of her appraisal, because when something untoward happened it was addressed immediately by other staff (I:2, p. 5; T:17, p. 9). Thus Annette's role in evaluating performance was one of mediating the event, helping a nurse to recognise where she was in the development of her practice understandings and, on the odd occasion, offering advice (Annette, I:2, p. 5). On a personal level, Annette found the performance appraisal a very stressful aspect of her role. She was unable to explain why this was the case other than to suggest that acknowledgment of others' worth remained her biggest failing. She felt that too many compliments would lead the staff to questioning her sincerity. But Jenny said that there were no expectations that Annette should comment upon the group trying to do the best they could all the time and this in itself said something about their self esteem (T:17, pp. 12-13).

Perhaps Annette's approach had a lot to do with her perception of her role in terms of her commitment to the staff. After all, Annette mentioned, it was the nurses on the ward who 'cared for the patients and people needed to understand that because of this you needed to care for the staff' (I: 2, p. 3). Maybe Annette's perception of engaging in performance appraisal was incongruous with her thoughts about fairness and justice. Given that Annette rarely took a patient load she was not aware of all the nuances of each member of the team and this may have influenced her thinking about who might be in a reasonable position to appreciate another nurse's practice. Although she regarded herself as a little out of touch in some areas she was always striving for something better—maybe seeking the advice of colleagues (I:2, p. 5) helped her to enact a more just approach to the evaluative process. There again, it could have been
due to a sense of her own power that she saw to it that a nurse completed her own evaluation. Many interpretations of Annette's approach might be offered but I suspect it had a lot to do with her values in trying to promote more equitable relations on the ward.

'We talk about standards but I don't know what we mean'

Vivien wrote in the margin of the transcript (T:6, p. 8). The way the participants constructed the notion of standards of care starkly contrasted those articulated by the hospital. Whereas the hospital rhetoric disclosed care as both efficient and effective, there were to some extent similarities which could perhaps be related to nurses' hegemonic and reified understandings of practice in a bureaucratised world. In addition it may well be that the group had adopted the language of bureaucracy whilst giving it quite a different interpretation. Thus they may have been acting to subvert the consequences of the dominant discourses, rendering them as contemptible. There is little doubt that participants believed that they enacted a very high standard of nursing care on 13 North, and the standard they believed they set was supported through the actions of the team. Whatever this standard was, it formed part of the taken-for-granted culture which it in turn mediated. Some of the conversation related to standards is captured in Appendix 4.

Perhaps the question is how and in what ways are standards and thus practices discerned as being right or wrong? Is being told what the expectations are tantamount to dismissing another woman's understandings, marginalising her difference and rendering her unheard desires irrelevant to the existing culture? Are these the ways the status quo is sustained? Being told that one's standard of care fails to match the expectation of one's colleagues suggests that each person engages in some form of self surveillance; the nurse monitoring her practice against what has commonly been accepted as 'the standard'. Drawing on Bourdieu's (1977, in Bottomley 1991, p. 97) conception of habitus it is possible to appreciate that one's understandings are drawn from the social group in which one has affiliations. Derived from object power
relations, these understandings become lived out and shared with others in the same circumstances, synthesised in the construction of meanings. In turn, these new meanings represent object reality which is socially reconstructed in the form of symbolic power, which in turn conveys its own meanings and values (Bottomley 1991, p. 97). If one takes this view it is possible to appreciate that bringing together both objective reality and one's intersubjective experience serves to diminish the dichotomy of objective and subjective power relationships, with the concomitant reconstruction of the self's identity, an identity that responds to these symbolic acts in the form of self discipline and surveillance (Foucault 1977). What is not so obvious is the obscurity of power—while remaining strong the gaze has become diffused, filtering through the ‘senior staff’, those who have been on the ward for quite a long time, to the group of permanent staff who have yet to become more experientially knowledgable.

The standard was not something concrete as would be expected, perhaps, in terms of technical performance; nor could it be readily articulated in behavioural terms. What was clear, however, was that the standard seemed to be something embedded in the culture of the ward. Clearly the lines of authority were not necessarily used in facilitating the standards of practice; rather each person as a member of the team shared this responsibility (T:1, pp. 9-10). It was obvious that some sort of code operated to encourage particular ways of acting and that this code was constructed and shaped within the context of the values and relationships of those in the ward. Although it appeared to happen in other ways, rather than necessarily operating through the hierarchical lines of authority, yet the ideas were supported by the leadership. It was as if one's responsibility to another could be framed along moral lines; that one was obliged to enact care in a certain manner, but at the same time extend this same moral positioning towards one's colleagues.

The interesting question was how and in what ways was the ward culture transmitted so that one apprehended what the values were? Were there sets of implicit
understandings that belied explanation, visible to some and not others? How were these meanings conveyed from one generation of nurses to another? The process was an enigma! Commentators such as Burton (1985), Connell (1977), and Bourdieu (1973), amongst others, believe that cultural transmission is a complex phenomenon mediated through forms of symbolic control and lived out as a constant process of struggle between competing claims. Bernstein (1975, p. 38), for example, suggests that cultural transmission occurs by means of two different but interrelated dimensions of agency—instrumental order and expressive order. If one imagines that culture consists not only of acquiring skills to enable one to perform specific tasks (instrumental order) which can be used to gauge one's performance in determining competency, but also upon the apprehension of knowledges that reflect one's conduct, moral stance or empathic approach (the expressive order), it is then possible to appreciate the manner in which understandings come to be taken for granted. It is these two orders and the relationship between them that perhaps support particular ideological underpinnings within the ward and which in turn act to generate boundaries that serve to endorse dominant interests.

Where, for example, the instrumental order is given precedence which highlights the technical or specialist skills as the valued dimension of work, instrumental order will accelerate individualistic pursuits towards technical prowess, leading to elevated status, but at the expense of the group cohesion implicit in the expressive order (Bernstein 1975, p. 64). Although technical knowledge is dynamic, the boundaries created around it can serve to limit access to that knowledge and thus its utilisation, while at the same time it can support the privilege of some, the elite interests, at the expense of the others (Minick 1997, p. 176) leading to divisive practices and exclusion. The reason for the divisiveness inherent in instrumental order might be situated in the individualism fostered through the development of high levels of proficiency in tasks encouraging the nurse to specialise in specific areas of practice. Moreover these boundaries are closely guided to enable exclusion, forming a pattern of symbolic control over knowledge. The standard is thus understood and apprehended as
something difficult to articulate but those on the ward by and large exemplify this standard in their everyday work.

Perhaps Foucault's (1977) description of the panopticon adds a further way of teasing out how symbolic control becomes embedded in one's culture. Continual surveillance with the threat of punishment encourages one to act in accordance with prevailing ideologies. Over time the actor's complicity mediates the culture of dominance, the practice of self surveillance limiting one's ability to act reflexively or for that matter differently. After all, the culture has become hegemonic and reified in the consciousness of individuals, rendering the self subject to forms of the symbolic. It is symbolic because now the actor places limits on their agency rather than on an authoritative figure. Thus symbolic control forms part of one's everyday understandings of self in the world. It encourages the adoption of dominant interests proclaiming other ways of understanding and acting in the world as marginal. The extent to which the dominant culture remains entrenched, devaluing nurses' understandings (and patients' as well) remains contentious. Such a view seems to reflect a rather deterministic vision (Burton 1985, p. 122) of nurses' agency and one that ignores the various forms of resistance enacted by the oppressed. Even though the dominant view continued to focus on labour outcomes and thus, to some extent, instrumental order, nurses on 13 North proclaiming the importance of standards see them as dialectically related to the expressive order, which appears to depart from the administrative view.

Inasmuch as a practitioner's technical knowledge might accentuate instrumental order which is then legitimised along bureaucratic lines of authority, expressive order offers insight into the ways in which social arrangements might be constructed and maintained through particular moral understandings which act to hold the group of practitioners together (Bernstein 1975, p. 38). Where there is general consensus with regard to shared values, social cohesion exists. However, with the advent of differing values coming to bear on practitioners' social relations in 13 North, a sense of
ambiguity has given rise to changing relationships within the expressive order. The extent to which the central values have changed from a focus on instrumental order to the expressive kind is not difficult to detect, particularly within the political climate and the emphasis on standards of care. While Annette, for example, acknowledges the importance of differences in the ward staff there remains a commonly-held understanding of what constitutes this standard and how it might be enacted (T:1, p. 9).

The shifting of focus from an instrumental view in completing tasks to another ethos by acting empathically highlights the ways in which meaning-making reflects knowledge that stems from one's practical judgement having its basis in reason. Grundy (1987, p. 61) likens this form of reasoning to the Aristotle's notion of phronesis. If Grundy is correct in asserting that learning proceeds from technical constitutive knowledge interests, it seems clear that other understandings come to bear on how nurses work. In an endeavour to enact a 'good standard of care' are nurses locating their notion of 'good' from a moral standing? If this is the case then the notion of a 'good standard of care' also conveys a moral intent.

'Where is Annette?' I asked Mel, having been unable to answer another member of staff's question. 'She is down in A and E trying to sort out an admission'. We walked into the clean utility area to prepare some IV drugs together and it was there that she recounted the story of Mrs M. Apparently Mrs M had been a patient on the ward earlier in the year and also in the year before having had a pelvic clearance for cancer requiring multiple admissions. Each time she had been admitted to 13 North rather than another location. On this occasion however she was very ill and the hospital grapevine had made sure that Annette had heard Mrs M had been admitted for palliation. Some hours later Annette returned, and with a flurry of activity a single room was made available and Mrs M arrived.

(Journal entry, early April 1997)
On my return to the ward the following week I heard more of the story. Mrs M was no longer in the ward, she had been moved to the Oncology unit so that the 'Oncologists would not have to come to this ward' I was told. I also heard from this same informant that the Oncology nurses may have thought that they could give Mrs M better care than she could get on 13 North. It was thought that this was an assumption and the staff member concerned openly acknowledged the expertise of the Oncology nurses. However, the member of staff felt saddened by what had happened saying that they could offer Mrs M something different but equally important. Before I could inquire what this might have been the nurse mentioned that Mrs M had a limited number of friends and no family to speak of and that she knew the staff well. The nurse supported Annette's contention that because Mrs M was dying she would be better off in a location where she knew and liked those around her. 'Surely this would be better than dying in a location where you didn't know anyone'. 'You see' I was told, 'Annette goes into bat for patients' cause she really does care, she'll do anything to help them ... so Mrs M was here for about twenty-four hours before they moved her and she cried when they took her'. The staff member went on to explain that Mrs M died two days later ...

(Journal entry, mid-April 1997)

The poignancy of Annette's comment (Appendix 4) 'that we weren't brought up to be empathic, were we' echoes as one looks back at nursing education in the past. Nursing was taught along procedural lines designed specifically to endorse particular relationships. Tasks were allocated on the basis of seniority, the most senior nurse giving out drugs, the junior nurse pretty well confined to the pan room. What was propounded through these arrangements was the dominance of the medical model, a model of misogyny designed implicitly to serve the interests of patriarchy.

Nurses enacted their own understanding of what constituted a good standard. It was a perception that varied between one another. Nevertheless one's contribution was
accepted as trying to do one's best for the patient. One's credibility in providing a good standard of care might have been seen as keeping up with the pace of work activities generally and with one's colleagues in particular, but this too was not necessarily a crucial factor. I noted also that credibility did not rest upon one's knowledge of medical technologies and associated equipment although this may have helped. Rather, what underpinned 'the standard' the group were reflecting on was that area of practice which has consistently been devalued as women's work or emotional labour. Indeed, it was the notion of empathy that seemed not only to count as a good standard of care but undergirded it as well. Thus 'a good standard' of care had a completely different interpretation from its more bureaucratic one.

Lyn (T1, p. 11), commenting in the margin of the transcripts, claimed it was empathy that constituted a 'good nurse'. This, she noted, may come naturally or it may occur with 'added experience and knowledge'. The fact that empathy appeared to consistently feature in discussions on standards, reflected a foregrounding of the patient in care. Despite these comments Vivien added this notation to the dialogue: 'we keep talking about standards but I don't know what we mean', suggestive perhaps of the illusory status of such moral underpinnings and the ambiguity forming the tensions implicit in the two orders, both instrumental and expressive.

Vivien's concern could represent a very real attempt to align the organisational interpretations of standards of care with those articulated by the group. Perhaps another way of considering these tensions is to reflect on what Moss (1999) asserts are the various dimensions of 'good practice' from a moral point of view. These include the practical life in reference to everyday aspects of work where ways of acting are informed by one's being or one's ontological self; the responsible life where care and responsibility for clients revolves around advocacy supporting the 'other'; the regulated life in which codes of conduct inform practice standards; and finally, the bioethical issues which are integral to one's day-to-day world. Embedded in these dimensions of practice are one's relationships, those of the nurse–nurse, client–nurse,
and doctor–nurse occurring in an organisational context within a broader socio-political
milieu. These dimensions of one's moral world encompass and take into account the
complexity of practice and assist in focussing on the areas of concern that have larger
political underpinnings (Moss 1999). While these ideas are helpful in locating
contemporary debates and their historical locatedness, questions relating to power,
interests and intention remain somewhat obscure. It helps to locate the rather skewed
bureaucratic ideologies in a vision of a moral world that seems to prefer the regulated
life as its moral stance and in doing so aligns one's moral world with that of ritual.
Clearly such a picture stands in stark contrast to the moral lives of these practitioners
who envisage a 'good standard' of care to be more than, and even different from,
regulated practice and rituals.

**The technical**

Practice rituals enacted by staff also endorse the culture of the ward, which in turn
affects the standard of practice. Tasks in care often deemed as rituals receive
appropriate attention. Often these tasks relate to the requirements outlined as necessary
activities. They are claimed to be so as part of the ethico-legal dimensions
(responsibilities) of practice. The extent to which these tasks comprise components of
a patient's objective data remain as important institutional protocols designed by the
bureaucracy to fulfil its obligations for funding. At the same time, however, these
ritual ways of acting serve to align nurses to practices that over the years have become
taken-for-granted and to the outsider remain questionable. For these and many other
reasons it is not surprising that nurses find themselves located in contradictory
territory. They are instructed by the organisation to adhere to protocols. Yet nurses
are also told that their practices are without foundation, outmoded and ritualistic. Is it
any wonder then that nurses find themselves living in a world of ambiguity; one that
constantly undermines their everyday practices?

The pace or business of work adds to the regime of control focusing on the technical.
It is not unusual for 13 North to have twelve discharges and fourteen admissions on a
Tuesday, and this is no exaggeration! Perhaps these figures (patients!) give some indication about what the patient turnover generates and the work involved. It is all part of the process, or should I say production line: greeting women and men coming into the ward, escorting them to theatre and returning with them, all in the space of a few hours. More recently, however, patients have been admitted to the ward following theatre which continues to be a source of some concern for all the staff. Nevertheless, the pace demanded of the staff in 13 North has, from time to time, required them to 'cut corners' (Annette, T:6, p. 8). In reality this has meant for Lyn (T:6, p. 8) a question of what constitutes standards of care and what does not; a situation which calls into question a sense of fluidity between what is acceptable, and to whom, and what is not. Mary, however, said even some 'experienced staff' continue to 'do things in exactly the same way' when the ward is busy, unable to alter their activities to take into account changing circumstances (T:6, p. 7). Whether this was part of the woman's resistance to the situation remains unknown.

In response to the heavy pace, rituals remain for many nurses part of the taken-for-granted ways of acting to which they can return in moments of crisis. Unquestioned as many of these activities are, they constitute traditional tasks which according to authors such as Hicks and Hennessey (1999, p. 28), Lawler (1999) and Hicks (1998, p. 248), reflect unsystematically evaluated knowledge. While nurses continue to engage in these traditions it becomes important to ask, with 'evidence' to the contrary (ignoring for a moment what constitutes evidence), why it is that nurses continue to pursue and/or return to these activities? Perhaps, as Hiraki (1998, p 116) suggests, it may well be that nurses have been left without a voice given the advent of downsizing and rationalisation. The corporate culture has rendered political questions surrounding healthcare as economic ones—problems to be solved economically prompting nurses to return to tasks. Clearly the culture endorses these rituals, and perhaps Foucault's (1977) notion of surveillance and the panopticon might shed some light on the reasons for their retention. Despite the attempts of many senior staff, self surveillance in the
form of an enculturated docile body remains, for me, one of the most poignant assertions enhancing existing imaginaries.

There was considerable tension between what the participants perceived as the necessary tasks in care and those deemed not essential. Perhaps this tension stemmed from using tasks as an means to spend time with a patient, or alternatively, perhaps they were understood by that individual as critical to enacting what they believed to be 'good' nursing care. Multiple interpretations existed surrounding why nurses continued to enact what was deemed by some to be outdated or outmoded activities. Even the language of 'cutting corners' suggested actions that were being closely scrutinised, serving to shape perceptions of acceptability, and why it was that some staff needed to have 'permission' to work in alternative ways (T:6, pp. 7-8).

The question of permission to refrain from particular activities clearly points to issues of power and the ideological hegemony that served to ensure that tasks in care more or less remained as they had always been practised. Cultural traditions of this nature are hard to disrupt, precisely because they are legitimated through other rituals, language and social structures especially those designed to support the need to have certain activities sanctioned to endorse divisions of labour (Bernstein 1975, p. 63) and thus power. In terms of their bureaucratic standing, those participants clearly recognised that some nurses needed to be told or given permission to restrict their work to those tasks which, according to policy or rhetoric, reflected behavioural standards. Given some nurses' reticence to depart from custom and tradition, one wonders whether the individuals concerned were caught within their images of the self. Was it an unquestioning self, split between contradictions: those that required the docile body to respond in particular ways as an alienated or fragmented self and the 'othered' self, the self who is the person (Young 1990, p. 155)? Were these nurses in their doing of care exercising what they thought to be their moral obligation? Did these women understand their engagement in these traditional ways of acting to be what was (morally) required?
In a critique of the limits of the Kohlberg-Gilligan debate, Tronto (1993, pp. 77-91) argues that, just like gendered morality, colour, ethnicity and the distribution of labour all assist in the preservation and the distribution of power in debates about morality and the self as a moral agent. In her discussion Tronto (1993, p. 89) notes that those participating in the larger moral questions are those in positions of power, whereas others in subordinated locations (for example women) have limited accessibility to these concerns and thus grapple with their own position within moral questions, perhaps understanding them privately. Yet, they (in this case women nurses) also try to apprehend themselves in relation to the moral discourses of the powerful. Realising their marginal location in relation to the privileged decision makers, nurses also attempt to develop their own sense of a moral life in the context of their relations in practice—through an ethic of care. After all, patriarchy has seen to it that ethical debates remain in the hands of a few who, in the main, continue to follow universal lines in making decisions whilst ignoring the particular, context, and relations. In addition those closer to the authorial voice (of the unit manager) are deemed to be more moral than those in subordinated positions, which gives a sense of legitimacy to the unit manager's voice on moral concerns. Unpacking this further, it is no surprise that nurses in general find themselves explaining to the polis that caring is their (exclusive) domain in health care. After all if caring is particularistic and situational then it stands to reason that nurses, precisely because of their subordinated position, find themselves in a confined moral and political trajectory. Meanwhile, nurses' attempts to understand their own position from the perspective of the powerful enhance their own exclusion. Moreover it is also little wonder that nurses attempting to grapple with exclusion recognise their marginality as they try to come to terms with the powerful discourses used by those in authority to enhance their own privilege. It is a rather deterministic debate and one that highlights its failure to take into account possible forms of resistance. However it does add insight into why some nurses retain illfounded ritualistic activities, for this is what they apprehend their position to involve. Yet Tronto (1993, p. 96) makes the point that whilst there continues to be a separation of
the moral from the political, care will remain located in the realm of the private. Nurses' moral location in terms of care will also retain its subordination in contrast to the universal claims of nurse's superiors surrounding moral questions. And yes, the fact that certain members of staff need to be 'told' to relinquish certain caring (ritualistic) activities comes as no surprise given the powerful heritage of patriarchy. Such a heritage was one which promoted the various images of the self, the self as the self, and the other as a different self but part of the self. This is highlighted in the debate between Mel and Vivien (see Appendix 3) about 'the best job possible' and/or 'the best possible job on the day' (R:1, p. 12).

But what of this self and its aspiration to work consistently towards making something better? Is this the sense of altruism that underpins the very real dimension of wanting to make a difference in trying to be there for the patient (Lyn, R:1, p. 11)? It is obvious that while the bureaucratic intention is to increase productivity, the participants aspired to provide the best care possible. Through an interesting weaving of these two ideologies, there emerged a slightly different picture of nursing care. Instead of highlighting what nurses think should be done, this picture moves the focus of attention from the nurse to the patient: what it is they desire in terms of what nurses might offer in caring for them. This interesting twist repositions the patient in the foreground rather than where they might generally be depicted in relation to care. The foregrounding of the patient's perspective realigns the rhetoric with practices engaged in by the nurses, as well as the nurses' values.
In a comment made in response to reviewing the transcripts Lyn (T:1, p. 12) writes: 'standards [form the] common aim, this is known from experience together'. Clearly Lyn is suggesting that each nurse has an appreciation of one another's values; an appreciation that has developed in the context of their relations over many years. It is perhaps this knowledge of one another and in turn an apprehension of each other as practitioners that places one in a unique situation of being able to work with others in unison towards making a difference in caring.

But just how harmonious the work environment was, considering the varying degrees of competence, was certainly a question worth asking.

*I began with my patients; helped one of the grads with a sponge, and assisted one of the students with a lift. I could have broken my back!!!! She had absolutely no idea about lifting! We moved to another patient who needed to sit up. Instead of doing a shoulder lift to move this heavy man up the bed she wanted to do a cradle lift because that was the lift they used in the nursing home where she worked part time, and it was the one we had just used earlier. I asked if we could do a shoulder lift instead which I explained would be less strain on our backs. She was not sure—'what is a*
shoulder lift she enquired?’. I could not believe the question and found myself getting irritated. We walked through the skill before attempting to lift the patient. Together we moved him up the bed; yes, a drag would have been the more appropriate term.

I could not help myself but say to the student just how important these sorts of skills were and that it was crucial for her to know this stuff so that she was able to access other opportunities to learn, basically having 'proved' herself. I felt cross because in some way this student like other students earlier had let the (university) side down thus raising questions about the educational process in the minds of my hospital colleagues. This thought was the immediate thing that sprang to mind ...

At tea I met up with Annette and asked about the ward’s energy levels which were obviously down. She explained that it was the lack of senior staff: 'say if we get the guy with the burns who do I turn to?' she asked rhetorically. Both of us knew that those senior staff members who were on already had very ill patients. I responded 'you mean you need someone to share this stuff with?'. 'Yes' she said walking off smiling. I was aware that she liked to have several of the senior staff on, staff with whom she could walk through ideas, on whom she could depend for their knowledges and competency as practitioners.

(Journal entry, early September 1997)

Competency

Competency, based upon individual pursuit towards some sort of elitist point, renders the personal knowledge of the practitioner as knowledge that is safe because it is privatised—owned individually and thus inaccessible to others. Rituals, for instance, act as a symbolic dimension in the maintenance of the instrumental order, a project that emerges as boundaries surrounding particular technical knowledges (in this instance
tasks) remain intact. The boundaries are protected by those who own specialty knowledges and for whom control over this knowledge is vested in methods of surveillance (Bernstein 1975, p. 74). Staff were actively engaged in strategies of protection readily seen in the group's attention to nursing students as well as new graduates. Annette commented that '... [what] we all realise too is that they're learning ... we are not necessarily satisfied with their practice, but, by the way the girls supervise them, at least we are also trying to protect those standards as well as ensuring the patients do get looked after' (T:7, p. 10). New graduates who were participating in a programme designed especially for them by the hospital, found themselves subject to the same sort of scrutiny. Recent graduates, for instance, spent a period of several months on the ward before they were moved to another one to gain additional experience. The programme overtly enhanced the consolidation of the newly graduating nurse's knowledge(s) while at the same time it acted to enculturate nurses into the meanings and discursive practices arising out of the dominant ideological interests of the organisation.

As part of the nurse's or new graduate's learning experience each person had a staff mentor with whom she worked closely.

Today was not the best. I had somehow 'acquired' G the new graduate. Oh dear! While I tried to be as patient as possible with her I got to the stage of almost asking someone else to give me a hand. Not only can she not see—it's like she's got tunnel vision, and she just hasn't got any idea. The drips ran through and two packed up. The woman fasting got breakfast and I could go on. I have to agree with Annette on this one when she wants to know what is going on at Uni. There we were trying to lift this woman who had had a CVA. She couldn't lift to save her life. I mentioned to her that she should try and get some practice in because her technique meant that her colleague might end up with an injury if her approach did not change. Perhaps this was unfair but that's how I felt; I was tired of watching over my shoulder having to
have eyes in the back of my head and perhaps disappointed that this was one of our University's graduates. Certainly she lacked experience and there had been attempts all week to provide a more sheltered environment in terms of the patients she was allocated ...

(Journal entry, mid-March 1997)

The mentoring begins with orientation, and continues throughout the graduate's duration on the ward. In addition, particular staff members serve as support people and are responsible for ensuring that their experience is encouraging. The new graduate or student spends time with one of the support people on a daily basis. This might involve discussions, informal educational activities and debriefing type sessions. As Jenny noted, it was sometimes difficult to work with new graduates or students but she would often commence by recounting how she felt returning to nursing after so many years out of the practice world (T: 17, p. 8). Others echoed this sentiment, noting that support for these people was a key concern given that the group believed that their educational preparation was increasingly inadequate due to cost cutting measures and the reduction in the clinical component (T:17, p. 2). I was frequently asked what my opinion was on the reduction of clinical experience. Invariably I would say what I felt: if nursing knowledge was embedded in practice then practice needed to be the focus of inquiry, which in plain terms meant that the severe cuts to university clinical budgets would foster larger tensions between the academic world and practice.

Moreover the lack of experience necessitated closer supervision, especially with some of the tasks such as monitoring the patient's intravenous fluids, for the patients' IV's would invariably 'pack up' (T:17, p. 6) the first few weeks the new graduates started working on the wards. Close attention to supervision, support and allocation of patients to the new staff formed integral dimensions in easing them into the culture of the ward (T:17, p. 8). At the same time it gave the staff opportunities to assess the practice understandings of the newcomer, which would then inform not only their future support but also the person's performance appraisal.
There were four of them gathered around the table in the day room. I had noticed that Tinks had collected the procedure book earlier and also raided the filing cabinet for some post op. instruction sheets normally given to patients at the time of discharge. I assumed that this was one of the 'educational' sessions specifically for the grads. Annette had mentioned that these sessions had always been important but now the availability of time meant they were happening less frequently than they should ...

(Journal entry, early February 1997)

Support for new graduates nurses was openly acknowledged as critical to ensuring that standards of practice remained high. Both Annette and Lyn mentioned how difficult the first few weeks were before they found their feet and their practice began to flourish. Until this time, however, their performance was 'pitiful ... and it's absolutely frightening' (Annette, T:17, p. 1) for the staff (and thus the patient) and that is why the group worked hard to 'protect them ... and look after them' (Lyn, T:17, p. 1). I was also asked many times what was going on in the education world when students and graduates appeared to be ill-prepared for caring for patients. In some respects I felt a little defensive of my university colleagues who were struggling with trying to make the programme work under extreme ideological, fiscal and staffing difficulties. The group talked about cutting students' clinical experience and the effects the cuts were having on themselves. It meant being attune to what was happening to patients, those being cared for by nurses undertaking the graduate year programme, and students as well. Annette wondered whether for the student at the university 'nothing was real—it was a bit of a game' (T:17, p. 2). When it came to the reality of practice their imaginaries gave way to a reality that seemed in stark contrast to what they understood nursing to be. And then there was the question of expectations placed upon new graduates and the staff's lack of confidence in educational preparation. I felt a momentary distance from the group—the outsider—as Annette recalled my commitment to nursing practice as the focus of inquiry, and if this was the case, then why was the clinical component being cut so drastically (T:17, p. 3)? I had no answer for the group except to say that 'we' had to radically rethink the education of nurses in...
substantive ways in order to better support the student's knowledge(s) development. Immediately, I felt as if I was at a distance, but then was I? Where did I really stand ...

... Where did I stand?

_I had had a big day, one saturated with emotions, death, life, grief ... I decided to return to the University for some made up reason I really can't remember now but realised on the way I wanted to spend time with my colleagues. Once again I drove through the gardens where the big gums stand remarking to myself just how beautiful this territory is. The merging colours of green and brown were alight courtesy of the late afternoon sun. Leaves sparkled as they danced in the breeze. I parked the car in the usual spot; it was about four. I walked into the main doors of the School where I expected to see familiar faces. But none greeted me - the lights were off and the door was locked. A little disappointed I turned around strolling down two other corridors to the administrative suite were other colleagues reside._

_As I walked gently down the corridor I called out: ‘Is there a nurse in the house?’ ‘Is there a nurse in the house?’ ‘Hello - Is there ... ? Silence._

_No one was around!_

_The office suite, while still open, was empty. I turned slowly retracing my steps in silence yet I could still hear the echo of my voice. My spirit felt the heaviness of what I carried ... All I wanted was to just sit with a colleague and be ..._
Instead of returning to my office I walked out—back to the car! Sitting in the driver's seat I began to think about what this all meant and how my life was changing.

Suddenly I felt a great urge—
I wanted to go back to the ward and be this time with them ...

(Journal entry, late March 1997)
Chapter 8

Confronting subjectivities: pawns in the system?

'I'll go with the patient to theatre and collect Mrs A after I have handed over—is that okay with you?' As we walked towards the doors I did a quick check of all the documentation. Mrs S was obviously very nervous and I found myself uttering reassuring comments as we walked to the end of the ward corridor. She wondered how long she would be 'in' as I found myself saying, 'not for long'. I wondered then if being 'in' was really a comment about being 'in' theatre or rather in the hospital. Somewhat distracted I qualified my answer as I was still in the process of checking the documentation. It had all happened so quickly. Mrs S had arrived at 0830 and now I was escorting her to theatre at 0915. Yes, all the documentation was there except for the consent form; it had not been signed. 'Lyn, the consent form's not signed'; she replied, 'I know, there was some mention that it would be done in theatre!' I wondered about the consent form, did Mrs S have a clear understanding of what the procedure involved? Was she properly informed? Would she sign the consent form under duress? As we moved towards the elevator I decided to quietly ask her about the impending surgery. Mrs S was going down for a dilation and curettage—a D and C. I reflected on one nurse many years ago calling it a dust and clean! Lyn called down the corridor 'Mrs L is next on the list, can you just check and see if they are on time?' Through the heavy doors of the ward and with a personal care attendant pushing Mrs S on a trolley, we moved towards the foyer to find the elevator.

(Journal entry, late April 1997)

This chapter commences by referring the reader to Appendix 5, where participants talk about coping and how in accommodating change and living with the busyness they identify themselves as 'pawns in the system'.

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To what extent is the notion of women 'coping' rooted in the historical location of women's oppression? Is being able to cope part of the dimension of performance, a behaviour, something that masks subjectivity? By rendering invisible the subjective dimensions of practice those in privileged positions in the organisational hierarchy are able to engage in the ongoing neglect of what nursing entails (Davies 1992, p. 239), thus widening the gap between those who make decisions on resource allocation and thus control even in an indirect way, those enacting care. Does the neglect also contribute to the isolation that individuals and the collective group feel in their work?

Do those with organisational privilege divest the physicality of women's work at the expense of subjectivity and in doing so render the emotional labour as something different to, separate from, or other, than the acts of nursing themselves? Such separations render invisible the emotional labour constituting part of the unproductive dimension of women's work purely because it remains outside the scope of that deemed objective or, indeed, that which is scientifically imputed.

We arrived in theatre only to find that again this week renovations were still causing a sense of disruption to the reception area and also to the whole theatre complex. Mrs S remained on her trolley which the attendant 'parked' in the middle of the corridor. At right angles to us another corridor linked the reception area. You could just see part of the length of this hall looking from right to left. People in theatre garb - the hurried steppings—walking up and down—the rhythmic click clunk on the floor—pause—quietness; someone occasionally peering into the rooms through the small windows in each of the doors. One staff member, a little shorter than the rest perhaps, leaped into the air trying to get a glimpse of what was happening in one of the rooms. We waited for someone to meet us. No one attempted to say anything, least of all offered a smile of acknowledgment as they raced by. It was as if we were invisible. We waited ...
Mrs S started to talk about her home situation and expressed her concern about the surgery. She did not want to leave the children on their own for too long for her partner was not really able to cope with them for any length of time. In addition she was looking to return to work as soon as possible, having only taken today as a day of leave. Mrs S was obviously nervous; we talked about the surgery and what might happen if she stayed overnight in hospital. As our discussion became more in-depth, a doctor (known as such only by presumption) arrived, asked her to sign the consent form and then she was wheeled away. I felt very uncomfortable leaving her almost mid-sentence, unable to hear what was really troubling her ...

What was it that made me feel uncomfortable? Was it that I should have stepped in earlier asking someone to help us or was it that I was concerned for Mrs S who was worried and somewhat ill prepared for the surgery, given her home situation? Was I making too much of all this? The fact no explanation had been given by the doctor also played in the back of my mind as I wondered if my response would have been the same in the event that the doctor had been a woman?

(Journal entry, late April 1997)

Points from outside serve to create inner imaginary boundaries bifurcating the self, tearing the self apart in living a schizophrenic existence. Lines differentiate and exhort the different selves as multiple appearances which are understood by those within the group. Are these lines representations that act at some point to demarcate a moment in which the self becomes incapacitated in the relationship with the client in order to maintain professional boundaries? Does such a notion of distance support and sustain the displacement of both individuals in a sort of false imaginary, part of one's false consciousness, a consciousness that separates the private worlds of both the nurse and patient, and one that reduces the nurse's agency from a meaningful relation to the objectified location of the public self?
The public self, keeping up appearances, reflects trying to fulfil the expectations of others. Meeting these expectations becomes paramount in avoiding the fear of disapproval. It is a situation which is perpetuated by the dominance of prevailing ideologies in which failure becomes understood as both a personal deficiency and a question of one's competence. Incompetence and personal failure allude to personal inadequacy (Davies 1992, p. 233) deficits that require attention so that they can be corrected. It is not surprising that nurses have a tendency to blame themselves for failure in this regard; after all, apportioning blame to nurses because they feel they are unable to cope with the workload reflects a reified depiction of their labour, work that is historically and contemporarily embedded in present representations of women and the coinciding rhetoric of questionable confidence in women's ability to solve everyday problems. In addition does this fear of failure constitute a sense of intellectual inferiority: a feeling that stems from the historical pejorative positioning of women with nature and their biological inadequacies? Even while there have been attempts to disrupt these stereotypical images of women's intellectual and emotional inferiority in relation to men, male privilege continues to be exhorted. Strategies that discern not only what counts as knowledge but also the means by which such knowledge is accessed and the ways in which one develops intellectual authority in the context of such knowledge (Code 1988, pp. 68-70) operate successfully to continue to exclude and sabotage women's epistemologies (Cox 1996, pp. 90-97). One such example is the pace of work in the ward and feeling that you have never really completed the activities in hand. These feelings arise from the idiosyncratic nature of the work itself, where the demands of individual patients are never the same, where work lacks consistency or any sequential pattern (Cox 1996, p. 97). The busyness, too, limits opportunities to engage meaningfully in reflexive conversations or journalling, both of which have the capacity to inform understandings and shape the wealth of practice knowledge. Clearly, the patterns of work are far from orderly. It is in this misalignment between reified and hegemonic organisational expectations of work as ordered, patterned and predictable and that of the reality—messy, constant, with lots of
interruptions, that women in particular find themselves doubting their ability and whether or not they can cope in the work environment.

Nurses trying to keep abreast of the idiosyncratic nature of their work often use language that reflects a challenge; the aim of this challenge is being able to perform or cope with the situation. The meaning contained in the discourse reflects an image of a war—part of the masculinist culture pervading the institution (Cox 1996, p. 93) in which being defeated means to loose. Is being defeated about making too many compromises, ones that result perhaps in widening the gap between nurse's expectations of what nursing should be (thus raising questions about her moral agency) and those decisions which in turn reflect a reality of work that is shaped by administrative imperatives and endorsed through nurses' willingness to work harder with less? After all, working harder with less places nurses in a position that enables them to feel less dependent upon other staff members, albeit to avoid extra nurses being sent to the ward which, in turn, incurs both financial penalties and or ridicule (Davies 1992, p. 238) from superiors.

Are winning or losing located in dealing with an object reality, one that relegates emotion to a separate sphere of being, out of touch; one that remains invisible to the self and through such neglect renders the individual as two separate selves, one a mirror image of the other but beyond reach? Is neglecting this subjectivity to position emotion in a private world of otherness? The metaphor of war highlights perhaps the extent to which the notion of coping reflects the separateness of the self, a war within the self that patently needs to be won in the context of doing care. Yet, does this metaphor of battle reveal something of one's false consciousness in terms of binary distinctions and the ways in which understandings have been enculturated into oppositional modes of thinking and the implications that this might have on developing alternative courses of action? Thus, is the war a metaphor that creates a boundary (Rudge, 1997, p. 78) acting to limit meaning making?
Does this perhaps highlight the tensions created from the notion of boundaries: ideological images of keeping the private self—woman—distinct from the public self—the nurse? Does the coinciding rhetoric of the cool competent disinterested other—a woman avoiding emotion because the legitimate order claims that feelings may unduly influence (her) objective judgements in assessing a patient's situation (Jaggar 1989, p. 393)?

Are you seen to be objective if you are a 'super coper' (Lyn, margin notation, T:4, p. 2)? Certainly, if you are able to do more with less! The super coper responds to the 'coping management' achieving the designated work within existing resources. Yet like a game of dominoes a ripple effect is created placing considerable pressure on the Charge Nurse and associates, which in turn has the effect of generating pressure on the staff as well (Davies 1992, p. 238). Circumstances such as this may act to support the camaraderie of the group or it may generate ill feeling.

Arising from their individual and collective support for one another, the group's solidarity increases simultaneously acting to endorse the staff's isolation from the nurses elsewhere in the institution, and in doing so, alienating the group which in turn invites horizontal violence (Duffy 1995). At the same time, it may also work to engender discontent amongst the group itself resulting, in particular, in individual nurses withdrawing from their relations with colleagues, a situation that may explain why it is that one or two staff members are later described as 'not working as part of the team' (T:8, pp. 5-8). It then becomes possible to see that those who, in the main, cope are believed to be 'good' team members and support one another, whilst those who are finding coping difficult are inclined to abjection. Equally, coping may also be seen to be a sign of passivity, toeing the line, or endorsing the status quo (Davies 1992 p. 240).
Distributing power

Raising reflexive questions about the self as woman and nurse helps to foreground the gendered relations with the ruling. As Davies (1992, pp. 242-243) notes, no other health profession more clearly exemplifies the unequal distribution of knowledge and power than does nursing. Insomuch as this unequal division of labour exists, it does so precisely because the ideological content embedded in existing divisions of labour remain obscure, masked behind appeals to science and debates that focus on the nature of 'legitimate' knowledge and access to it. Moreover, the ways in which gender acts as a category, one that assists in structuring relations in hospitals, endorses a form of bureaucratic logic that seeks to clearly separate the private from the public world. It is a separation which is also implicated in the enactment of care and the gendering of nursing as women's work, as well as nursing's associated images of dedication, self sacrifice and altruism (Davies 1992, pp. 243-235). Is it any wonder then that the expectations of the public continue to anticipate that nurses remain as they always have, in the image of Nightingale, a stark contrast to the organisational pursuit of efficiency?

Past and present stories promulgated by the media serve to shape the popular imaginary with icons: doctors as 'godlike', beyond reproach; doctors as the sexy youthful Adonis—doctors as white male heterosexuals with privilege; or doctors as the authorial father; the patient—childlike and vulnerable acting with deference; the patient as the silent participant in the medical care received; the patient as victim—quiet observer of their body upon which others work; the person constrained—trying to avoid incurring the wrath of the medical practitioner—the voiceless reducing the risk to their body? But what of the images of nurses ...

... and their work? Is it secondary only to the 'saving of lives'; menial perhaps in comparison? The notion of menial work suggests some practice activities are clearly ranked as more prestigious than others. Where, for example, the dramatised version of hospitals valorises the technical prowess of certain practitioners, other colleagues'
actions become marginal. What are depicted, however, are images of people that are in pain, those that are overtly suffering; illustrations that serve to horrify, thus presenting to the audience a drama that contains content revealed within the texts, a politics of perverted disembodiment. Such a politics disenfranchises nursing in the context of the space in which caring acts take place. In addition this disenfranchisement continues to endorse and sustain traditional ideologies that subordinate and render unimportant nurses' body work, as well as their bodies ... in what ever attire they choose to wear. Comments related to image, such as those made by Diana and Vivien about the labelling of women nurses as 'tarts', remain prevalent (See Appendix 5).

Acting as text, dress symbolically depicts particular images of groups signifying roles and social relations within the hospital's divisions of labour (Game and Pringle 1983, p.114). Dress codes not only mark out the territories where one belongs but also, implicitly, where one might traverse, as can be seen most visibly in the theatre garb.

**Identity politics**

**Body work**

The implicit messages conveyed in dress also continue to carry with them other legacies of the socio-cultural kind; significances (Bordo 1990, p. 96) which mask gender, sexuality and privilege. The wearing of uniforms by nurses in particular is connected to the religious and military traditions of the past.

> *Even when I trained, all nurses dressed in highly starched uniforms that chaffed the body often to a point of bleeding. Despite learning how to stop the chaffing, these small abrasions almost acted as a reminder of the pain others felt when wounded. Perhaps the constant rubbing encouraged one to place one's own discomfort at a distance enabling the body to get on with the work ahead—the useful body.*

*(Journal entry, February 1997)*
Was this part of the process of enculturation in which binary distinctions endorsed two quite separate selves, the nurse and the person? Or was it that in the act of blood-letting the nurse as woman, as person, took on a new image, as if by bleeding from an incisional wound acquired from the starched edges of the clothing, the nurse was cleansed from the ravages of disease or evil reminding her of her alignment with nature—to be purified?

Historically, the wearing of white uniforms conveyed an image of purity, virginity or the 'good female nurse' (Street 1992, p. 22). This legacy of the Victorian era has successfully been sustained through the various social constructions, for example through popular culture, an image which Ashley (1980) asserts exhorts misogyny. In the past, long untailored garments only interrupted at the waist with a belt, served to desexualise women, hiding their naturally curved body from view. Moreover the desexualisation of women in nursing has been favoured by myths that consider women symbolically aligned with evil (Griffin 1984, p. 9; Griffin 1981, p. 119; Ashley 1980) or through menstruation, with nature (Griffin 1984, p. 85; Starhawk 1982, p. 5).
It was not only because women had knowledge about healing, birthing practices or herbal remedies that they were the subject of persecution as witches (Griffin 1984, p. 15; Colliere 1986) during pre-Victorian times, but it was also because women were considered to have knowledge of the erotic; hence, like the sirens of antiquity, women luring men to succumb to their carnal desires of pleasure. In order to change this view, Nightingale in particular sought to disrupt, albeit temporarily, the Sairey Gamp image of nursing—the drunken, misguided creature, the profane—appropriating the image of nurse as sacred, carrying the lamp as if to light the soul. Adding to the depiction of purity, images of women continued to portray a sycophantic disposition, a construction of femininity depicted passively in the ultimate submission—death. These depictions of the sensuous premorbid woman seemingly sleeping allowed the (male) onlooker to gaze at the woman, engage in some sort of lustful fantasy and retreat from temptation knowing that it is only an image (Dijkstra 1986, pp. 62-63). Such iconographic representations of the innocent sacrificial virgin reveal to the viewer an object representation of the virginal (ideal) woman, one which calls attention to would be possession, even exploitation, but also to be pushed asunder; the seducer, the other—perhaps—would-be male.

The extent to which the ideal woman has been inscribed in the stereotypical depiction of nurses remains problematic, for such stereotypes see woman as victims (of male privilege) incapable of any form of agency and therefore in need of (male) protection (Cornell 1995, p. 99). The contradiction of being victim to men and yet requiring protection by men highlights, perhaps, the insidious ways in which the control over women's lives has been difficult to resist. Notions of passivity through the inscribed imagery of ideal womanhood reflect forms of sexual submission disclosed perhaps in the ultimate expression of power over women—rape. These reminiscent images parallel those of women today, subordinated albeit in a different historical context as part of the pornography industry.
Cornell (1995, p. 106) in focussing on heterosexual pornography, suggests that pornographic material is considered to be the open degradation of, exploitation of and violence against women. She is robbed of her personhood through the exposure of her body—bit by bit revealing her flesh, those parts of her body that stimulate heterosexual desire or imply the sexual acts in his imaginary. What power she has! He loses himself in his fantasy stepping into his flesh in the control of her body. In the context of pornography it is clear that the disposition of women is that of object, devoid of self, a body positioned at a distance enabling sado-masochistic fantasies (Cornell 1995, p. 112) and which might be better understood as a commodity to be manipulated.

Drawing on Lacan's analysis of the phallic mother, Cornell (1995, pp. 126-132) explains that it is precisely because the phallic mother (a fantasy) possesses both female and male genitalia, that the woman becomes the feared other. The phallic mother has the phallus and thus the ultimate control of the terrified man for, in his unconscious fears, he is depicted without his penis, the phallus is displaced in the hands of the phallic mother. She becomes the ultimate object of his desire. This is because the phallic mother is the all powerful figure. She is capable of seducing him while at the same time being able to grant the man his power. Understanding that in aligning his desire to recapture the phallus in order to make himself whole, (in control) and at the same time taking seriously the phallic mother's threat to withdraw his power and thus his independence, both scenarios work as threats to his integrity. They form a nexus situated in the notions of desire and object woman or seductress, and one where he realises his own vulnerability and the potential for his own humiliation (Griffin 1981, p. 121).

It is this Cornell (1995, p. 134) suggests, that might help to explain the heterosexual pornographic depictions of subordinated women. Where women's bodies are rendered the object of men's desire, bodies for men to control and where, as objects in a material world, binary oppositions become evident in the playing out of the
dominator and the dominatrix. Despite the fact that cross-gender roles are 
interchangeable in the pornographic sense, they remain perverse. Women are stylised 
in their portrayal as 'bad girl' representations serving the interests of patriarchal power, 
and where challenges to such discursive encoding is at best difficult, at worst 
impossible. As Cornell (1995, p. 139) points out, much of the difficulty in such a 
critique can be located in the dualism of body and mind, pornography being regarded 
in behavioural terms, and thus in cause–effect relationships.

If Cornell's (1995, p. 148) assertion is correct in that pornography is very much a 
masculine symbolic image played out as a fantasy within the (male) unconscious, and 
while such images remain as constructed truth claims about women within the public 
domain, they will continue to forcibly influence the self image of the viewer. In doing 
so, pornographic images of women, whether disrupting the woman's self integrity by 
objectifying her body parts, or whether they convey the violation of women (as in 
rape), such images will remain imprinted upon one's imaginary self. Put another way, 
through the blatant depiction of women's violated bodies, women's self identity will 
continue to be encroached upon, harming the feeling of body integrity (Cornell 1995, 
p. 148). But this damage to the self of the woman/nurse does not end there. Her 
humiliation extends to the fullness of her very existence in life and in death. Her death 
we mourn as if part of ourselves dies with her; the loss then is part of the self, her 
body and my body; her body subjected to the gaze of the other which is also my body. 
Silently tears fall. She feels in her emotion the unification of her selves, a unity that is 
thwarted by the humiliation she experiences. Her voice is silent.

In granting her choice the male must retain control (Griffin 1981, p. 131) of her body 
but under another guise, in her attire, in the white the body of the estranged virgin or in 
the corporate blue the body of material possession. Are these then the vestiges of a 
denied reality, a disguised image of the self whom he seeks to control through the 
delineations of territory and privilege?
Thus what one wears restricts and/or enhances one's ability to move from one location to the next acting as a form of privilege. Designated colours and patterns also reveal one's position as well. Navy blue skirts or pants/slacks are relatively standard; however, tops depend on one's employment status: pin-striped shirts of white, dark blue, and tan for the personal care assistants; pale blue 'blouses' for enrolled nurses, and white 'blouses' for registered nurses. What a fashion parade—matching navy blue shoes complete the outfit!

Nurses can also choose to wear the traditional white uniform, as do Annette, Vivien and one or two other staff members. Although one can choose blue or white shoes, they remain a personal selection, something that persists as a competition to see just who can get the most fashionable ones (Cash 1995, p. 7).

It is well worth asking if the purchase of the most fashionable shoes reflects one's resistance to the power situated in the uniform. Not only does what one wears reflect power relationships (Game and Pringle 1983, p. 114), it also reflects the corporatisation of health care and an allegiance to the white, male, heterosexual, middle-class, corporate world of professional elites (Bordo 1990, p. 104). Moreover these icons remain tied to the continuing legacy of the 'good nurse' (Street 1992, p. 22), an image of angelic perfection, bitch or whore (Ashley 1980). But the donning of a uniform also represents the nurse as someone being, as well as working, in a world of the depersonalised other, another world ...

_I wondered if my attire had something to do with the lack of explanation by the doctor. If I had been wearing what was typical for an RN—either a white uniform or blue pants and cream shirt, would the response have been the same? I felt we were completely ignored and was angry too that the doctor had interrupted our indepth conversation as if it didn't matter. Yet, when other RNs arrived, the approach was different ... Before I started, I had spent time thinking about what I would wear. I had acquired a pair of dark blue slacks just like_
the students wear and these would match one of my blue and white striped shirts. I had spotted them at the shop where students buy their uniforms and they were on special! What a bargain!!! My shoes were from another era when, as a Charge Nurse, I purchased them at the time the hospital changed its uniform to a more corporate look. My shoes were no fashion statement but much to my amazement aroused some comments on how 'fantastic' they were!

In making these choices about what to wear I was very conscious of the uniform as a signifier. I wanted to be just like the staff, well almost, a little bit different, not readily identifiable as one of 'them', but not too different either. I wanted to fit in ...

But this gear was not going to help me pull any weight ... and I didn't have my various badges on either!

(Journal entry, early April 1997)

... where what one wears carries a group's symbolic content. Dijkstra, (1986, p. 29) for instance, traces the various historical images of women conveyed in paintings as representations. In the Victorian period these images are those that reveal men's sophistical portrayal of women (Bordo 1990). They are often perverse artefacts that act to sustain prevailing ideological views of women. Changes to nurses' attire, for instance, disrupts the image of the 'desirable picture of womanhood' promoting a new image one of sexual ambiguity. One wonders then, if this changed version of women's image, one that challenges the traditional depictions, acts to generate a sense of anxiety (particularly for men) regarding women's affiliations. Does women's sexual ambiguity encourage the objectification of women's bodies and the phallocentric desire to control (Dijkstra 1986)? The disrupting influences of sexual ambiguity call into question women's passivity acting as a source of resistance to the taken-for-granted dominant discourse of heterosexuality (Cash 1995, p. 7) and the politics embedded in the commodified body and bodily inscriptions (Grosz 1994b, p. 71).
Making public the body of the nurse by exposing it to herself as a derogatory image of women, serves to commodify the body of the woman/nurse. Possessed thus, she is symbolically controlled, humiliated in the public (male) gaze. She relinquishes her body as the object of control. Are her cries audible?

Having left Mrs S I walked around to recovery. I stood there waiting—waiting for the nurse to hand over to me to take Mrs B back to the ward. I did not know who this person was; he was dressed in theatre gear but I finally gathered he was an anaesthetic nurse only because of the recordings he was making. I wondered why it took me so long to realise that he was a nurse? The nurse was moving quickly between patients, taking their blood pressure, checking colour, warmth, movement and sensation, looking at dressings, searching for aberrant signs. I waited and watched, and waited. Suddenly I realised there were no curtains separating patients, no attempt to give these people a sense of privacy.

What a wonderful example of the panopticon so aptly described by Foucault (1977). Each person is assigned space, the equipment acting to segment the room into definitive areas. Placed thus the patient can be observed by all, 'under' the watchful eye of the staff ...

The theatre towels covering the woman were flung back, her leg was hoisted into the air and her genital area exposed to the scrutiny of all—her peripad was checked ... he let her leg go—flop—it fell awkwardly back into position on the trolley. I stood there aghast ... I found myself speechless! The lower part of her body remained partially obscured with the towel but her upper thighs and buttocks remained exposed. If I said anything, what would be the political ramifications for the staff—for Annette—for myself as the stranger here? I remained silent—enraged ... Suddenly as if by accident I found myself walking over to her—draping the towel gently across
her body and asking her quietly if this was more comfortable ...

Was my silence reflecting my own position, one in which I chose not to act, perhaps fearful of the consequences? Or, was it that my self surveillance was engaging me in complicity, avoiding confrontation and thus preserving both my position and endorsing the status quo?

(Journal entry, late April 1997)

Silence speaks in jagged echoes around the room. This corporality, that of the sexualised body of woman, has and remains an unrepudiated body, a body inscribed as carnal knowledge, ritualistically assaulted by the imposition of wounds to the exterior surface, a result of power enacted by those engaging in medical surveillance (Grosz 1995, p. 35; Foucault 1977). It is almost as if the surgery itself and the care in the post-anaesthetic environment afterwards serve as a kind of symbolic punishment for her carnal knowledge. Her body deemed dirty is thus subject to the normalising effects of the surgery, a point at which she is not only defiled, but also a moment where she surrenders to the power of an external authority. The surgery acts as a cultural text marking the terrain of her body in ways that both exhort the superiority of medical knowledge (Grosz 1995, p. 35) and confine the corporeal knowledge to the private sphere. Moreover, the nursing attention works to objectify her body, alienating her sexual identity from the person she is, a form of estrangement where a woman is unlikely to see herself in her own image but rather as a duality; herself, and the stranger inside, part of a dominant imaginary hostile to one's being (Bartky 1990, pp. 38-42). Stemming from this imaginary, the woman's corporeal knowledge can thus be discarded as a fragmented consciousness, an irrelevance to the preordained. It is precisely because women's bodies in particular mediate dominant social practices as inscribed texts, that certain judgements associated with accepted cultural terrain become 'written' on the surface of her body, lines acting as transgressional recordings of body's errant ways. Indeed these marks on the surface of the body become enfleshed, written in the body, becoming part of one's interiority. These
understandings become lived out in the everyday world of material reality, as the
inscribed self, a body located in spatial relationship within a world in which one
engages. But the body is not just a body in a location, for it carries with it the cultural
artefacts that not only define its location but also shape the relations as part of the
body's being in time. In addition, the space surrounding the body also becomes part
of one's exteriority as a social extension (Grosz 1994b, p. 79), some areas
surrounding the body being more vulnerable than others. Sensitivity within this space
not only varies between individuals but is heightened around portals of entry and exit,
the mouth, anal area, vagina, etcetera, and includes attenuating bodily products,
menstrual blood, urine and faeces. Grosz (1994b, p. 80) notes that variations in
sensitivity are 'psychically, socially and culturally "privatised"' and as such are prone
to concealment.

Perhaps it is because of these sensitivities that nurses find themselves working with the
enfleshed body, the private self, in ways that render invisible their work. Relegated to
the private sphere also are other everyday practices of nurses as they engage in
working the spaces that constitute both the image of the body/nurse and body/client.
The space occupied by both is one that connects the embodied selves of patient and
nurse, reinscribing one another's exteriority in intimate ways. Neither want to speak
of what is mediated in these spaces, for they are acts that make public the private selves
in a manner that exposes one's vulnerability as the public body of the self. Close
contact with extensions of one's enfleshed body through body products (such as
blood, saliva or excreta) retain something of the body image within them, projecting
the same sensitivities from whence they came. Thus, body products become coded
with socially constructed meanings that reflect their importance and/or significance. It
is precisely this encoding, those meanings attributed to these products, that confines
them by extension to the same judgements or attitudes inscribed within the body or part
thereof. For Grosz (1994b, p. 81) these associations depict a sense of narcissism, the
enfleshed being as loved by the self, while the body products and the meanings
attached to them are something to be repulsed. Thus excrement, for example, can be
deeled dirty.

It becomes possible then to appreciate the ways in which the body and its image serve
as an exterior surface, an inscribed surface which connects the enfleshed body of the
patient to the exteriority of the nurse. The merging of these two spaces becomes the
location and the medium in which nurses work. It is a space charged with multiple
meanings emerging out of the various constructions that both individuals bring to bear
within this space. Because nurses work within this space, much of their everyday
activities and relations with patients remains invisible as part of the extension of the
body abhorred. Exposing sensitivities that remain cultural taboos, nursing work
sustains images of women in the context of body care much as the mother does for the
child, and in doing so aligns the practices of nursing with work deemed dirty, work
that is second only to the authority of the distant patriarch. It is precisely because of
the alignment of nursing with the work of the body and its historically mediated
inscriptions, that nursing's contribution to the wellbeing of others remains unclear,
obscured by the technologies which valorise the objectified self as a disembodied state
of being ...

In the transcripts, the group lamented the ways in which their work is generally
invisible to the public. This invisibility lies behind a letter of complaint from a past 13
North patient which was forwarded from administration to the ward. Annette raised
the issue of the complaint and she, like others, had difficulty in talking about it (see
Appendix 6). Did the complaint help to affirm feelings of disembodiment, rendering
the self as other, generating feelings of guilt having failed to fulfil expectations?

    Annette's echo: My mother said I was always being too
          responsible
          responsible

          (I:2, p. 4)
The struggle the staff had in 'coping' with the letter of complaint is detailed in Appendix 6, where as much of the dialogue as possible has been preserved to reveal the depths of anguish they experienced.

Does guilt serve as a form of self surveillance perpetuated with a complaint? Complaints, especially when written and forwarded to administration, expose the staff to criticism that plays on nurses' inadequacy—not measuring up to either the historic image of the dedicated nurse, nor to the present images being generated by the media or by the bureaucracy, that of the problem solver, even the technician? There is an obvious sense that damage has been done; no recourse exists for the staff, no possibility of an explanation to those in power, just the overwhelming sense of betrayal. In many respects the sense of betrayal arises from a number of contesting claims: claims that surround the idea that they failed to care, as well as others, the institutional imperatives, those that endorse competition in and amongst employees, set standards, respond to the customer's requirements, and place emphasis on individualism (Massey 1995, pp. 110-111) rather than any sort of group-based enterprise, in this context, 'the team'. Moreover, it is through the institutional imperatives, those of efficiency and effectiveness, that at times nurses come to construct their work around activities that reify and render hegemonic the separation of body and mind, a dualism, enacted through the doing of care. In particular this separation is enhanced with the use of problem-solving techniques, nursing diagnosis or by engaging in habitual actions that serve to render invisible both the patient's and nurse's subjectivities. This dualism, the body and the mind, stems from the assumptions underpinning the notion of reason itself and the masulinist versions of rationality which ordain sexual divisions of labour along intellectual lines.

Tracing reason historically, Lloyd (1979, p. 25) puts this concisely, suggesting that 'given an already existing situation of sexual inequality, reason—the godlike, the spark of the divine in man—is assigned to the male. The emotions, the imagination, the sensuous are assigned to women. They are to provide comfort, relief,
entertainment and solace for the austerity that being the man of reason demands'.

Lloyd's comments on the influence of Cartesian ideas on rationality were such that the 'Man of Reason' must control and discipline his imagination, train his intellect in the exactness of scientific inquiry, and must transcend sensibilities, leaving women confined to what was deemed as the non-rational, the field of emotion.

It is in the Cartesian tradition that dominant masculinist views of rationality have been sustained as part of the social imaginary, images of masculinity and femininity tied within symbolic structures (Lloyd 1997, pp. 288-289) that support particular understandings in the everyday world of practice. Is it any wonder then that the staff feel betrayed; after all they are in the first instance, enacting care that the scientific tradition supports, and in the second, they are separating the body from the mind thus appearing to act rationally. But in acting rationally they have neglected to 'care', a situation that has resulted in an expression of dissatisfaction and a failure to meet expectations.

What is it about a complaint that acts to enrage? Could it be about the contradictions located in notions of rationality? Is it that one feels guilty for not enacting the sort of care to which one aspires? Does it call into question the notion of the 'good nurse', highlighting the moral and political understandings embedded in caring (Cash, Brooker, Penney, Reinbold, and Strangio 1997, p. 250)? It is no wonder that some feel angered by what one might call a sense of betrayal amidst a work-load that requires nurses to do more with less or, in Vivien's terms, where 'Vonnie moves her legs faster and faster' (T:7, p. 6). It seems as if the patient, in documenting her concerns, is making her perception of care visible. These views become a public statement to those in administration who, for the purposes of maintaining control, use the complaint to endorse conformity (Schweitzer 1995, p. 42). Such exposure leaves the staff open to ridicule and disfavour within the organisation. The complaint thus acts to create awareness of the patient's experience with consequences that invite increased administrative surveillance and a coinciding opportunity to isolate women.
nurses from each other as well as from the rest of the nursing community in the hospital. Further, surveillance strategies introduced at this point remain a taken-for-granted practice. Indirect or veiled threats, such as those that call into question particular nurses' competence in performing their job, or questionable skills on the part of the leadership, act to encourage complicity. As each person reflects on their interaction it becomes possible to see that the complaint is an act of public humiliation not only questioning these nurses' agency, but also something that could cause self esteem to falter.

Moreover, the fact that administration are aware of this complaint and will address the issue in particular ways exemplifies the contradictions inherent in dominant institutional ideologies. The staff then, are caught in the tensions that both surround and arise out of competing claims located within the scientific tradition, as well as those associated with the emotional dimensions of caring commonly accorded to women. Is this then a question concerning being irrational women—the nurses or the woman lodging the complaint? Or, is it about nurses unable to accomplish their work—unable to manage ...

... coping ineffective a nursing diagnostic category that serves to label human responses to life situations and thus generates boundaries that act to confine ...

... potentially marginalizing one person at the expense of others. One of the staff is singled out as being able to care for the woman who complained about the lack of care. In other locations these circumstances may have resulted in nurses engaging in horizontal violence. However, the framing of the language used by the staff offers the opportunity for the nurses to refocus the agenda away from the individual nurse who provided care for the woman, to the collective. The use of the collective 'we' grounds responsibility within the group but at the same time diminishes individual inadequacies, encouraging women to try and create alternative meanings and make sense of the experience in different ways.
What other interpretations are possible? Does the sharing of knowledges work to enlighten? Are they searching for a scapegoat, another group to blame? Is it that nurses feel ill prepared which leads them to questioning their confidence in educational programmes currently available? Considering nursing's inheritance of knowledge development is it any wonder that nurses highlight divisions of labour, divisions that seek to separate intellectual labour from manual labour in nursing, a situation that augments the traditional theory-practice-research gap? As Massey (1995, p. 116) puts it, the separation of conception from execution reveals a social division of labour that considers the academic world separate from practice, and that this contradiction serves to highlight the politics implicit in conceptions of work—between those that 'do' nursing and those that 'think' nursing—distinctions rooted in Cartesian materiality. Such a contradiction also pertains to the epistemic nature of nursing for, as it has been claimed, if nursing is a practice discipline, then it is the practice site from whence both conception and execution arise. Nevertheless, such a position stands at odds with neo-positivist ideologies perpetuated within institutions epitomised perhaps in language such as 'coping ineffective'.

Is coping an expression used to mask what one might feel? In the past nurses shared the common space of the nursing home to talk out loud their ideas, thoughts, circumstances and everyday experiences. The orality of nursing’s culture (Street 1992, p. 18) was fostered in the seclusion of an all women's environment, a culture that helped to sustain one's self in relation to the other nurses, enabling a group identity. Trying to grapple with these sorts of contradictions Etter-Lewis (1991, p. 53) explains that seeing oneself as part of a collective with its own identity enables that 'community identity' to refute the potent normalising images imposed on the group by the dominant culture. In addition, as part of the nursing community, individuals can also construct an image of/for themselves one that might be at odds with the dominant impression, thus contesting reified stereotypes (Bordo, 1998, p. 53). Individual images of the self, while often subversive, are quintessential in the reclaiming of the
'authentic' self through self narrative. Even though one was/is tied to the group as a whole (in this case the nursing community more generally) the location of the nurses' home enabled individual nurses, with the support of one another, to re-assert their self esteem and self identity as if to gather strength to resist the ongoing domination of the patriarchal culture in the hospital.

But the discursive practices of hospital institutions denounce the authentic self as part of the mystique created by the rhetoric of the commodified body blurred from vision by the tensions that surround the metaphor of the body as a machine. It is a compartmentalised body, one in which certain dysfunctional or dead components are erased by an array of medical therapeutic interventions that regard the body as a series of bits and pieces warranting control. Moreover the body as machine is rapidly reinforced by the medical profession who in a somewhat presumptuous way seek to act upon the body as if it were a passive recipient of treatment, only to be further 'worked on' by nurses. Both groups together, in their acts of engagement with the patient, promote a sense of disembodiment, 'you're here to have this fixed'. The patient's experience of illness becomes denied as the focus moves to one's physicality.

_I had finally returned to the ward, having brought back one of the patients from theatre. I could hear Annette's voice as she spoke to someone in the corridor—'aren't you going to first tea? Come on then ...'. I wondered about why it was that Annette always insisted that breaks such as tea or lunch etcetera were taken on time. Who was going on what breaks was written in the open book at the nurse's station. It was very obvious that the times were strictly adhered to, the designated staff leaving the ward on mass. Often Annette would seek out staff members and send them off to tea. If you were engaging in activities with a patient, frequently another staff member would relieve you to ensure you accompanied the others to the cafeteria. It was not until some weeks later that the ritual of gathering the staff going together and sitting with one another, and Annette's adherence to what I now was_
understanding as a ritual, began to unravel. It started as we walked through the heavy doors of the ward, found the stair well and paced our descent two stairs at a time to catch up with the others. Pam had insisted that I go to tea with her immediately. She explained that Annette liked the staff to take their breaks on time because it was important that the ward ran smoothly. If you did not take them at the appointed time it would be unlikely that another opportunity would arise without major interruption to the ward’s activities. I reflected on this comment and found myself thinking about the days when Annette had not been on the same shift. Pam was right, the organisation of activities was affected by the staff going to and from their tea breaks at odd intervals. Although Pam mentioned that on other wards there was not the same attention to when one took their tea or meal breaks, she felt this rather haphazard attitude resulted in the staff not knowing what was going on leaving large gaps in the general organisation of the ward activities. Moreover, she believed staff were unhappy about not knowing who was going when leaving one feeling as if nobody really cared whether you got a break at all. ‘You needed these breaks otherwise it would be too long between meals and you needed to keep the energy levels up.’ Here Pam was not only talking about the physical energy, but rather the energy of the group.

Sitting listening to the chatter of what was happening to various patients, I realised that much of the talk was focussed on sharing understandings that related to patient care. Many times concerns about patients were raised, experiences were recounted, suggestions offered or ideas affirmed. When patients were not the topic of conversation, one of the staff might talk about their lives outside the hospital, their children, relatives or friends. It was in these moments sitting there with the group that I felt involved with them in their everyday worlds, a part of the nursing culture, not estranged from it. I yearned for what had been my other world ...
Returning to the ward after tea, I found myself getting the area ready for the woman I had taken to theatre earlier. As I walked into the area I found a woman standing in the middle of the room. I bid her good morning and asked if she had been admitted yet. She looked at me blankly as if she did not know what I was saying. As I moved closer I could see she was distressed. I asked her whether she was alone or if someone had accompanied her to the hospital. She said her husband was out there—pointing to the corridor. I asked when she had arrived to, which she responded 'only a few minutes ago'. Somehow I knew that she had been asked to get undressed and ready for theatre. Hennie walked in and said that the trolley was on the way up to collect her for theatre. I looked at Hennie who gestured she had no idea what was going on. My attention returned to the woman and I asked her what surgery she was having—she was unsure, having been sent from the radiology department to the ward. 'I have these wires in here (pointing to her right breast) and they are hurting; I can't even move my arm it hurts so much ... ' She began to weep, her left hand covering her face as the tears trickled down her cheeks. I stood beside her touching her shoulder. From the distance I could hear the theatre attendant, 'they're waiting for the mastectomy—I've got to take her now; I can't stall it any longer'. I wondered if she heard. The quietness suddenly gave way to a whispered voice—'I've had these boobs for sixty odd years and I don't want to part with one now'—the weeping gave way to sobbing as I moved to hold her gently in my arms.

Diana walked in, 'Thanks Penny', she said 'I'll take over from here—we have to help her get ready, they are waiting in theatre'. I mumbled something back and then Diana responded 'if she doesn’t go now then who knows when they'll be able to fit her in! It'll be absolutely ages!' At this point I left Diana to help her get ready and went to look for her
partner. He seemed to have vanished. (I found him later in the day room with a cup of tea Annette had got him from the pantry.)

As I walked out of the room I almost collided with Annette. 'Upset?' she asked, 'furious!' I responded. 'Well' she said with a deep breath, 'this is how it is'. Our eyes met one another’s—we turned and strolled thoughtfully down the corridor together. The silence was broken by Annette who suddenly said, 'you don't like it do you!'. 'No, I think it's disgraceful, it's as if they don't really care about how this might affect her ...'.

I found myself at a loss to know how to deal with my anger at that moment. I began to question the tensions; those that arose from knowing that Diana was right; any delay would result in the postponement of surgery for some time and due to such a delay, possibly placing her at greater risk of a 'full' (physical) recovery. Yet at what cost?

(Journal entry, early May 1997)

And what of the body? Scars re-signify one's knowledge (Porter 1991, p. 13) of the self in-relation to the world, moments of realisation in which the self becomes fragmented and destabilised. At a conscious level the instability is foreseeable, the disruption of the embodied self becomes vanquished against claims that threaten life. It is important to recognise the ontological and epistemic nature of this situation (Porter 1991, p. 7) for the woman's agency constitutes knowledge of the self and one's genealogy (Cixous 1994, p. xx) embodied in everyday experience. It is her reflection, the woman that she is now, but shortly the woman she is as a different self. Knowing herself in the context of her being in relation seems to confound the sorrow of the loss of her breast, the loss of part of her sexual self, her identity as woman.

The new lines of the body following the mastectomy mark out a material body signifying imperfection. It is a line just like other lines, yet one(s) that draws attention
to the manner in which her body was appropriated. New lines mark out the pathologised body—forms of material correction endured with suffering—the living with rather than the living without. Was there choice? Being pathologised serves to renounce the integrity of the self, yielding to the coercive tactics of those who deem the disease to be life threatening. These tactics act to disempower women, a claim that rests upon women's inability to make choices whilst vulnerable. Yet it is this vulnerability that enhances the power in paternalism, the power of legitimate knowledge disclosed in veiled threats to life. But these threats ignore women's subjectivities, her body, her being. Instead the fascination lies in the militant cells which are to be conquered—the loss found in the distorted being of woman, the superficial site of penetration into her world. It is a body now marked, humiliated against the crimes of womanhood. She must be conquered, brought to submission then ultimately defiled, destined to become the disintegrating product constructed as an artefact in the image of the father. Is this really the underpinnings of an acceptable form of pornography—killing the mother as a phallocentric act that seeks to protect the ego of the other and ensure his own immortality?

It seems that inasmuch as the emotional needs are considered to be dialectically related to one's physical disposition, tensions in how or in what ways this woman's care was enacted begin to emerge. Clearly, the technical complexity of the everyday world coupled with the demands created by the sheer busyness in the performance of nursing tasks generates an almost tunnel vision effect supporting both habit and ritual in the everyday working world. The picture created is one in which the person/patient becomes disembodied in the Cartesian tradition, the body and the mind are split. Responding to the physical demands of patients as taken-for-granted imperatives that stem from the mechanistic view of medical science underscoring their disembodiment (Leder 1992, p. 121), the nurse sustains this distortion by resorting to habitual activities that not only enhance this mechanistic view but also add to her a feeling of being in control and thus coping. At the same time however, as the nurse gains a sense of accomplishment through the completion of work tied to the object physical
body she further obscures the patient's sense of subjective experience (Leder 1992, p. 121-125).

**Tuning in: Tuning out?**

What is it about the care that one can offer that seems to strike a chord with another person? Is it a situation in which one apprehends another's reality, being 'in tune' and able to grasp the patient's 'bodily intentionality' (Leder 1992, p. 123) as one engages in one another's worlds temporarily? Is it an experience of being that would otherwise be rendered invisible by the mechanistic views inherent in the medical model? Could it be assumed that when a nurse is in touch with a patient's being in ways that inform part of the nurse's taken-for-granted ways of acting, then such engagement comprises part of the nurse's therapeutic agency that goes beyond the confines of the disinterested other? How and in what ways this space becomes constituted remains an enigma. Perhaps it may have been a mutually created location, one in which a relationship was forged out of reciprocal understandings that acknowledge the particular patient's enfleshed world and the context of the embodied knowledge(s) of the nurse?

And what about these experiences that lead to marginalising a client's way of acting to the realm of public ridicule? Is the example of the conversations surrounding the letter of complaint (Appendix 6) as if to suggest that her actions were deemed over the top or clearly psychologically disturbed, not only serving to excuse the patient's actions but also the staff's as well. If one considered the patient's 'strange' behaviour to be 'non compliant' (as in the nursing diagnostic statement) then such a label would, by its very nature, render that person's subjectivity to be marginal. The label acts as a category that endorses dependence on others, allowing the organisation through its structures and discursive practices, to correct the situation (Ferguson 1984, p. 137) primarily by disempowering the patient which at the same time supports the authority of others. Any excuse offered by the staff to account for her 'not so normal' response to her care, loses its legitimacy. In addition the client's complaint having been disclosed to those in power enhances their authority, using the knowledge derived from the complaint as
an additional axis on which to exert control (Grosz 1990, p. 92). What seems to emerge from within these tensions is that both the actions of the staff and the results stemming from the complaint lodged by the patient endorse the institutional ideologies. It may not necessarily reflect what the patient anticipated, nor the alternative meanings that begin to surface in response to notions of care, notions of first- and second-rate care (see Appendix 6). It is perhaps the unconscious division of first- and second-rate care, followed by the acceptance of second-rate care as 'it's just the way it is', that comprise understandings taken-for-granted.

If institutional ideologies seek to commodify the body, are there implications for enacting care constructed around normalised levels or ratings? Recognising the hegemonic and reified understandings that inform ways of acting helps one to problematise the manner in which nurses' scope of practice has been constrained. While nurses recognise that they talk of first- and second-rate care, these categories form boundaries potentially limiting the nurses' scope of practice as they engage in acts of caring. Clearly the ranking of care acknowledges a duality, a binary distinction that drives a wedge more deeply into the separation between the physical and the emotional selves. Despite the acknowledgment that such an understanding does exist, it discloses an uneasiness not only with the ranking itself but with apprehending what it is the patient is experiencing—in being ...

Focussing on the physical displaces knowledge of the self as it is lived in a corporeal world, a situation that endorses the knowing of ideas as a form of intellectual supremacy. Ideas are thus representations, knowledge produced through (mis)appropriation of the world through particular discourses that universalise everyday experience. These depictions disguise the masculinist disposition embedded in representation and the manner in which bodies become inscribed with masculinist norms. Such etching is for Grosz (1993, p. 204) part of the representation of women's bodies which, in their lack of the phallus make the interests of men explicit and legitimate. Male domination through the phallus (or lack thereof) is inscribed in
the various social texts constituting the everyday social world in which men live these bodily inscriptions as a product of inscribed cultural meanings. These systems of representation inform the epistemic nature of a universalised view of the world and one that is depicted as a disembodied self rather than knowing that is corporeal in the fullest sense of the word.

In the living of these texts do nurses not see what is visible before their eyes, or is it that nurses make allowances for those for whom they care? Do the institutional ideologies of power-over encourage caring work as looking 'over' the patient rather than seeing her/him as her or his embodied self, in a performative role that masks their vulnerability behind forms of self that are quite distanced from who they really are? Thus, one's being is masked, and what is seen by nurses is a resistance to the social control of their body (Bordo 1990, p. 85) engendered by institutional authority, a body acting as text.

In re-figuring this text are nurses able to position themselves in the hermeneutical sense 'in the shoes of the other', offering considerable insight into acts of caring and their moral underpinnings? Noddings (1989, p. 185) argues that caring relies on knowledge drawn from reflecting upon one's experience not only of caring but also of being cared for. It is in reflecting on these moments, those in which empathy transcends the experiences of caring acts themselves, that an ethic of caring emerges.

In addition, these understandings draw attention to the knowledge/experience dialectic. Code (1988, p. 65) suggests that knowledge and experience are differentially considered, albeit in the political arena. Experience is always regarded as secondary to knowledge, especially in the context of stereotyping female understandings to authoritative voices who discern not only what counts as knowledge but also epistemic questions concerning the processes of knowledge construction.
Despite trying to turn this experience around as a 'learning experience', it remains a disturbing one. But voicing and affirming these feelings of being demoralised and angry counteracts the feelings of shame and humiliation which contribute to self doubt and loss of confidence (Griffin 1982, pp. 172-173) in one's practice. At the same time the voice of the client is heard. Feelings are shared, made visible in the hearing of one another's stories. The voices of rage become part of a counter hegemonic form of resistance, acts that confront the usual silencing created and sustained by dominant reified practices (Bartky 1988, pp. 76-79) endemic within the lives of all these 'good' women.

The ways in which the complaint permeated the lives of all these women, whether on or off duty, is perhaps best captured in Annette's comment 'we're grouped into one in this ward and your name might as well be pinned up 13 North' (T:4, p. 8). Reiterating the collective 'we' reaffirms that the group needs to bear the brunt of the complaint, rather than individuals themselves. The collective disposition of rage, anger, trying to work through the situation, is cushioned only by bearing the complaint together. Even though several staff members were not involved in the care and could therefore exclude themselves from any misgivings, it is quite clear that the accusation must be carried by everyone. Carrying the accusation by the staff avoids separating women from each other. Including everyone disrupts the possibility of horizontal violence, a situation that arises from the allocation of blame to specific staff members; and, importantly, it acts to support the connections in and between the group, helping to sustain the feeling of community (Frye 1989, p. 122).

Now documented in letter form, the inadequacy of care disclosed in this letter serves as an edifice, a solid stabilising object that reveals to the powerful meanings which symbolically speak to the self in-relation. And of the symbolic, is it the imposed order, or is it what one understands through one's imaginary (Rose 1996)? By what means is the imaginary self an imposed self, a reality of the sights of the self/selves, gazing, reflecting and gazing in/upon the images?
Is this space different from where one was last; a new way of thinking about the complaint?

Multiple angers?

'How dare they complain!' (Vivien, T:4, p. 8)

Jaggar (1989), in an article entitled 'Love and knowledge: Emotion in feminist epistemology', contented that both love and emotion are integral parts of one's engagement in the world. Because of the influence of western philosophical thought along positivist lines, much of what one feels, the emotional self, has been neglected as a source of knowledge. Situations such as dealing with this complaint seem, on the surface, what might well be thought of as a highly irrational and confronting experience. Yet beneath the complaint and in response to it, there exists in the dialogue (Appendix 6) a sense of outrage, anger at what has happened. For the client it was an expression of concern about the 'lack' of care, whereas for the staff it was an issue that such a complaint had been made in the first place. It was almost as if both were angered by what had happened and that this anger served to mask clues as to why it was that the group in particular felt the way they did. Using the term 'outlaw emotions' to describe what might be termed as inappropriate emotions, Jaggar points out that these sorts of feelings may well offer some important insights about which values are being or have been transgressed. Thus, noting the feelings of anger as the 'outlaw emotion' may help to identify that the situation arousing the rage had to do with unjust practices. These 'other' emotions, as Jaggar suggests, constitute feelings that are deeply situated, often arising out of oppression, the privileging of some feelings at the expense of others, and so on. Insights gained from becoming aware of what underscores these emotions can illuminate alternative ways to make sense of
experience, contributing to knowledge of the self and others, which in turn potentially supports change (Jaggar 1989, p. 399).

Annette mentioned to me that she had sent Pam home early given that Pam was so upset. ‘We had a talk about the situation and there was simply nothing she could have done! You know what it's like' she said to me. 'All you can do is respond as quickly as possible and try and reassure the patient'. There was no mention of Pam grabbing the saline packs, nor about the other aspects of dealing with someone with a burst abdomen. 'She did the right thing—she was there for him'. I heard later that the incident had been very difficult, with Mr J going flat in front of everyone's eyes no matter what was done for him. He was extremely agitated and this is what Vivien said made the whole thing awful, 'he was just so frightened'.

(Journal entry, early March 1997)

Yet, fathoming emotions such as anger can illuminate sensibilities such as those surrounding feelings of being let down by another in whom one places trust. It is not surprising that statements like 'as if she's betrayed us almost' echo the sentiments of many of the staff members. Feelings of betrayal often arise when one's hopes are dashed, particularly where there is moral intention located within the hope (McFall 1991, p. 147). For instance, when one engages with another in the nurse–patient relationship, the intention is to support the patient. The work therefore carries with it hope: hope that you as the nurse are doing the right thing in the best interests of the patient—for this is your intention. Hope is thus focussed not only on the now but also upon the future (Cutliffe 1998, p. 755) and while it involves the self, hope is frequently expressed in the context of expectations that revolve around the self in-relation (Cutliffe 1998, p. 755; Kylma and Vehvilainen-Julkunen 1997, p. 365). Hope therefore seems to arise out of an actor's legitimate moral intent and the (assumed) acceptance of the intent by another. It is worth asking though whether one's hopes in-relation to another are shared as a reciprocal arrangement, and indeed whether this sense of reciprocity is also underpinned by intentionality? Nevertheless,
if hope is shared it is highly probable that whatever one hopes in relation to another will be realised. However it could well be that despite these hopes and their moral foundations, such hopes may remain unfulfilled due to the competing claims within women's moral lives. These claims surround the complexities of the multiple identities which are part of material reality within which women live influencing (women) nurses' engagement with one another and of course the client. While the nature of the nurse–client relationship might be discerned as a caring one, it seems important to ask, on what is this relationship modelled? Is it similar to the nurturing relationship seen between mother and child (incorporated in the historical image of the nurse) or is it something else? If it is the former, is such a relationship imbued with familial representations serving the political ends of exclusion (Mendus 1993, p. 141)? Alternatively if it is a relationship in which there is an acknowledgment of the meaning and significance of being a patient as an experience in this woman's life, then the implications of this shared experience may well be found in the romantic values (Gergen 1991) of compassion and hope, connectedness and meaningful engagement (Herth 1998, p. 1058) woven together as part of the fabric of the client–nurse relationship. The latter situation reduces the fragmentation and alienation focusing instead on the particular relationship between these two people and on the hopes, commitments and emotions that comprise the meanings of the experience.

Where one's hopes fail to be met, bitterness becomes an avenue to account for disappointment (McFall 1991, pp. 147-157). Moreover, the patient's disillusionment might revolve around alternative images or understandings of the health care climate, images substantially different from the reality, which together may have added to this complex scenario. Having felt let down, probably betrayed, these sorts of feelings could well have contributed to the patient exercising her right to lodge a complaint. Betrayal and thus the sense of bitterness may have also arisen from existing distortions surrounding the popular image of health care and what the woman client anticipated. Was this how she felt, just as one might feel with the loss of an important dream, one's hope that one will or might be cared for or be cared about? After all it could be
assumed that in her mind it was question of failing to care, a situation which could also be understood in the Kantian sense as failing to enact duties within the realm of practical reason. These tensions are furthered if one adopts an interpretation of the notion of duty as one depicted in the notion of hope, where the desire to care for/about another stems from freedom and possibility (Spivak 1999, pp. 20-21).

From the nurses' perspectives, the loss of hope in a dream that was once possible becomes a point of sadness, regret, even concealment. That the letter was circulated slowly, giving time for people to absorb it, could have been an attempt to soften the issue enabling the staff to deal with the complaint in their own ways and in their own time. Whether this approach was designed at an unconscious level as a concealment strategy to counter horizontal violence from outside the ward remains unknown. It does however, leave the group open criticism. Perhaps circulating the letter slowly helped to down-play any demeaning treatment by those in control (Bartky 1995, p. 363).

Was it part of the dream to corporatise caring? Don't people have a right to health care? Comments such as these are never far from the surface. The notion that business stands at odds with caring reveals a disparate ideological position within a capitalist location. The aim of business in this context is to ensure that the hospital achieves the economic targets negotiated with the state government in order to ensure its status as well as the fiscal reimbursement. Thus the question of capital accumulation or debt servicing becomes paramount to the operation of the institution. In this context care is bought and sold as a commodity.

Living and working with differing values: those of an institutional nature focussed on care as a commodity; those held by the nurses reflecting a vision grounded in an epistemic and ontological position on caring; and those held by the patient which speaks to relations of trust and hope, reverberates in a spiral of competing claims. Trying to think about these claims and work out priorities places nurses in an invidious
position. Gauging what these priorities are or what they might be and then thinking about how to work with them will depend upon the manner in which nurses understand the issues pertaining to the priorities. The way nurses see the order of things may not necessarily reflect the interests of the patients per se but rather, what nurses have become enculturated to understand to be the important concerns. While participants are aware of these tensions they have difficulty coming to grips with making hypothetical decisions about what might be more critical than something else.

How does one feel when one problematises practice by asking critical questions and confronting the self? What does it reveal about the self and one's subjectivities?

(What about me?)

And what of these competing claims? Do they act to enrage? Are nurses left feeling inadequate?

And what about me?

From the metaphorical voice, am I betraying my self through my own failure to act in ways that are more just, given my status? Where is my power in the organisational context and am I trying to grapple with my privilege in relation to my responsibilities? Am I cognisant of my privilege and responsibilities within the hierarchy and do I thus attempt to resist them by forming a new identity (Heldke 1998, p. 90)? Is this new identity, in resisting institutional culture, that of a traitor ...?

... or is it something else? Do my actions as a person of privilege have consequences? After all, I stand here as a nurse and am privy to knowing more about what is medically wrong with you than I can say. I need to overlook this knowledge, conceal it from you, for this is what my position as a nurse requires of me (Heldke 1998, p. 96). So I focus on other things ...
... does this mean that am I a traitor to myself ... and to others?

And what of my body? Can you read me? Are my actions constrained or enhanced by what I—my—woman's body—believes I can/ought to do right now in this situation? Are my moral understandings embodied in my agency, inscribed in my interiority (Grosz 1993, p. 196) that has, in part, been shaped by the socio-political context in which I - my body - myself is located (Dwyer 1998, pp. 33-34)?

Am I engaging in self abnegation?

Strickling (1988, p. 190) notes that where moral self-abnegation occurs one relinquishes one's desires or interests for the moral good of someone else or indeed others. In acts of self-abnegation women, in particular, engage in the renunciation of the personal in order to apprehend another person's views—a form of self-abnegation that may deny one's selfhood either partially or completely (p. 198). Where self-abnegation occurs, and providing that the person has a sense of the self, then it can be an experience that leads to involvement, participation and cooperation. However, where women in particular apprehend the views of another to the extent that self-abnegation becomes sacrificing selfhood, as might be seen in the displacement or denial of the self completely, for example in motherhood, and where such displacement augments the self in the shadow of the other, living vicariously, women are considered by patriarchy to be enacting their moral duty. It is in these instances that, over time, self-abnegation leads to feelings of helplessness and hopelessness culminating in despair.

Thus, tensions seem to exist in the extent to which a nurse's self-abnegation is both enhanced by and enhances their moral position, whilst at the same time sustaining an appreciation of her selfhood that both enables yet preserves her self whilst she acts in ways that apprehend the position of the client. It is not that women nurses have these existing attributes or traits per se, nor is it essentialised in terms of gender either. Just as self-abnegation denotes a moral position usually associated with women especially
mothers, so to are other values such as sensitivity and compassion, values that are more likely to be associated with the oppressed than the oppressor. It becomes obvious then that these features signal the very real politics embedded in dominant discursive practices that seek to depoliticise and subordinate these values, whilst at the same time appropriating them under a different guise, sustaining power (Ferguson 1995, p. 377). It becomes possible to see then that in so far as these qualities exist in women they are not especially aligned with gender. They are designed to consolidate power in the public sphere and in so doing devalue the contributions of nurses, creating an imaginary of inadequacy in the everyday worlds of these women.

And to whom am I the traitor? The patients? Colleagues? Myself? ...

Thinking about the power of the care provider in answering my metaphorical questions reveals only a partial answer to the question posed. These answers are reflective of her moral location, a partiality embedded in her own values. To continue ...

Have I distanced the self from the client by being distracted? Is there an attempt to maintain privilege and in doing so help to secure the self in-relation? To do otherwise would require one to confront the marginal position of the client. Reflexive critique of these positions might add to the disparate locations of the self in-relation. The fact that the letter of complaint stood as a resistant act to the possible totalising effects of the 'lack of care' the complaint experience helped to focus the staff's attention upon their cultural practices. Through the act of complaint the patient asserted a form of epistemic privilege and one that saw to it that the woman asserting her epistemic privilege was different from the rest of the ward's patients. Indeed this act also highlights the subject as a neo-romantic one where, at first the woman is seen as irrational and emotive (Bar On 1993, pp. 94-96) but later, from a more reflective stance, to be an agent that sparks insights into the struggles of a socio-political kind. These struggles are those born out of oppression and it is in the confronting of her voice that the group faces a voice of authority, one demanding care. It is as if the participants are struggling within themselves, a struggle that entangles the self as a moral agent attempting to enact their values in trying to care. Through this struggle they 'other' themselves.
Yet in othering themselves, marginalising their feelings there is a foregrounding of the patient's voice, an appreciation of the patients' worlds as legitimate. Hearing the othered voices can lead to a better understanding of the various locations from which othered ones speak. But whose voices are they really? The voice of those left to carry the voice and the feelings that voice implies? Is the voice the voice of the self—a resistant cry among the audible sounds of private selves made public. Is it the other side of silence—a voice muted through the quietness echoing and reverberating in my head—yours and mine?

Mirror
mirror
on the wall—
just whose reflection stands so tall?

It was later that day I returned to theatre to collect Mrs A. She was in recovery and this time I did not have occasion to see the male nurse who was there on my earlier visit. As I waited outside I had wondered what I would say to him if he happened to be in recovery when I collected Mrs A. As it happened Mrs A's surgery had been delayed several hours due to an emergency and it was now well after lunch as I waited in the foyer for someone to let me into recovery to collect her. Perhaps by luck he was no where to be seen but instead, I was greeted by the very friendly face of a colleague with whom I had had a lot of contact over the past years given she had been/was a student in the various postgraduate courses I had/was chairing in the academic world. She said 'Hallo stranger! How nice it is to see you here!' I felt immediately at ease, her warmness softening the atmosphere which was until that moment a stark and hostile territory with its clinical coolness supported by apparatus attached to the walls, rows of people in an unreal world and colours of insignificance. Greeting one another across the bedscape and noise of the recovery room it was as if our surroundings had no bearing on the relationship we had enjoyed over the years. It was as if
everything else was invisible, just the two of us standing at some distance but immediately close. She inquired as to my activities and I explained why I was there. Our attention was thus punctuated by the woman I was to collect and here it remained. The 'see you laters' were quickly exchanged following the brief but informative hand over ....

She smiled at me as we left recovery to catch the lift to the thirteenth floor. Drowsy in her post anaesthetic state she commented: 'I wasn't sure if you would be here for me when I woke up'
I smiled back and squeezed her hand ...

'Thanks' she said.  

(Journal entry, late April 1997)
Chapter 9

The silenced voice - the stranger within

It was my first day back after several weeks in Canada for conferences. Vivien was on in charge for the morning. I struggled to maintain my attention rather than wander off into another pattern of thought taking me elsewhere; I began to contemplate the ways these women were different; the ways they resisted the authority of the hierarchy and how and in what ways their resistance manifested itself.

I wondered also about the extent to which I felt one of them, part of the team; a member of the group as well. My first morning back after a break of several weeks encouraged me to think of myself once again as an outsider stepping back into the ward.

As the report flowed onwards I listened to Vivien's voice warmly delegating patients to the staff in her own particular style ... 'Mrs So and So is your patient Diana ... ' and thus it went on. A couple of issues were raised as ongoing concerns; for example too many overnight admissions, given that there were ten women coming in for gynaecological surgery during the course of the morning. If these women went to other locations around the hospital, the staff in these other locations may not have the knowledge to care for them appropriately, just as with those admitted overnight. Quite clearly Vivien was referring to the skilling and deskilling of staff, a major political struggle at present. This struggle had been ongoing. The patients coming in overnight should, according to Vivien, have been admitted to a medical ward, they had conditions such as Chronic Obstructive Airways Disease (COAD) and having these people on the ward (mainly men) restricted the availability of beds for women patients. In addition because these patients were admitted to the ward it meant that they
would need to be moved to another ward (or area in the ward) to accommodate the women. There were more comments about putting male patients into female rooms and how women might find this offensive. As Lyn mentioned, older women were particularly vulnerable, not wanting to have their privacy invaded ... 'How would they like it?' (in reference to administration) brought the detailed conversation on mixed gendered rooms to a natural closure, the group agreeing the best way to prevent this from happening was to juggle the beds, moving patients around the ward.

Then Vivien turned to me and said, 'I guess we need to welcome Penny back after her trip—how was it?' she inquired with genuine interest. Somewhat taken aback I began to talk a little about the conferences, the major themes covered, and some of the questions nursing needed to address that arose from the both venues.

Suddenly, however, I found myself moving into talking about the land I had traversed in Canada. The colours apparent in the multiple landscapes in which I had found myself temporarily located: the ice blue of the lakes and the arid escarpment of mountains bearing the scars of glaciers in which patterns of descendence formed somewhat jagged edges to seemingly smooth terrain; walking in the forests amidst the strength of tall birches, cedars and pines with squirrels scampering between the trees filling their winter larders with the necessary food supplies; large black bears with their cubs tracing the boundaries of the forest and the ski runs; driving across alpine marshes in a four-wheel drive, catching glimpses of a moose and her young one finding shelter from the roar of the Ford's engine as it retraced its tracks in order to move forward through the four-foot deep snow drift; and catching in a lake trout that was later cooked simply in a pan over the smouldering of cedar logs, the aroma from the fire filtering
through the atmosphere wafting away just as the day had merged into the dusk and finally to the darkness of night.

(Journal entry, late September 1997)

I was not only surprised at the way I had focussed more on creating the visual beauty rather than the two conferences; I had found myself wandering towards what I had thought the group would be more interested in hearing—the landscapes rather than the conferences and what they had to offer. Why had I done this? Was it because I already knew that the group were much more focussed on the environment than the talk of ideas? Were their local concerns to be found all but fleetingly in the myriad issues arising from either one or both of these conferences? Was it that the images of the landscape made more sense in terms of a deeper impression than the information about what nurses were experiencing in other parts of the world? Was it that the images conveyed painted a story in and of themselves, something that would resonate for each person, given the oral tradition? Was it appropriate that I had made the decision unconsciously to talk about these things and in particular several nurses' experiences rather than papers given at the conferences? Whilst my comments were kept brief I was surprised at the genuine interest that had been shown not only by Vivien but by other participants as well. But again, why should I be surprised? I finished speaking ... the room seemed still ...

The momentary quietness wraps around the group like a blanket as individual members reminisce in their own spaces. It is as if these times are used to enfold the group, cushioning the impact of their worlds in the joy, pain and anger.

Quietness.

**Me and my shadows**

At this point I refer you to Appendix 7, where the conversation revolves around feeling supported at work and where support was lacking and the experience was bleak. The
group shared their stories and were encouraged to turn negative experiences into positive ones, learning from them. What is it about these moments in which individuals are able to surface and share what for them have stood out as profane times?

Is it here that one can see the transgression of boundaries, those fragile moments in which the self is contained and then suddenly, as if to shatter the illusion, these boundaries dissolve leaving the self/selves exposed to the presence of the abject self, the self from which one needs to be protected. But is the abject that which contains the self, a discourse rather than necessarily the body of the self (Oliver 1993, p. 6)? Here it is possible to see that if the body is subject, then the self within the body also has another self like a shadow of the self, a sharing of one's identity with the abject, yet not part of the self or the other. But is this abject a discourse of narcissism arising out of the shadows, the in between. Abjection gains its significance from threats to one's identity and the day-to-day order of everyday life (Wiltshire and Parker 1996, p. 25). The abject, Kristeva (1982, p. 3) claims, is something opposed to 'I', the abject is the intolerable: 'what I permanently thrust aside in order to live'. It is at once something that repulses, meanwhile holding your attention (Oliver 1993, p. 55). There is a certain honouring of these feelings in the ways in which these instances are held; they are not awkward periods, rather times of quiet contemplation in which each person immerses themselves in memories ... other times, in elsewhere communities (Kenner 1998), spaces often steeped in sadness. Suddenly, just as the stillness began it is broken with black humour; threads of deeply held feelings re-emerge.

As participants listen to the dialogue the moments are shared as each one recognises their mutual vulnerability. In surfacing these feelings one exposes dimensions of one's interiority, revealing an authenticity laid bear for others to see. Experiences such as these privilege one to another. There is no doubt feelings are mutual, carried over decades but reverberating around the room in that moment. Situations in time past touch the present, echoing as if they had just occurred; freshly recounted as embodied
depictions of the abject self (Wiltshire and Parker 1996, p. 27), experiences that threaten the present image(s) of one's identity, yet never healed. It is as if such conversations spontaneously act to enhance the containment of the self through self surveillance.

I left the room with a pan, walked down the corridor to the pan room to measure and test the specimen. Mel was doing the same, checking the amount of residual urine. 'The dishwasher needs emptying' she said—'half a tick and I'll help you do it!' It had been a while since I had seen Mel on the ward. She had now just completed her midwifery course. During the period of her studies she had worked casually when study permitted. Now, Annette had offered her a (her) job back on the ward. She said she 'jumped at it because of the attitude of some of the staff 'at ..., the location of where she had been practising midwifery. 'Of course', she said, 'in mid[wifery] your concerns should be about making the experience a women-friendly environment. Some of the staff actively disempower the women, making it difficult post-natally'. Mel went on to emphasise supportive practices such as the importance of 'coaxing the woman through the birth and avoiding using pethidine'. The use of pethidine Mel said 'was difficult because you had a baby who wouldn't suck ... and wouldn't wake up'. Also, they wouldn't listen to your opinion!

(Journal entry, Chatting with Mel in the pan room ... mid-August 1997)

Speaking on/of the self is integral to one's world and who one is within it. How much does one reveal—the inner depths of your being, who you really are as the person? Who are you, or for that matter who am I anyway? Do you see me as the person I am, or another, other than you?

Sharing thoughts about one's background enables others to begin to appreciate a little more of the selves that you or I bring to bear in our working life on a day-to-day basis. It also exposes the self's vulnerability in the context of one's everyday world in terms of the more particular concerns that weigh heavily upon one's consciousness in
everyday action during the course of any particular day. It was these moments, moments in which I opened up to the group that seemed to turn the tide of my being in-relation with my colleagues.

They listened ...

I went to tea with Mel. Suddenly I found myself saying to Lyn and Diana, 'You know I could hardly bring myself to come in over the last week or so—I've been so upset!' I proceeded to say what was happening to me at School, about the difficulties I was having, particularly at meetings where my opinion was not being taken on board; where I would be interrupted when I was speaking and thus unable to finish; ignored or told that what I was saying was irrelevant and so on. Like a rumbling volcano ready to erupt, the emotions accompanying the devastating sadness began to seep through my body. I struggled to remain calm yet the power of these feelings by now was so overwhelming. As the tears fell noiselessly I found myself revisiting the past—recounting the loss—of colleagues who were more than part of a team; of what was shared—a valuing of nursing in its caring epistemology—and most of all the estrangement of self from the other, all acting to alienate. I mourned the passing of passionate visions in/for nursing and the manner in which these passions had been 'snuffed out' just like a candle ... Suddenly, as if from a distance, I could here Diana speaking—she was obviously quite agitated as she said I had to see the Head of School and if she wouldn't see me (which was part of the issue) then I had to go higher—to the Dean. Diana mentioned that 'effectively you are being silenced and that shouldn't happen!'. We sat for some time talking; talking about why—being challenging or appearing to be a threat could lead to a false interpretation or misunderstanding of where I was coming from etcetera. They were concerned for me: 'you can't allow this sort of thing to happen' Diana said. 'Yes' said Lyn 'it's horizontal violence and it's appalling and it shouldn't happen!'.
We talked about caring; about the importance of dialogue: 'stick up for what you believe in—these are important ideas that need to be visible', Diana stated emphatically, continuing her thought with 'you need to confront the issue and find out why she is reacting the way she is'. Lyn gently touched my arm, saying 'it's damaging to your health and you can't do your job well under these circumstances ...'.

In many respects I felt relieved having shared these experiences, and having at last confronted what they were in naming them as horizontal violence I began to see why it was that my world was beginning to change significantly. Until these moments I had been somewhat blind to the ongoing barrage and had not really noticed the ways in which my usual confidence was being eroded. I found myself looking back and being increasingly aware of the change in my speech patterns: increasing difficulty in expressing myself, unsure of appropriate words, and in some instances I could even hear my lack of clarity, all of which were old friends from the dim dark past.

(Journal entry, mid-September 1997)

Looking back now, it was in sharing the details of a dimension of my personal world of things loved and cherished, even if only briefly, that my relation with these women seemed to extend to something deeper. It was perhaps in my expression of sorrow, worry and concern that those surrounding me could appreciate my depth of despair. Moreover that each of these women seemed to share these feelings as if the feelings were resonating with past and present narratives within their own lives, reverberating with an intensity one could almost hear.

They listened ...

As I put a pan in the now emptied 'dishwasher' Mel said, 'like here we plan, help each other out and listen to what each other is saying! You are heard ...'

(Journal entry; Chatting with Mel in the pan room ... mid-August 1997)
Distancing the self

Sometimes I think that it is easier to expose the unthinkable by asking questions that require a narrative. Perhaps this tactic creates a sense of distance between the self who recounts the story and the you who is embedded within it, thus relocating the author and at the same time enabling one to have a sense of power within the narrative. Digging a little deeper, why had I posed the question in this way, asking participants to recall narratives in which they felt unsupported (Appendix 7)? Was I moving dangerously close to engaging in oppositions, just like the haves and the have nots—binaries that exhort the either/or; the one or the other; the black and the white? Did it have something to do with my recognition that the question posed in this way might be easier to answer? Does it assume that experience of something enables one to grapple with knowing that experience for what it is, or for that matter, what it was? That the participants had encountered support from other nurses also raised a series of other questions surrounding the notion of support itself, something that remained unaddressed. It seemed enough to ask the question without teasing out possible meanings right then and there ...

Mel went on 'what really gets me is they really don't hear or they really don't want to hear'. Mel then began to recount a recent practice story about a woman for whom she was caring. The woman was given syntocynin pessaries. Mel said 'she was contracting strongly so I rang labour ward and told them what was happening—strong frequent contractions!'. Mel said she had done what was expected: taken the woman's observations and she had been monitoring the foetal heart. 'The woman had to stay sitting out there in the corridor waiting to go to labour ward!' (Mel's expression was now one of indignation.) 'The woman stood up and her waters broke!'. Mel's tone of indignation had now become one of utter annoyance. 'I rang delivery suite and they said well you better get her down here immediately!' The pans and urinals are now loaded ready for the next dishwashing cycle. 'Anything else to go in? Mel asks. 'No' I respond, 'that's it!'.
Mel gives the dishwasher door a brief push. The door slams closed with a bang, the dishwasher shakes in response, as if acknowledging the angst Mel feels ...

(Journal entry, Chatting with Mel in the pan room ... mid-August, 1997)

Wrapped within the narrative, particular significations are etched in memory. Why is it that these impressions remain over such a long period of time? Is it because these nurses' narratives stem from their moral disposition—an ethical location that considers caring as an exemplary ideal? In instances where such moral positions were thwarted, particularly in the early stages of one's career, did these acts of remembrance serve to inform one's actions? Clearly, for some of these women, their narratives remained sources of outrage reflecting the often invisible effects of horizontal violence.

Violence and the self

Sometimes the stories of horizontal violence depict women in subordinated roles to others; women in subservient positions under patriarchy and, in this context, hospitals. That women are portrayed as subordinate, oppressed, and lacking in voice could be construed as giving a somewhat over deterministic impression of institutional life. One wonders whether this picture, a representation enshrined through the mass media, is part of the recycling process of institutional oppression outlined by commentators such as Warelow (1997, p. 1023) and Delacour (1991, p. 421). Yet in many nursing conversations one is left with an indelible impression of subjugation. The narrative reveals and augments the ongoing obedience to authority (MacLeod 1992, p. 544). In addition, obedience to what now might be understood as institutionally circumscribed rules in the absence of the subject's consent renders a cultural hegemony that seems to foreclose any alliances in resisting the authority of others. Even in the event that such unity were to occur, would acts of subversion stem from the coercive tactics of some members of the community?
Frequently, as Freire (1972) notes, violence arises from agents who themselves have been subject to oppression and who, upon appointment to powerful positions within the organisation, know no other way other than to enact the oppression they have experienced (Freire 1972). For Bunch (1981, p. 194) the source of women's (nurses') oppression is firmly rooted in patriarchy and the colonising effects of white male heterosexual supremacy that permeate through all social and institutional arrangements that structure everyday realities. Understood in this way it is possible to appreciate why it is that many of the commonsense understandings constituting existing practices, by their very nature help sustain the oppression many nurses feel and many attempt to subvert. On occasions, nurses' agency is contradictory and the ways in which this group acts is no exception. For example, could nurses' willingness to engage in subordinate action be designed to help sustain relations in the interests of patients and each other? In other instances could one argue that nurses' willingness to comply be understood as avoiding alienation from their would-be peers? Again, could such actions be understood as an opportunity to engage with others in a culture that supports modernist conceptions of individualism, which in turn vicariously act to discredit the self (Gergen 1991, p. 13)? At the same time does one's obedience reflect the tenets of romanticism, where values concerning altruism and care remain the hallmarks of nursing? Such a parody!

Disguised power, ideologies of phallocentricity embedded in institutional life, work to mockingly enhance one's false consciousness! But is this more than a struggle of hierarchical relationships, ones in which power is embedded in a top-down model of authority (MacLeod 1992, p. 534)? Why is it that what happened to these women all those years ago seems to remain in their minds as unjust practices decades later? It is interesting to note how these stories reflect a variety of tensions and ambiguities, contradictions that work to distance the self from the other self; they focus on the description of what happened and how that participant felt at that time, as well as how they feel now, so many years later. Is it that injustices are carried not only as part of one's cultural heritage but also as part of women's inheritance in institutional life?
Various authors offer some insights into why these ambiguities exist. Delacour (1991, pp. 412-413) argues that powerful discourses (gender, economic rationalism and medicine), those promulgated to support the status quo through the mass media, have subsequently worked to penetrate one's subjectivity, acting to diminish nurses' relationships with one another as well as disconnecting the view of the self from one's sense of self identity. If one apprehends the world to be socially constructed and that one's actions within this world are embedded in one's understanding of the self within it, then it seems plausible to suggest, as does Glass (1996, p. 21), that the manner in which one perceives taking risks will be underpinned by one's ontological positioning in terms of security in one's self identity. Thus, how one sees the risk in any situation will be dialectically related to one's sense of security and issues surrounding interpersonal and self trust (Govier 1993, p. 105). Moreover, the sense of security as part of one's interiority withstands the contradictory practices of either choosing to take risks or to avoid them, remains complicated by one's early experiences as women and as nurses and the importance of conforming (Glass 1996, p. 21) in order gain acceptance by one's colleagues. Glass (1996, p. 21) makes the point that in instances where women radically engage through processes involving critical reflexivity in which power relationships are rendered problematic, 'women can experience an 'inner security' and therefore feel connected at an inner level when they take risks ...'. Such a departure disrupts one's false consciousness, enabling the exposure of the interests vested in existing power relationships and the manner in which such relationships can distort one's reality. By speaking the story does narrative become clearer? One can feel what is taking place within the self. An all too familiar story is this one! And what of you—you like me are an onlooker of the narrative, powerless accomplices perhaps, knowing the text as it is, laid bare for us to see, for each of us in our own ways can add to the tragedy in which looking back, the self becomes separated ...

... a stranger to the self?
Glimpsing into the mirror

Reflection on the self, according to Sartre (1958, p. 150), is the being on which one reflects, thus reflection is the consciousness of the self, looking at the self, being. The self is the image upon which one gazes, just as one might gaze at oneself in the mirror. It is not the experience per se that attracts one's attention, but the image one's consciousness observes. To this extent, consciousness gazes at the picture of itself, the reflection of the self as an image (Sartre 1958, p. xli). As one reflects, one is aware that 'I' is the 'me' reflecting on the image 'me', which Sartre (1958, p. 151) considers to be a consciousness of enduring. In this sense Sartre is suggesting that conscious reflection (knowledge, the 'T') on an experience (an object or quasi object in and of itself, me as the image) is akin to reflection on the reflecting. Here the notion of reflection, that is consciousness, engages in the witnessing of an appearance (reflecting). Both the reflection on or witnessing of the appearance (the reflected) exist as part of one's being, one's interiority; conscious reflection which by its very nature is part of the self whilst the reflecting on something exists as it were outside the self. It is possible to see that Sartre's (1958, p. 153) contention of the 'dissociated' selves exists insofar as the interior self, that is conscious reflection, attempts to grapple with the reflected upon.

For Sartre (1958, p. 155) there is little doubt the reflection constitutes knowledge, knowledge that confirms the object other or that on which one is reflecting. Such reflection affirms the existence of something other and by engaging in an affirmation of the existence of the image, conscious reflection requires that such confirmations are advocated on a basis that one is not that object. Hence Sartre (1958, p. 155) suggests, 'to know is to make oneself other'.

In addition, conscious reflection has a sense of historicity for consciousness is fundamentally living the past, Sartre (1958, p. 155) claims. The past, as lived through the body in the form of embodied reflection, informs the reflective act if only partially, for there is a point at which the reflection on the reflected yields to the limitations of the
reflective self reflecting on the reflected. Here, one imagines that the conscious
reflective self, in becoming the object self, falls prey to the self upon which one is
reflecting and at this juncture becomes the outside self, a disembodied state of being.
Thus in living the conscious reflection the self is able to apprehend appearances by
engaging in binary oppositions, the reflective self which becomes the object on which
one is reflecting. According to Sartre's thesis, what becomes apparent then is that the
self, in its present state of living the past as conscious reflection, is able to consider
possibilities arising from this state. In addition, conscious reflection prompts the
reconciliation of the other, the reflected dimension of one's interiority placed as it
were, outside the self, the appearance, which is now subject to conscious reflection.

Sartre (1958, p. 155) speaks of knowledge which emanates from placing the self as
other. Is this depiction of the self and how one's gazing at the self serves to illuminate
understanding of one's self in relation consistent with the ideological hegemonies
embodied in institutional life? As Weiss (1999, pp. 46-50) argues, women's
embodiment is more inclined to be mediated by her understandings of self in-relation,
an identity constructed from what the woman anticipates others are thinking about her
self, thus giving it a social reference as an object. The body object becomes
enculturated as a split-self, fragmenting one's being. Part of this fragmentation is
about protecting the self from humiliation.

**Being humiliated**

In a study on horizontal violence in nursing in Victoria, Clements (1996) recounts the
humiliation some nurses come across during the course of their careers. Sadly, the
humiliation is wrought against them by other nurses, often in positions of authority.
Ballou and Gabalac (1985, pp. 81-83) believe that humiliation may occur over an
extended period of time with the ongoing trivialisation of one's experiences and the
devaluing and exploitation of knowledge. Moreover, they believe that bearing witness
to these sorts of events can, over time, lead to a general understanding that such
actions are both appropriate and legitimate. Bottomley (1991, pp. 96-105) explains
that strategies such as these ones, enacted by those with power (the ruling) through various structures and processes within the organisation of one's everyday life at work, enhance the symbolic capital of the powerful. As relations of power are reproduced through social processes, over time what were objective power relations become reproduced as symbolic power. It is therefore not surprising that relations of power in their symbolic form are dialectically related to socially reproduced meanings that come to be taken for granted, embedded in the everyday life of the ward and the material world of work. The fact that such relations continue to exist, even in the memories of the participants, speaks to the symbolic violence that has remained imprinted as a cultural artefact in these women's consciousness.

The participants in Clements' (1996) study spoke of moments when their self confidence had been shattered; where acts of humiliation included being 'yelled at' in front of others or kicked in the shin; being made to feel foolish or embarrassed; and, where staff were unkind to one another, everything served to diminish the self. Some of these situations of sabotage and violence were reported to more 'senior nursing staff' in nursing administration but to little or no avail. Where the nurse experiencing the horizontal violence mentioned it to nursing administration, the concern was restated as the nurse's problem. Whether nurses in positions of authority chose either to blame the victim or ignore what was happening, by their actions they condoned the violence and in doing so, perpetuated a culture of intimidation (Clements 1996, pp. 57-59). Moreover, the fact that the horizontal violence was ignored rendered these women's experience as invisible and without foundation. Just as Clements (1996) found in her study, it is hardly surprising that whilst the nurses' worlds were devalued, nurses themselves carried with them feelings such as shame, guilt, anger, doubt and rage.

Shaming the nurse by denigrating her in front of other nurses or patients or where ideas are dismissed as irrelevant, are amongst the many acts that serve to humiliate leaving the nurse feeling very vulnerable. Stevens (1994, p. 220) found in her study that those marginalised felt unsafe and afraid. Unlike the lesbians in Stevens' project
who sought to guard against the many denigrating practices of health professionals, one could well ask if these strategies in nursing continue to endorse divisions of labour between women, as practices deemed natural, desirable and even legitimate under patriarchy (Ramazanoglu 1989, p. 147). In addition it also perpetuates the homogeneity of identity, generating a fragmented culture of (women) nurses. Insofar as patriarchal ideologies are masked behind the social organisation of the material world of everyday work, horizontal violence functions to keep the appropriated power located with the powerful. This is not to suggest that acts of resistance work to disrupt the colonising effects of domination, for clearly they do.

However, in the context of the participants' herstories, their material conditions in their early nursing careers in hospitals were such that the overwhelming ideological hegemonies reflecting phallocentric endeavours were carried with them as part of their cultural heritage. Whether these ideologies were those of economic rationalism and/or medical dominance they remained all-powerful and pervasive. But it was not just a question of rationality, for clearly the myths of true womanhood remained entrenched sustaining the subordination of some at the expense of others.

Despite attempts by subordinated groups to appropriate the culture of the powerful, contradictions begin to emerge as those attempting to be like the dominant culture find themselves marginalised from their group of origin. What makes this situation more alienating is that the culture from whence they came rejects them as well (Duffy 1995, p. 8). Thus, the effects of colonisation run deep within the various personal identities of the oppressed. Strategies enacted by those in power have over the years supported many nurses' submissiveness; for some it is their self hatred and for others still a faltering self esteem. Acts that work to humiliate are designed to foster submissiveness, compliance and divisiveness (Roberts 1983, p. 23). What inflates this oppression is not only adherence to the medical and corporate models but also the rapid rate of change.
For many nurses, concerns surrounding the way technologies have become incorporated into practice have contributed to a stressful environment (Marles 1989, p. 30; Report of a Study of Professional Issues in Nursing (SPIN) 1988). Nursing administration staff have, in the past, acted as situational 'messengers' between those who want the technologies used and those who have to use them, the nurses. 'Technology is a necessary evil' Annette (T:9) points out, and with its introduction many skills previously held by nurses as part of their everyday practice have diminished. Lyn cites the use of intravenous pumps, saying that now 'many nurses are unable to look after drips the old fashioned way'. While the advent of technology is often claimed to save time, this is perhaps a fallacy for the costs of such technologies are often hidden. Jenny mentions that 'caring technologies are a bit of a paradox; until you become competent with the machine you are looking after that machine, which takes away from patient care; its about instrumental activity not human activity!'. Other costs involve 'chopping nursing [staff]; the loss of skills' and, as Lyn continues, 'it's frightening if technologies replace nurses' knowledge—the machine becomes the master' (T:9). These comments serve to highlight some of the contradictions surfacing with the advent of technological efficiencies constantly being introduced into the participants' worlds.

Nurses on the ward often regard these changes with some degree of frustration and it is this frustration plus lack of consultation that further marginalises nurses from one another. Acting as 'go-betweens' nurse administrators support the perpetuation of horizontal violence by denigrating those further down the bureaucratic ladder (Roberts 1983, pp. 28-29) for their inability to adjust to change. Ashley (1980, p. 16) argues that structured misogyny in the material reality of everyday labour is at the root of horizontal violence which has, over centuries, actively worked against women's power and of course their interests. Is it any wonder then that many nurses fail to trust not only those in leadership positions but also their colleagues, and so they stand alone.

_ Mel was clearly perturbed. She began to fiddle with some of the equipment as I put away bowls which I had temporarily_
stacked on a clean bench. Suddenly she turned and said 'Yes, they seem to be angry at women some of them—I don't know why and that also relates to the way they act towards us too!'.

(Journal entry, Chatting with Mel in the pan room ... mid-August 1997)

**Being alone**

Standing alone brings little solace. Feelings of isolation are not uncommon, particularly if one is perceived as different from others in the group. That Tinks felt separated from the rest of the nursing staff (see Appendix 7) is not unusual, for many nurses have felt this way in their work location. Why is it that some nurses feel isolated from their peers and that feelings of being alone or unsupported continue? Does the social organisation of the working world sustain these feelings of estrangement? Do the structures and relationships initially developed by male misogynists in health care bureaucracies and subsequently enhanced by women in the world of work, act to fragment women nurses' power and mask their interests (Ashley 1980, p. 16)?

Clearly, ambiguities begin to surface when raising questions about various work practices. On one hand there are expressions of feeling marginalised, whilst on the hand concerns are also raised about other staff coming to work in the ward, especially staff members not known to the group, who might be from the hospital casual bank or those designated as 'pool staff'. In one particular instance the participants talk about an older nurse who works on other wards throughout the hospital. Her reputation precedes her as an 'absolute half-wit' and being 'elderly' (T:7, pp. 7-8). She rarely works on the surgical wards. Her reputation around the hospital is considered by the group to be unfair and exceedingly critical given the 'unreal expectations' demanded of those who occasionally come to work on any of the wards, least of all 13 North. The injustice of such a reputation is well recognised and militates against the woman, Vivien believing that now, with this impediment, she would never be 'allowed' to 'reach her potential' (T:7, p. 7). Even though the nurse had worked on the ward as an
occasional reliever and according to Lyn had looked after two ill patients 'perfectly', such pronouncements had in the end, little if any bearing upon the fact that the nurse had been 'labelled' throughout the hospital. There was a feeling of needing to be more charitable to others given the often 'unreal expectations' placed upon those who walked into the ward to take the place of someone else, and who, while standing in someone else's shoes were not necessarily able to engage in the same ways as the woman the newcomer was relieving.

In addition, as Annette noted, the staff had their own way of working which was difficult to describe—but as Vivien puts it, it is just 'like a relay'. Diana mentions 'each member of the team knows the track, capabilities of others and the change points and distances involved ... it happens on each shift' (T:7, p. 13). This knowledge of how and in what ways the group collectively works is exceedingly hard for the newcomer to fathom. The knowledges involved surpass explanation—they are in the individual and collective endeavours and through movement and rhythm a dance is created; its waves of connection, separation and rupture intertwine forming an elaborate simulacrum of lives woven in multiple directions which in the process dialectically converge as one.

For a person stepping into such an environment, if only momentarily, becoming part of the team that conducts itself through relations of connection remains hard at best, almost impossible at worst. Sometimes pool staff (who form a casual work bank) are sent to the ward when permanent staff are unable to relieve one another, either when the ward is busy or when someone else is unable to work. The casual nurse is obviously going to be at a distinct disadvantage. As Jenny records in the margin of the transcript, 'what it must be like for casuals [is] scary' (T:7, pp. 8-9). However, recognising what might be experienced by others could also be a common feeling for the staff as they reflect on their own experiences in other locations.
Clearly there were some legitimate concerns that revolved around staff who relieved. Could it be that these concerns are grounded in an ontological perspective involving the staff’s expectations and beliefs about the care that patients require? These feelings become more apparent when relieving staff are sent from one ward to another, something the staff convey as an increasingly common practice.

I could hear Annette gathering up the first group to go to tea. Staff grab extra clothing, money, fruit, biscuits and other bits and pieces from the cloak room. Together all those attending first tea exit the ward en masse ... At tea we talk of the lack of rain; the need to feed the animals: Annette says she has been feeding the cows for weeks now and the hayshed is almost empty despite buying about four hundred bales, including round ones as well.

I began to realise the significance of the tea breaks. It was about being together sharing in one another's worlds. Often the conversations focussed on the patients with whom they were caring; difficulties they were having and seeking counsel with one another regarding ideas and strategies that might adopted.

In other instances talk might relate to the organisation itself with the latest information concerning impending changes. During these times, suggestions flowed on how and in what ways alternatives might be enacted. On this occasion however the talk was different although not unusual, focussing on staff holidays.

Spontaneously the conversation shift—attention turns to a staff member who is about to take leave—'the honeymoon before the marriage' tease Vonnie and Annette who both enjoy the banter! Comments about a changing world ensue - 'well this is how it's done these days—imagine—what fun!' exclaims Annette. I am not sure about how to respond perhaps because I feel the potential 'underplay' ...
Suddenly I am conscious of those on my left. Where had they come from? Instantly I found myself being aware of the student; a first-year student, it was her second day on the ward. I did not know her despite teaching in the first-year programme. It was as if my work in the 'other' place (the academic world) mattered little. I did not belong there but I belonged here and my position here really did matter to me. What could I say to her and the first-year graduate sitting opposite? I felt lost for wards. The student's tenseness was noticeably palpable. Her conversation suggested that she was totally at sea although trying desperately to converse with the woman opposite about the programme in which the first-year graduate was currently engaged. It was as if I heard this conversation in the background of the other one, the stylised talk of sexual innuendo following sexual innuendo. The space seemed naturalised as heterosexual, whether others at the table noticed their own sexuality remains an unanswered question and one that would lead to suspecting that the dominant discourses of heterosexuality are inscribed in both private and public places (Duncan 1996, p. 138). Laughter seemed to punctuate the good humoured conversation as those participating revelled in the banter backwards and forwards. I wondered if anyone would take offence but nobody seemed to at the time. The invisibility of alternative worlds was notable by its absence ...

(Journal entry, mid-August 1997)

For the most part, those new to the environment are encouraged by the core ward staff. For example several staff members are recognised as primarily responsible for mentoring new graduates. Their role is to act in a supportive way to ensure that they are developing their practice understandings in the context of this ward. Rostering in the initial period ensures that new graduates work on the same shifts as these women. In addition, particularly during the handover period in the afternoon, these staff
members spend time walking through procedures or talking about care with the graduates.

**Destabilising the self**

But for others the scenario may be somewhat different. As nurses are relocated from one ward to another, the level of knowledge about the specialty will vary. This situation is compounded by the day-to-day movement of staff from one specialty to another. It is this constant shuffling of staff from ward to ward that encourages the ward members to question the competence of nurses coming into their territory. The movement of nurses is disguised under the banner of ‘reskilling’, ensuring that they are multiskilled and able to care for a client in any situation. Written employment contracts are sufficiently vague as to render those who object to being moved from their specialty area (the ward area that had employed them) unable to assert any legal claim about breach of contract. Moreover, the irony is that while specialist knowledge is being touted through educational and health care institutions as the maxim of professional practice, they are at the same time acting to disempower specialisms through altering the structuring of knowledge (collection codes) which gives rise to the so-called legitimate knowledges (Bernstein 1975) of specialisms and their associated boundaries. At the same time this renders other knowledges as invisible. Meanwhile the health care institution proffers multiskilling based upon principled and ritualised action.

Bernstein (1975, p. 92) suggests that collection codes with some clarity around boundaries enable one to grapple with knowledge(s) from the superficial to deeper understandings. By the same token, however, processes of enculturation and the development of false consciousness facilitate a hegemony that reifies ritual understandings which effectively reduce access to deeper knowledge and at the same time generate a resistance to change. In contrast, weakened boundaries surrounding knowledge enable access to deep meanings which can then provide opportunities for the more superficial practice knowledge of a technical nature.
For the staff, there are some very real dilemmas surrounding the collapse of these traditional boundaries and the group voice their strong distaste at being sent to another area. Interestingly, even though the ward was originally a gynaecological nursing specialty focussing on women's 'reproductive health', it is now a mixed gender environment with patients requiring or having other types of surgery. Tensions emerged as the staff argued both for a continuation of the ward's focus on women and the avoidance of staff being moved. The group acknowledged that if they were moved or if the ward lost its orientation towards women's health issues, their specialist understandings in practice would be denied and their standing as knowledgeable women dismissed as unimportant. In the blurring of boundaries surrounding understandings, coupled with the loss of the specialty focus, practitioners' knowledges can then be transfigured to understandings of the 'less able' (Bernstein 1975, p. 92), their selves' identities becoming ambiguous under these conditions while the authorial arrangements remain in tact. Clearly the staff are concerned about this very point, for they suggest that 'with experience you see things more broadly; as time goes by your understanding grows; [if you] lack awareness you only see the immediate tasks' (Journal entry, end December 1996).

But there is more to this than immediately seems apparent. By moving staff from one location to another, the social patterns of the ward become disrupted. The community of staff members has over the years established its own particular culture in which each person's public self identity is constructed so that the self knows its location and derives meaning from it (Geertz 1983, p. 67). In speaking of the participants, it is possible to suggest that the self is not only publicly constituted, but also that the private self is dialectically related to the notion of one's public identity. Thus, the self is firmly rooted in-relation to others in the context of the ward. This self draws its identity from relations with others forming a deep and abiding pattern of connection that resonates through ward life. Patterns become disrupted by the movement or addition of nurses, times when relations with one another begin to reflect a sense of disjointedness. These times encourage the permanent staff to engage more fully in
practices of surveillance. As one of the staff commented, 'people know they're being watched—it makes it hard; you have to watch them like hawks especially the new grads; it's unfair to people' (Journal entry, mid-January 1997). The issue here is the ward staff's perception of the incoming nurse's competence. 'The more competent the staff judge them [incoming nurses] to be, the more they feel they can trust them' (Journal entry, mid-January 1997), reveals another nurse.

With the advent of increased staff mobility, concerns about mutual trust about the ability to offer care acceptable to that required on the ward, are a source of worry. The group realised that in moving to another site they too become the outsider and that the cultural practices they are familiar with may or may not exist in their temporary location. Questions of self identity also become apparent when one begins to realise that one is different from another in the context of self in-relation. Just as Saddul (1996, pp. 2-3) explains in coming out as a homosexual, support in learning about identity is paramount to one's relationships. Where there is a lack of support, issues surrounding one's identity begin to surface alienating the self from one's colleagues.

In addition, the group also expressed their feelings of rage about being moved. Comments about taking 'sickies' (sick days off) were part of the resistant activities to preparatory arrangements for staff shortages in other areas. The sense of total dissatisfaction with staff mobility was extremely obvious. Someone else mentioned 'they don't move doctors from one specialty to another; why should they move us?' (Journal entry, mid-January 1997) which revealed an echoing sentiment, perhaps contesting the view of so-called specialisms but also hinting at the corporate gaze. It is not surprising that these comparisons were being made for clearly staff recognised their own vulnerability in the devaluing of their knowledge which appeared to foster feelings of humiliation.
The self as a commodity

It becomes possible to begin to see that the institutional arrangements were clearly reflective of the commodification of women's labour. As Annette noted '... management continually say there is no money but there must still be a certain amount ... we have to do this, this and this to ... prove our productivity and if we don't we're failing on the business side of things and we now have to be business people as well as nurses'. Mel responded 'and probably caring doesn't come into productivity ...' (R:1, p. 10). Irigaray (1981, p. 255) makes it clear that women are traditionally a commodity used by men as caretakers of their material world. For this reason, women work to serve a purpose to/for men; they are rewarded on the basis of their ability to perform that work. Moreover, in attending to the material world of man, woman becomes the marketable commodity. Commodification of the body of the nurse means that she is dispensable, the work she undertakes or in what circumstances she accomplishes this work, is of little relevance to those with power. The woman nurse serves institutional purposes only inasmuch as she is giving of herself, so that the self becomes an unrecognisable identity enacting the desires of patriarchy. Her self becomes lost. The loss of self is largely because the self has given way to the phallocentric rule of the father, dispossessing one's identity. One might well ask in the context of these women's herstories whether their attempts to keep their public and private worlds dialectically related constituted an endeavour on their part to resist the symbolic violence embedded in the desires of dominant interests.

In trying to sustain one's identity even in these circumstances the body of the woman nurse is subjected to the symbolic order, rituals acting to delineate the borders of what is acceptable and what is not. For Kristeva (1982) as well as Oliver (1993, pp. 48-49), it is a matter of abjection, a theory operating outside of Freud's notion of unconsciousness. Freud's analysis of psychosis and neuroticism rests upon a dialectic of negativity in which denial and repression feature in the unconscious. Kristeva (1982, p. 7) however suggests, in contradistinction, that the abject acts to exclude, rather than negate, repression. Thus the abject acts as a thread connecting the
preconscious self as subject and the self as object 'other'. It is not repression that brings together the selves but rather abjection, the abjected 'other' (for example, the child that was once contained within the mother) that authenticates her as an object self (in this case, as mother).

Meanwhile, for the mother there are two dimensions of the abject—the sublime and the phobic. If the mother remains sublime rather than the phobic object then detachment from the mother will not be possible. Likewise when the child renders the mother abject in the phobic sense then separation becomes feasible, enabling the development of self identity. Thus, in the phallocentric culture the once male child now man, abhors that reflection of what he once was part, the maternal self (the abject). It is the abject (his mother now the phobic 'other') which threatens his autonomous self (Oliver 1993, p. 61). However, if the male child remains abject rather than the mother, she (the mother) will retain a 'sublime' state, the woman's self never free of the 'other', her abject self. As a consequence of this sublime state the woman might never become the desired object of another person in the heterosexual world, a loved and desired object of man.

For the male child it is crucial in the development of the self that the child becomes the abject and the mother the threatening object. What facilitates this movement is the auspicing father who enables the successful symbolic movement in his dissociation from the mother's identity and in the formulation of his own. He is able to overcome the abjection whilst establishing his identity and his ability to love and to trust. In the event that the child does not move through these processes, continuing as abject to the self, it is unlikely that in the future he will be able to form enduring relationships.

However for the girl child the scenario is a little different. Women, according to Kristeva's (1986) account, are twice damned rather than blessed in a corporeal sense. In order for a woman's self to develop her own identity, she needs to make her mother the abject thus rejecting her as part of her body. In making the mother abject she does
so only to reject herself, for herself's identity is enshrined in the body of the other—the mother in its resemblance or image and of which it was once part. But this requirement to abject the maternal is critical to being the object of man's desire. Positioned within the heterosexual narrative a woman becomes the object of man's desire abj ecting herself to phallocentricity. This scenario has major implications for nurses when it is elaborated further. The nurse carries with her as part of her imaginary the loss of her mother's body, the body that contained her, her mother's body which she has come to negate as the abject. It is therefore not only a repudiation of the lost maternal body of the mother that is required for the development of a woman's identity, but also a denunciation of the image of containment (matricide). The denial of this image enables her to love another as the object of desire. This narcissism is carried, suggests Kristeva (1986, p. 304), from one generation of women to the next; from mother to daughter as daughter becomes mother then to daughter and so on as part of the symbolic. It is the objectification of mother, the abjection and re-unification with the self as mother–daughter that enables the girl child's movement into the symbolic order of the corporeal realm of the father. Butler (1993, p. 41) notes that this view in particular is, for Kristeva, a central ordering thesis of symbolic relations and social practices in the everyday world of material reality.

Perhaps it is this transition that acts as a requisite for the women working on the ward and why their allegiances with the women around them in the patriarchal world of the hospital are the way they are. Again it is also this movement that presupposes a sense of the self, one's identity and an apprehension of the body of the woman as a source of love. The love Kristeva is referring to is not a love for the body which once contained her, rather it is a divine love from the maternal (Kristeva 1986, p. 313), a love stemming from caring. Drawing on Kristeva's somewhat essentialist analysis, could it be that participants' unconscious engage them in the recognition of this love; a love that perhaps exists beyond any known lexicon (Frye 1987, p. 115); but also a love emanating from the mother/daughter/selves which individually and collectively are
brought to bear in the language and meaning (Oliver 1993, pp. 62-68) of caring in this ward?

Surveying the self

To shift the situational perspective again—have you, just like other nurses, been chastised for actions where forms of punishment have been used to humiliate the self in front of others? As Foucault (1977) argues, punishment comprises part of the strategies or systems of surveillance. Actions which endorse conformity carry with them symbolic power where the risk of being castigated becomes inscribed in the body. The extent to which these inscriptions of symbolic violence are contained within the self, being lived out as the enfleshed dictates of the 'father', remains in question.

For how long is it possible to live with the self in a way that one's subjectivities are distanced or kept separated from the self, rather like an out-of-body experience in which the 'I' is not really the self I perceive? It is for Sartre (1958, p. 222) the object that 'I' appear to the Other. In a critique of various philosophers' work on the relationship and existence of others in the world, Sartre argues that, in contradistinction, it is precisely because the self and other 'encountering' one another rather than constituting the other, which supports the existence of the other—the separate selves. Moreover, that suggesting that the other exists acts to endorse the opinion that this other is not me (1958, p. 251), but rather someone that interests me (1958, p. 252). When the self encounters the other it negates the other as the self; however, as the other recognises that the self is not the other, it is then that one realises one's own self identity. In this situation the self glances at the self in the context of some connection or relation—to another. That this recognition occurs always in relation to another is to augment the manner in which the self defines the self in relation to the other. At these moments the self as object is alien to the interior self for it is this alien image which the other beholds and it is also one which as exteriority is also alien to the self. Even though Sartre's thesis falls into Cartesian dualisms, these ideas help
us to appreciate the patriarchal hegemonies underpinning nurses' identities in the world of work.

She, the nurse (object) works, doing the things that need to be done. But is she really herself? Is she in touch with the self as the person nurse? Is this a picture of the enfleshed docile body of the nurse one in which the self is disconnected from the spirit or one's ontological self? Is her body separated from itself, dismembered because of the symbolic forces that have over time come to act upon it? Do these acts of and for themselves serve to alter one's identity? If one's identity is constituted from the past but is also dependent upon the body's projection into the future as an anterior self facing the future, then as Cornell (1995, pp. 39-41) suggests, the body needs to protect its self projection in the context of the future, in order to safeguard one's self integrity as a self identity respected by others.

Repositioning the self
Can one see the self in a new light—a passage of meanings; fragmented understandings that are situated and then resignified as one tries to hold multiple intertextual readings (Barthes 1977, pp. 155-164)? It seems as if each person has given some reflexive thought to what has happened as the past informs individuals' agency in re-assembling the fragments, forming yet a new text. Nevertheless, in talking about these instances, the telling of the narrative acts to position the self in the context of practice now. It is why, for instance, Vivien is very emphatic about making sure patients have 'good' analgesic cover; or why new staff members, graduates or those coming to work on the ward find themselves with considerable support. But this support is also dialectically related to systems of surveillance as a taken-for-granted dimension of the group's ongoing attention to metaphorical 'standards' (Journal entry, mid-January 1997).

Mel continued: 'Yes they seem to be angry at women some of them—I don't know why and that also relates to the way they act towards me too. The supervisor has got a big job ahead of
her to turn things around. So I really—I work 60 hours a fortnight. Even though I tried to get a job in the birthing suite or in areas where they're women friendly I was unable to get in. People have been there for years and aren't going to move. It's also lack of experience and people need to keep up to date.'

(Journal entry, Chatting with Mel in the pan room ... mid-August, 1997)

Systems of surveillance which include informal remarks on performance can and do facilitate the docile body of the nurse acting to confirm one's self. Take, for example, Lyn's comment regarding never being told that one is doing well, no offers of direction and no pats on the back (T:3, p. 11). Why is it that these nurses seem to require the approval of someone else? Is this really a question of validation or is it, as Cornell (1995, p. 42) suggests, part of the process by which the self is reintegrated, an affirmation of the anterior self projected into the future and one which depends upon the others to validate the value of the self not only as a nurse, but as the person of the nurse as well? Is it because there is a constant focus on acting obediently, carrying out the imperatives designed to endorse the authority of some and not others? Does it reflect nurses' shattered self esteem or the questioning of their own confidence in engaging in care that is deemed correct by other interests? Could it be that patterns of self surveillance work to harbour self distrust, isolation and alienation meanwhile endorsing a sameness self, a self amongst many similar selves, homogeneous—invisible (Khayatt 1992, p. 125)?

As I continued to put equipment away Mel went on to elaborate further: 'Sure you have got progressive ideas in the hot spots, you know, teenage pregnancy etcetera and then the home birthing unit too. But generally speaking it's traditional—rituals—no change at all'.

(Journal entry, Chatting with Mel in the pan room ... mid-August, 1997)
It was Pam's birthday! Celebrations of one another's birthdays are a usual practice at afternoon tea. Hennie, who is referred to as the 'corporate organiser' for all festivities, outings, group functions, running the ward football prediction pool and so on, has organised cake and tea. As our meeting closes the tea trolley is wheeled into the room. The group break into song ... 'HAPPY BIRTHDAY TO YOU ...' the rather rowdy rendition of the common refrain signals to the rest of the ward that Pam's birthday is being celebrated. Pam is then invited to blow out the candles and speak. She thanks everyone and acknowledges Hennie for going to so much trouble. Cutting the two cakes is accomplished with a flourish; one a very rich looking chocolate cake, the other a black forest torte. 'Welcome to heaven!' she says, biting into a piece of mud cake while inviting everyone to have some and do the same. The staff remaining on the ward are also encouraged to come in and take some cake and tea but they do not enter the space. Instead they wait outside until the trolley with what remains of the celebrations is wheeled out of the room. Several of the staff then pour themselves a drink and take some cake. Inside the room the noise continues.

(Journal entry, early February 1997)

And what of this invisibility?

I call out your name—

Can you see me? ...

(In)Visibility and the self

It was not until two weeks later that I heard just how upset the staff on the ward had been, having felt excluded from the birthday celebrations. Details about the birthday cake situation are found in Appendix 8, and include thoughts on strained relations and more anguish about how to make sense of and deal with the tensions of this event and the impact of the study upon the staff.
Comments about alienating the staff left on the ward to respond to calls or engage in patient care began to surface. Clearly there were several staff members very upset, having carried these feelings over time. Some of those present in the room on Pam's birthday were also concerned that those remaining on the ward had taken umbrage. Lyn, for example, had reflected on the situation at home afterwards (the evening of Pam's birthday) trying to work out how it had happened and how such a situation could have been prevented. Lyn spoke of the excitement surrounding Pam's birthday. She had tried to get organised in order to complete her work prior to our weekly get-together and then the party afterwards. Lyn had felt the exclusion of other staff had been an oversight. But as the discussion broadened into whether one would take exception to the situation or not, it became apparent that what happened with Pam's birthday ran much deeper. Pam's party was the trigger for the feelings of alienation encountered by some of the staff members not participating in the research and it was prompted by my question 'what do you think you have gained from the research so far?' (T:13, p. 1).

One of the notions stemming from Lyn's opening comment (Appendix 8) is the kind of ideology that purport divisions of labour so often thought of in nursing as those between the physical work or the manual labour, and that which is to do with thinking or intellectual labour. This view endorses present day rationality emphasising productivity. It is a technical view of rationality enacted by getting what is deemed to be physical work done; by commodifying the body into divisions of tasks in labour and measuring work outcomes in terms of throughput; or, by delineating what constitutes 'real' work from that which is seen as unproductive time, for example the handover period (report). Economic rationality in this form acts to deceive one's consciousness, rendering invisible the 'real' self but enabling the emergence of a self in the image of a socially constituted self. This socially constituted self is a self created for appearances' sake and one that is required by the organisation to accomplish the institutional 'mission'. Yet this appearance is a false self. This false self is a
deception. It deceives the 'real self' diminishing and then finally destroying the real self's experiences. Thus, the real self becomes lost to the false self in the service of patriarchy

(Griffin 1988, p. 202).

**Outside Myself**

A thin ice
Covers my soul
My body's frozen and my heart is cold
And still
So much about me is raw
I search for a place to unthaw

Something in me
Broods love into fear
It veils my vision leaves my thoughts unclear
My eyes
From blue turn to grey
Hoping to mask what they say

I've been outside myself for so long
Every feeling I had is close to gone
I've been outside myself for so long ...

(k.d. lang/Ben Mink 1992, Track 8)

A lost self, displaced; now stand further images crumbling as they diminish into the never-never. I began to reflect on Annette's very early comment about not wanting to change existing relationships between the staff. At the time we discussed the research she expressed that one of her concerns was that existing staff relationships might be jeopardised.

A little arrogantly, perhaps, I indicated to her that maybe relationships might change, but, by my very presence, these would change anyway as part of the research process. I began to feel very uncomfortable thinking that this precious space might be disrupted through the process and in the long term serve to create disharmony between the staff more generally. Then again the research might have been the catalyst for this to occur anyway.

Somehow I found myself thinking about some of the ground rules that were first established, especially in the context of agreement about the 'private' nature of these discussion groups. The group had agreed not to share the information coming to light
in our meetings. Keeping details privy to the group supported confidentiality and the feeling that if participants wanted to express what they felt then these ideas would be held and respected by the group (T:1, p. 6). Now, however, this confidentiality was encouraging the very thing I was wanting to avoid: the marginalisation some might feel (T:13, pp. 2-3).

**Blurred self images**

Keeping things confidential serves to exclude, creating possible feelings of rejection. Adding to what might be deemed a prohibition on information, tensions begin to rise when claims surrounding issues of confidentiality compete with positions that are underscored by an institutional consciousness that prizes a work ethic of manual labour over intellectual activity. Fuelling these tensions is suspicion. Questions about confidence in the self are exacerbated through feeling left out, not participating, yet carrying the gaze of surveillance whilst conforming to images which have seeped into one's everyday consciousness. These inconsistencies contribute to feelings of betrayal as images begin to depart from what one has taken for granted as ways of acting over the years. Placating the experience of those not participating in the research minimises what others feel, yet trying to work these boundaries in ways to enhance the team remains at that moment somewhat complicated.

Vivien writes in the margin of the transcript 'I think perhaps we made too much of this supposed friction' (T:14, p. 2). This point of view is echoed by some of the other participants as well. Despite its focus here (which is relatively short in comparison to some of the other discussions) the degree to which the birthday celebration acted to surface ill feelings enabled the group to reflect upon their colleagues' understandings and what it must be like for them as non-participants.

Again Vivien comments in the margin of the transcript: 'Should we ever [have] felt guilty about leaving the ward? Was this in fact a form of debriefing that we haven't participated in before?'. It is not at all surprising that feelings of guilt were raised.
Perhaps these emotions stem from reified and hegemonic notions of women's labour as well as those notions surrounding forms of self surveillance.

The impeached self—divided

Those in positions of power disregard the complexities of women's lives. The organisation asserting regulatory norms does so through materialised practices which from time to time become reiterated. Although these norms are frequently subverted, they are unstable given their need for restatement. Moreover, norms become enacted by discerning the norm as a norm, which then constitutes boundaries creating exclusion (Butler 1993, p. 75). For some, contesting these boundaries initiates a sense of misconduct.

In the context of the friction following the birthday celebration, Vivien raises the following questions against the comments in the transcript: 'Why do we feel guilty about sitting down and talking once a week? Would it be any easier if all the staff were involved and would this lessen our guilt?, (T: 14, p. 3). Understanding the guilt from the position of separating the team into 'them and us' resulted in some of the group thinking about being alienated from one another. Mary (T:14, p. 3) pointed out that those who were not engaging in the birthday celebration were the participants' friends and they, their friends, had a 'right' to feel alienated. The group's selves had been confronted by a sense of dissonance between the usual conception of the self on one hand, and on the other, the actions individual group members participated in on that particular day. These actions were perceived to be at odds with their individual and collective modus operandi. In addition, the inconsistent actions of individual staff members participating in the research violated their understanding of themselves, contributing to the participants' discomfort (Gergen 1991, p. 88). Feelings of uneasiness prompted the participants' attempts to make sense of how and in what ways the circumstances led to what they now named as feelings of exclusion and of alienation.
At the outset, the research process had been discussed with all staff members when it had been made clear that it would be impossible to gauge the effect that the project might have on the staff's relations in the ward. It was a risk the group were prepared to take. Now however, the growing tensions surfaced, and for some they were untenable (T:14, pp. 3-4). I began to wonder what participants shared with their colleagues about our times together. Certainly, some information in general terms was a topic of conversation. Perhaps in the sharing of knowledge one of the obstacles to the ward staff's shared 'becoming' had been named (Greene 1988, p. 132). Indeed, was it that non-participants' voices had been subjugated by those of their colleagues? It was not until much later on that I realised that those not participating in the research were far better informed than I would have expected and can only suggest that the group, or some of its members had made a decision to share with their colleagues some of the more in depth and specific material. Over the coming weeks those participating in the research felt closer to their non-participating colleagues and the tensions had noticeably begun to dissipate.

Looking back it was obvious that in order to work through these difficulties - those fractious moments - any sharing of information helped to demystify what was happening in the group sessions. While such sharing of information was in breach of the guiding principles established at the outset of the work, clearly these principles could not be sustained. In particular the one principle which seemed to create the most difficulty for everyone was in reference to the content of the discussions and how this information would be held in confidence by the group. For the staff participants, questions of confidentially holding the ideas generated within the group appeared to be the big stumbling block. It was something that now confronted the group of participants individually and collectively. The tensions resulted in the following dilemma: to breach the research group's confidence or to live with the growing sense of distrust amongst the other staff members. It was an almost obvious choice—the relationship with one another was far too important.
Whilst what was said in the group sessions was privileged to those participating, this privilege had acted to erode other staff members' trust in the participants. At the same time, if the content of our meetings was being shared with other members of staff, would the participants, in breaking confidences held by the group, diminish the group's trust in one another? The cyclical evolution of trust amongst staff members in the ward was very evident from this moment. Obviously, the relations with one another were based upon trust and goodwill but trust had become threatened and the way to address this threat was through disclosure—breaking the silence. Perhaps group members intuitively thought that there would be a resurgence of trust if they talked about the meetings with other staff? Once these conversations had taken place, then maybe there would be possibilities for re-establishing trust in one another enabling the research to continue without these mutually dissident feelings.

Baier (1991, p. 234) makes the point that it is precisely because women have so frequently been the 'victims' of exploitation and betrayal that they too cannot trust one another nor are they exempt from engaging in similar breaches of trust. For these women nurses, trusting one another was/is an integral part of their practice, something that would appear to be taken for granted. Also for these women, trust may have developed as an unconscious act, now notable only in its absence, exposing the risks and vulnerabilities inherent in trusting relationships.

Trust involves risk, becoming vulnerable, relying on someone else to care for/about what is of value to the self and assuming that no harm will eventuate. Trust therefore involves others. In this sense trust is intentional insofar as one has a tendency to trust those in whom one has confidence. Moreover it also develops when an individual has experienced trusting relationships with family and friends and where the social conditions surrounding the development of trust exist. Baier (1986, p. 295) points out that much of the moral debate that has focussed upon trust has been developed by male philosophers. These scholars gazed at their relationships of trust in the context of their male counterparts, situations of relatively equal power. Some relationships developed
along the lines of a request for trust, while in other instances the promise of trust would secure the relationship, signifying an obligation or duty, ostensibly in the short term. Promises of trust therefore implied certain obligations, a moral position that finds its hallmarks in consequential, utilitarian or adversarial systems of judgement.

Yet, in the context of the ward, the inequalities in power relations, and more broadly the hospital community, work to support, and at the same time, undermine trust. Baier (1986, p. 296) notes that certain conditions foster trust and do so often in the presence of duress. Threats surrounding compliance with the dictates of the ruling encourage one to engage in trusting relationships albeit maintained through systems of surveillance. Over the longer term these relationships of trust become part of the ideological hegemony and false consciousness of practitioners.

In attempting to explicate issues of trust surrounding inequitable power distribution and the moral embeddedness of trust, Baier (1986, p. 292) uses the example of the mother and child. The child's trust in the mother is something that develops over time and has a tendency to be taken for granted. In these instances trust builds as part of one's taken-for-granted relations with others, only becoming apparent when it is breached. In the main, the development of trust in someone else stems from situations in which one realises latently that one trusted the person involved; where preconditions exist - one has first learned to trust others, for instance one's family and friends - or, where the need for sufficient reciprocal trust in ones' colleagues is realised.

For a large majority of women, both historically as well as contemporarily, the trust relationships into which they enter are not necessarily those of promise; nor are they those in which power relationships are relatively equal (Baier 1986, p. 295). Instead, relations of trust have had a tendency to be characterised by the holding of something of value, for example the care of a child, so that there is a moral position embedded in trusting someone else. Here the trust focuses upon caring about/for what matters to the other (Baier 1986, p. 301). Nevertheless, where the interests of a group or an
individual are at odds with one's own, where one's status in a network of people is questionable, or where unjust practices or coercive tactics are wrought against the self, it is unlikely according to Baier (1986, p. 302) that an individual will place their trust in someone else, thereby sustaining that relationship.

Where a person places trust in another nurse and this particular nurse, in whom one places trust, decides to take an alternative course of action, the relationship will most likely remain harmonious because the trusted nurse endorses the same ideological position as the trustor (Baier 1986, pp. 301-304). This could be why nurses often engage in subversive acts with the good of the patient at heart and yet their colleagues (both nursing and medical) refrain from taking disparaging or disciplinary action. If one's actions are those that differ profoundly from the ideological position of the person trusting, then the trustor will feel betrayed.

It was around lunch time when Pam and I could not help overhearing: 'Well, what do you think I've been doing!' the first-year graduate stated accusingly. We looked at one another and peered out into the corridor to some twenty feet or so away to see Annette stepping back physically from the first-year graduate who had clearly uttered these remarks. She stood still for a moment as if to let these comments sink in and then walked away saying nothing at all. Both of us looked at each other somewhat amazed as if in disbelief. We turned back to what we were doing then Pam turned to me and said 'Annette takes a lot you know - 'it' will get sorted out'. I felt quite uncomfortable - I'm sure Pam did too. I found myself thinking 'wow! there is no way I could have said that and especially to Annette. Basically, I felt the comments were rude and in the earshot of everyone near the desk, patients, doctors and other staff members. Obviously the first-year graduate was put out - cross, if not angry, and I wondered what had been said to encourage this sort of response. I shared these thoughts with Pam and she agreed. Having briefly mentioned the episode it was equally quickly dropped as Pam and I now began to focus on the midday drugs for our
patients. As we moved on I wondered why it was that the scene was so freely minimised when it could have been inflated. Pondering over what had happened earlier I began to reflect on Pam's comment 'it will get sorted out', then my thoughts turned to wondering whether Annette would talk to her later or would it be someone else. Alternatively, would the graduate nurse's comments be deemed as a trivial matter and glossed over subsequently forgotten?

(Journal entry, mid-July 1997)

I came in for the meeting on staffing issues and asked Annette what had prompted the first-year graduates' response several days earlier. Annette mentioned that she had 'jovially' inquired what she had been doing and why it was that she had not gone to tea. I inquired how Annette had dealt with the situation and she mentioned that the best thing to do was to listen and then let it go. 'You have to with first-year grads! Some think they know everything - they'll soon learn'.

(Journal entry, end July 1997)

Certainly there seemed to be a general feeling that the group could mutually depend upon one another and count on one another in moments of unsuspected upheaval. Later (R:1, p. 15) I realised what Pam had meant when she had said that the situation would get 'sorted out'. On this occasion the group were discussing staffing and in particular the fragility of the balance of staff in terms of 'smooth sailing'. Annette reiterated a point she made early on in the group's time together, specifically when she mentioned that 'you people train them, I don't; they come and I have very little to do with people coming here, other people tell them what they should or shouldn't do, I don't, and then when people get in here and say you know that we should have this standard and that standard I think well where did they find that out. I don't tell anybody anything it's the group [who] controls any new member coming in, they tell them what they should do, train them up basically'. Lyn confirmed Annette's comment with 'self regulation'(R:1, p. 15).
Looking at the self

These comments highlight perhaps the nature of the surveillance strategies enacted by the group. Rossiter (1994, pp. 8-9), using an example of a children's first dance party explains that the shaping of one's relations and an understanding of them has considerable bearing on recognising one is being watched undertaking a task. The onlooker gazes at the nurse as an object enacting the task according to accepted rules. Knowing one is being observed encourages one to act appropriately. The task is thus accomplished in ways that support institutional norms. Engaging in practices that adhere to these expectations helps to secure recognition of the self in terms of the valuing of the contributions one makes to the ward.

It seems evident then that unless a nurse has access to this knowledge there is no guarantee that she will be recognised by the staff. Moreover, this situation is compounded by a context that purports a common practice 'standard'. Even though this standard is invisible and unable to be articulated in any particular way, it is something accepted by the participants as a commonsense understanding. What is clear, however, is that these standards revolve around caring and it is through the enactment of caring for, and caring about one another, that questions of the fragile boundaries or territories within which these women work become negotiated.

Perhaps for the first-year graduate it was a question of asserting her identity, an identity that had thus far resisted the social imaginary of the enfleshed docile body of the nurse. Could such an imaginary be part of the reified depiction of the circulating myths about the ward? Why was her reaction so strong, and could this have been an act of resistance to what she had apprehended as part of the mythology of strictness (R:1, pp. 16-17) surrounding the reputation of the ward? How and in what ways might Annette's silence be interpreted following the first-year graduate's outburst? Were both of these women, in their different ways, engaging in forms of resistance to the manner in which dominant discourses of power have come to be both subverted and inscribed in their bodies, enfleshed in ways that mark out locations of
vulnerability, humility, and compassion as spaces in-between (Grosz 1994a, p. 95; Parker 1997, p. 25)? Are these spaces the in-between locations where the raw sensibilities of the enfleshed body form sites that later become tarnished by reflection and rationality? In addition do they constitute moments in which the enfleshed body, one's interiority, becomes extended into these spaces, traversing a plain that is filled with intensity; space in which the body extends as a virtual self (Massumi 1996, p. 224) momentarily marked, then only to be imprinted as one becomes conscious of what has emerged (Grosz 1994a, p. 174)? Do these moments comprise the abject dimension of the self; the stranger, an other self that threatens the proper, an apparition that extends beyond the self (Kristeva 1991, pp. 191-192)? Such extensions of the embodied self - the preconscious moments (for want of a better term) - are what Deleuze and Guattari (1987, p. 23) might term the assemblages.

Assemblages are connections in space, things penetrating space linking the self, with/between one's situation within multiple realms of possibility. The raw emotions extending from the self into the space exist in a reality that is textual; emotions are not only perceived in the context of certain conditions but embody them as well. It is these rhizomatic like processes, extensions of the self as expression but not the expression itself that appear to the other. Expression has its own limits inasmuch as it is revealed in time and then disintegrates. Feelings such as rage leave the body, they unfold and become enfolded in the material world of/in which they are a part (Hardt 1993, p. 114). Emotions of the corporeal blend into this between space, forming an extension of the body, but at the same time connecting the emotion by appearance and location into the space. This, suggests Massumi (1996, p. 228), is why intense emotions are often described as if the person felt their self was located outside their body, a dislocated self.

Outside Myself

... I've been outside myself for so long
   Every feeling I had is close to gone
I've been outside myself for so long ...

   I have been
In a storm of the sun
Basking, senseless to what I've become
   A fool to worship just light
   When after all, it follows night
I've been outside myself for so long
   Every feeling I had is close to gone
I've been outside myself for so long ...

(k.d. lang/Ben Mink 1992, Track 8)

The embodied feelings charge the in-between space with energy. Expression and its antecedents can then be captured in appearance by the self and the other - the person or thing to which one is connecting. At this point the persons and the space become the engagement, the energy of in-between dissipating over linear time (Massumi 1996, pp. 228-229). Moments where one's emotions extend into the in-between space create possibilities if only partially connecting with the self through recognition that this emotion has confronted the self but also that it constitutes the self as well. Moreover, that as an appearance waves of energy connect to, but also extend beyond the other so that at any point its flow is unable to be completely grasped, captured or apprehended. Nevertheless it is through the engagement, the intermingling of energies which are at one and the same time the self, the extended self as perceived, and acted upon in a material context, that for Deleuze constitutes an ontological encounter (Hardt 1993, pp. 117-119).

Was this such an ontological moment? The raw emotion of the first-year intertwined by the penetrating silence of Annette revolved around a layering of the material world of power relations that extended into the in-between. Was the sense of goodwill towards one another floundering amidst implied questions of competence? Whether interpersonal trust for these two actors was being rapidly eroded alongside trust in one's self and one's situational self esteem (Govier 1993, p. 112) remains problematic. Could it be that both women in this situation where participating in territorialisation, maintaining particular boundaries because of the threat to the self?

Where did one stand in this moment? Was it in a private world of the self as other - memories - the abject construed as oppositional, separation, dejection (Kristeva 1982, p. 8); memories - of a repudiated self lacking; changed countenance infused upon the faces who become temporarily another; memories - of bygone places - transfiguration
of the self into the me that is also not me but the other (Cixous 1998, p. 137) ... the actor - the public and the private?

We listened ...

... as Chris asked how long it would be. Pam and I turned to one another; a knowing look of 'do you want to respond to the question or shall I?' passed between us as our eyes met. We could not tell we said, but the time was getting closer. Glancing down Chris would probably notice the colour draining from the now sweaty body of her mother. Her face was marked by the tortuous furrows that were once part of her expression of life. It was her - yes - a body of a woman who once was, but now on the edge of a mortal world. Yes it was her, despite the years that had elapsed and the difficulties that had confronted their relationship. During the course of the day stories about Chris' Mum emerged - her loves and hates; the hard life she had endured and how she had responded to Chris' separation and subsequent divorce. These reminiscences seemed to help Chris as she became more aware of her mother's laboured breathing. Now as her mother lay there distorted by the lines and tubes leaving and entering her body she had become 'a failure to cure'. She was 'brain dead', said Chris, after being resuscitated twice in intensive care. Chris was her mother's only living child, although her mother had 'three sisters who had just arrived [from another state] but were at the Casino!' mentioned Chris with distain in her voice. Tensions between these four women were eclipsed by admonishing statements that were not only derogatory towards one another but fuelled their distrust. Chris was angry with the situation; she talked and wept apologising to us for being upset. After several hours we urged her to have a break but she would not leave. She was 'here to stay'.
Having organised something for Chris to eat we asked her to have it in the day room whilst we turned her mother and sucked her out. Amidst protests that Chris could not eat I took the tray into the room next door where she could have some quietness and glance at the outside world through the windows overlooking the harbour. As I sat there close to her she began to eat. A conversation began and ended in nothingness - we shared these moments in a place elsewhere - silence - in being together yet apart.

I had grown familiar with Pam's movements as she had with mine. Back in the room our talk was quiet, 'a mouth toilet again don't you think?' Pam asks rhetorically. 'Yes and we should suck her out too; she really is beginning to gurgle' I respond. The intercostal tube oscillated silently draining small amounts of fluid. From the puncture site large amounts of haemoserous ooze spilled the life of this woman onto the blue disposable sheet beneath her body. We turned her and washed her back and completed a mouth toilet before rolling her onto her side propping her up further in the bed.

While I was out with Chris, Pam had got everything we needed to do the trache dressing and suctioning. Now as we came to suck her out I could feel Pam's tenseness. As Pam put together the equipment I turned on the suction. She attached the catheter to the tubing and checked the suction power. Something was not quite right. Pam looked a little unsure - I asked her 'are you okay about doing this?' (the suctioning). 'Yes, but I haven't done this for ages'. I said, 'It's okay - I'm here with you', I felt comfortable and able to do it. I looked up - we smiled, I began to speak out loud the physics of the equipment, having recognised that there was something amiss - 'if you have a low pressure created in the bottle then ...'
The suction equipment had been incorrectly assembled and therefore required reconnection. I could not remove the top from the suction bottle on my own. Pam came round from the other side of the bed. Because there was not much surplus tubing and very little space to move, it was necessary that one hold the bottle close to the floor and the other pull the top. It must have looked comical. Suddenly with a one, two, three, the lid came off and Pam and I became entangled in one another as we lurched towards the floor. It was hard to control our muffled laughter, giggles and giggling as we picked ourselves up and checked if we were hurt! ....

Why is it that situations are even funnier than they ought to be? Is our laughter a way of relocating abjection (Kristeva 1982, p. 8)?

... Later she asked me what I had meant before we had sucked Chris' mother out. I mentioned that I was completely confident about sucking someone out. Pam said 'I should have let you do it - I wasn't that confident'. 'Well I wasn't confident about other things' I responded. We laughed, 'It's great isn't it!' said Pam, 'Yes' I said touching her shoulder knowing what she was saying - that we worked well together in a complementary way. I felt a great gentleness and warmth in the time with one another, and wondered if this warmth washes over to what patients feel, a sense of confidence. Despite the situation Chris seemed more at ease as we worked with and around her and her mother. We told her what we were doing, inviting her to help us if she would like to do so. Chris commented on how frightened she had felt in intensive care with all the 'stuff' and 'machines' going on around them. She felt much more at home here and it was easier for her to be with her mother, talk to her as well. At one point we walked in and Chris said 'don't worry I do talk in tongues you know!'. I asked what religion her Mum was and Chris mentioned she was an Anglican and then I inquired if she would like us to get the local minister or ask the pastoral
care people to visit. Chris declined the offer 'I've got my own religion - it's okay - I can be in touch with my minister and ring any time'. Pam reiterated the point again: 'would you like us to get the Anglican minister for your mother?'; again Chris declared she would prefer to wait until her family members arrived and consult with them.

Later:
We could hear a commotion outside in the corridor - Chris' voice was bitter and filled with pain. Pam and I left the room together having completed the necessary tasks only to find that Chris' three aunts had arrived and awaited the opportunity to see their sister. They stood in a semi-circle talking, resisting other staff members' attempts to move the group into the day room. Seeing Pam and I emerge from the room prompted their attention and we too became part of the circle responding to their questions. I felt we were located in a particular space unaware of the rest of the world other than each other and the woman in the room beside us. The visibility of the group was evident, but the group was unaware they were being watched ...

(Journal entry, early August 1997)

... Watched - in a public yet private space.

Was this very public space of the corridor regulated by staff who were attempting to sanitise the emotion of this family? Could the public remain free from passion and pain, expressions of the self that remain hidden from the public gaze? Were attempts being made to shelter the group from the normalising affects that in the public realm might be perceived as an individual and private concern? Despite the public/private space of the ward and its separation as a private yet public space within the hospital, were staff members trying to stand in the borderlines of the private-deemed-public location, shielding the group by facilitating the formation of a circle. Was the circle symbolic of containment, holding the grief and sharing in it as well; a dominant image of a safe space, a metaphorical expression of unity (Northup 1997, p. 29)?
... We stood beside Chris as her mother died, her last breath leaving her weary body - a shell of its former self. She wept - I could feel Pam's eyes seeking mine - we held one another's gaze, comfort in these moments of sadness; a knowing of the mortal self.

(Journal entry, early August 1997)

Walking from one room to another
the sacred
amidst the profane

I could hear the echoes of laughter behind me ... enjoyment, sharing in the horror of the other yet excluding him ...

Mel, Pam and I were all in the same space, an empty four-bed room, preparing for incoming surgical patients. Pam began to tell the story of the male patient in a room down the end of the corridor, a middle aged male patient who had come in for a penile prosthesis - amidst much laughter the story unfolded to reveal that the prosthesis had become infected and subsequently it had fallen out. 'You can do the dressing' said Mel to me in a jovial tone 'yeah, you can look after him!' 'I'm doing an Annette - I don't want to know anything about them so I'll leave it to you!' We all laughed! Neither Pam or Mel had seen one before 'so - it's been a real education!' said Mel. Like three young girls we walked out of the room and down the corridor giggling ...

(Journal entry, mid-September 1997)

And yet, was this space a location which contested the stability of masculine and feminine, a private world in which gendered positions are prone to disruption and against which prohibitions (usually in the form of guilt) are brought to bear to enhance the exclusion of difference but also the maintenance of an inscribed compulsory heterosexuality (Butler 1993, pp. 51-53)? Moreover, does instability in the private realm of one's material reality work to resignify the private as public which in turn normalises the abject? In particular are institutional attempts to control public spaces and the territories in which ward staff stand, designed to depoliticise the bodies of
women in the ward and contribute to appropriate gender body performatives in heterosexual relations? As Butler (1993, p. 118) suggests, where identities are fraught in terms of comparisons between groups in coalitions, inevitably the machinations of power will create a rift, resulting in the exclusion of some at the expense of others.

**Where does one stand in space?**

Both public and private spaces are subject to maintenance and erosion of boundaries, processes involving the deterritorialising and reterritorialising in which local power is held, challenged, and then claimed, resulting in the privatisation of the sphere or space in which the challenge occurs. Often, as Duncan (1996, p. 129) suggests, these changes may initially lead to the formation of sites of resistance, locations which become private spaces and over time act to depoliticise that space. In addition, private space can be relatively free from systems of surveillance, at least from the inside. Where, however, the private spaces depend upon the public realm for their economic existence then the private world is more likely to be subject to external systems of surveillance.

In these circumstances there may be relative autonomy on the inside, but they are more likely to experience intrusions from the outside—the public realm (Duncan 1996, p. 129). Moreover, these spaces remain somewhat differentiated by the various social and political practices not only endorsed by the organisation itself but also, in more general terms, through the territorialising effects of political and economic theory (Duncan 1996, p. 129). The public space is frequently the cite of contestation over the colonising effects of dominant ideologies; at the same time it also exerts a sanitising influence rendering the public space as a depiction of a homogeneous community. One wonders if this homogeneity arises from dominant discourses that render silent the counter voice, where depictions of the self as the 'generalised other' are reflected in terms of nurses' sameness self?
The ward is contained physically by boundaries but clearly there are others as well delineating it as a private space. The private space of the ward could well be understood to be the a prime location in which patriarchal authority is enacted. The authorial voice of the doctor is legitimated institutionally and legally, serving to endorse specific power relations in the ward. Moreover this legitimacy reflects a historical legacy, one that preserves the rights of patriarchy whilst at the same time relegating dissenting voices to a life at the margins. Being marginalised in the private space of a public world augments the enfleshment of stigma perpetuating the myths surrounding what then might be referred to as the enfleshed body of the 'docile' nurse.

Duncan (1996, pp. 133-135) suggests that where private spaces remain significantly unregulated by state intervention, the status quo will be retained. The implications of liberalism in private locations appear to mask the results of oppression and differential relations of power. In these circumstances it is not only possible to appreciate why it is that dominant discourses inherent in the present day private space of the ward remain so powerful, but also the manner in which this private space cushions the impact of the public world of the hospital, enabling the retention of some autonomy by the nurses who work in this private space. One of the tensions which arises from such a depiction of the public and private spaces reflects questions surrounding the rights to privacy and autonomy. Tensions do exist, however, where attempts to ensure the privacy and autonomy of one's private space are upheld while avoiding the misogynist and disempowering effects potentially existing in the sphere of the private. These tensions are commonplace, signifying perhaps the struggle in politicising the private realm of one's everyday reality, particularly when one is vulnerable.

At the same time the private domain of the ward serves as a site of resistance. Here staff work to affirm their lives, the lives of one another, their practice and everyday experiences as legitimate. Moments of affirmation strengthen the self in a number of ways. Not only do they assert one's identity, restore one's sense of dignity, but they also help create an environment that values the care that one offers to patients and, importantly, to their individual and collective selves as well. Thus, the private space is
often the site of fluidity where alterity adds to new images and imaginaries contesting the very spaces dominant ideologies work to sanitise.

It is precisely because the ward's work is associated with the medical speciality of gynaecology that the ward staff participants feel themselves to be marginalised and relatively invisible in comparison with other specialties or locations. As Duncan (1996, p. 128) suggests, public spaces are normalised by means of regulating social practices which support homogeneity in acting and being in the world. In addition they repudiate alternative understandings, feelings and emotions which do not serve the interests of those in power, rendering them invisible to the private space of the self or home. Thus, women entering the public space of the hospital for surgery associated with their gender and/or sexuality, are at once normalised with the medical label of their condition. Moreover that this label is borne by a woman is to expose her private self to the public sphere, the domain in which the self becomes public. She bears the medical problem, becoming the label of her condition, the 'ectopic pregnancy' for example. Making the private public in this way denies her of her-self, her embodied self (Duncan 1996, p. 141) and she, or at least her body, becomes territorialised by medical discourses.

Perhaps it is because the participant nurses engage in these private spaces of the body with their patients, especially in their work with the sexualised self of the client, that the group find themselves marginalised. Their work forms part of the invisible labour precisely because it takes place not only in private spaces of a public location but also because it deals with the taboo of women's sexuality, their corporeal lack upon which certain social regulatory practices come into play to rectify the symbolic order. It is therefore not surprising that the nurses on this ward find themselves somewhat alienated from their colleagues in other wards for their work, by its very nature, contests the boundaries of the public and private realms. The extent to which participants resist the territorialisation of women's bodies (and indeed their own) is perhaps to be located in the openness with which these women engage with one
another. Nevertheless this visibility retains within it many regulatory and self-surveillance practices that support the hegemonic appearance or reading of a heterosexual space (Valentine 1996, p. 150).

However opening up their private worlds to one another's gaze through the various discursive practices on the ward seems to be one of the strategies used to disrupt the false distinctions between private and public (Duncan 1996, pp. 141-142). Another is reflected in the manner in which individual identities are valued, each acting to support the individual and collective work of the group. Despite the development of a somewhat heterogeneous ward community it is radically different from what one might anticipate in the present day public space, one that contests the trapping of one's imaginary in the divisive tactics of patriarchal authority (hooks 1981, p. 157). Rather, it is in the recognition of the corporeal that nurses are not only set apart from one another and patients, but also in that separation they are placed in relation to one another (Weiss 1999, p. 86) and in this way struggle to retain fluidity in the (re)formulation of a corporeal world.

I've been outside myself for so long
Every feeling I had is close to gone
I've been outside myself for so long ...

I've been outside myself for so long
Every feeling I had is close to gone
I've been outside myself for so long ...

(k.d. lang/Ben Mink 1992, Track 8)
Chapter 10
Standing together

In this world, to touch another is to express love: there is no idea apart from feeling, and no feeling which does not ring through our bodies and our souls at once.

(Griffin 1981, p. 160)

Trying to unravel the notion of the self left me with a question: why was it that I could not move from seeing the self as a stranger that occupied the depths of the self within; a stranger that lurked in the shadows waiting to be brought to the fore? I desperately tried to see another way, one that could move the self into a different location as if reunifying the self with the other. I endeavoured to move from the psychoanalytic perspectives of Freud in particular, but also from the work of Lacan and Sartre, to another way of seeing. It took me a long time to realise why I had this difficulty, one that persisted. Perhaps it was because the group's material life was caught up in a reality that valued, signified and took for granted ways of being in the world that spoke to dimensions of these perspectives.

Grappling with the ideas raised by the group I came to understand more fully the embeddedness of psychoanalytic theory and the neo-positivist ideologies that supported and enhanced the hegemonic and reified meanings of the dominant ways of being as they underpinned the agency of ward staff's understandings of themselves, but also the ways in which they were resisted. That I too found myself engaged in these views reveals my own false consciousness, at times being unable to see outside such paradigms, particularly when I was within the culture(s) meanwhile engaging in subversive strategies. Again this highlights just how powerful such understandings are.

I was left feeling perturbed. I hasten to add that it may have been because of my long-standing view that psychoanalytic theory, particularly the work of Freud plus his legacy regarding depictions of women's moral development 'around the construction
and resolution of the Oedipal problem' (Gilligan 1977, p. 484) endorsed misogyny. This work has, to a greater and lesser extent, contributed to the manner in which phallocentric power has endorsed and even, in some circumstances, justified the unwarranted inequalities (and abuse) of/for women (for example Grosz 1994b, pp. 70-77; Jack 1991, p. 8; Abel 1990, p. 182; Bartky 1990, pp. 22-32; Kristeva 1981, p. 70-72, Chodorow 1979).

Not wanting to confine women's oppression to universalistic depictions of male power as might be evident in a position which considers misogyny in institutional life to be solely the province of masculinity (Young 1989, p. 32), I have wanted, instead, to inform this work with authors such as Grosz (1994a), Butler (1993), Bordo (1990), Flax (1990), Kristeva (1986), and Irigaray (1985), who, amongst other women writers, have disrupted patriarchal images of a bifurcated self so often seen in the foundationalist effects of psychoanalytic theory (Meyers 1992, pp. 136-138). Such work, while present in the feminist literature, has yet to be felt more fully in the health care arena. It seemed, therefore, to be important to unpick the nature(s) of the self of the participants in an attempt to illuminate the manner in which some of the social relations in/of power come to be lived out in the ward.

What this journey seemed to expose was just how compelling psychoanalysis remains as an embedded approach to working in/with the realities of practice. I was at pains to try and bring to bear other understandings in attempting to unravel the notions of the self. Having now taken this journey and realised that I was searching (and still am for that matter, as you probably are too) for ways to see the self differently, I have come to see that the women I have been privileged to work with apprehend their worlds first and foremost in relation. Participants understand the self as being in relation. Whilst I had recognised this some time ago, what I had not appreciated was that this location had much greater meaning than I initially understood. I began to think being in relation was dialectically linked with caring. Thus being in relation constituted an ontological
position, one which is inscribed upon their bodies as nurses but which is also a
position that signifies the self in the world.
In this final chapter on the narratives, the conversation turns to relationships, shared
goals and values and knowing each other well—a kind of knowing that leads to
admiration. This dialogue appears in Appendix 9 and you are encouraged to read it at
this point in the text.

Standing outside now and looking back through all our discussions, the term
'collegiality' was not an expression commonly used by the participants; rather it was
mine. This could have been because collegiality was not a natural part of the group's
lexicon. Perhaps collegiality was a term used to name something that did not always
ring true as part of the day-to-day conversations. Again, this thing I call collegiality
may be part of the culture in the ward, un-named but nevertheless there. Not having a
vocabulary that describes or explains something does not mean that it does not exist,
nor for that matter that this something is not understood or experienced. What it does
say though, is that such understandings are not named. They are present perhaps in
another conceptual, linguistic or pre-cognitive notion. Instead of my term
'collegiality', words such as 'teamwork' or 'being part of the team' were
commonplace. Indeed it was Jenny (T:2, p. 2) who said '[w]ell the thing that comes
to mind most is working together, I mean it's the first thing that comes to mind', and it
was this sentiment that continued to be echoed throughout the study. However the
understanding of what it meant to be part of the team was notably different from much
of the aforementioned literature. Moreover, rather than being a thing of itself, team
work or more precisely being a team member, had something to do with a mode of
being, an ontological view that spoke to the ways in which one engaged with one's
colleagues; first and foremost, as Jenny suggested, as it was reflected in
understandings that surrounded being in relation.

I began to wonder to what extent the participants' relations were better understood in
the context of friendships (for example; Bowden 1997; Cox 1995, p. 30; Freidman
1992; Chinn, Wheeler, Roy, Berrey, Madsen 1988; Raymond 1986) given the social support and acceptance of the differences in and amongst the staff as a whole which appeared to create a feeling of solidarity. Underpinning these friendships there seemed to be various epistemic and ontological ideas, amongst others, drawn sources ranging from the ancient Greek and Roman traditions to present Western Judaic and Christian heritages. Here again I was left wondering, given little mention of the notion of friendship by the participants, despite raising it on several occasions. Could it have been that friendship was a taken-for-granted notion or even a notion that did not necessarily convey the type of relations these women experienced?

The Bike Rider

Annette was already there finalising the workload for the day. Nods of acknowledgment were exchanged as the night staff continued to recount the over-night activities, how each patient was and any concerns they or the patient experienced. (Journal entry, mid-August 1997)

Why was it so easy to slip back to past patterns—arrive early, dress appropriately—participate in the rituals of the early morning without thinking twice about what was going to happen next. Words of explanation where not necessary, I just knew ... This knowing seemed to be about yet another narrative, being somewhere else before recounting the experiences as if they were ever present. Such convergences carry with them a much stronger appeal, embodied in one's desire for deeper meanings. Yes, much of it was about coaching the less experienced staff (Dyson 1997, p. 200); a time to prepare for what might transpire during the course of the day; about general 'gossip'—a time in which 'small truths' (Belenky, Clinchy, Goldberger and Tarule 1986, p. 116) are shared with each other, affirming one another's worlds; a time that allowed one to unwind (Annette T:7, p. 11) in the sharing of one another's load. By speaking these truths does one engage in a form of critical reflexivity, often unravelling the symbolic, serving to transform one's understanding and from which one can begin to think anew (Chinn 1990, p. 321)? These times
together saw the cooperative growth of understanding (T:12, p. 8). The talk itself somewhat masked many of the deeper meanings; nevertheless, participants commented that the periods they had together, such as the report or handover, served to affirm their everyday worlds (Lyn, T:7, p. 11). Many of the understandings one had of the other had to do with what one's goals were and how these goals contributed in one way or another to the larger picture of caring on the ward.

But what seemed to unite the group in common purpose was a bond (Lyn, T:8, p. 14); an intentionality that rippled through various sub-texts but was expressed in their goal in trying to apprehend what the experience was like for a patient and, in grappling with what the experience might mean for them, offer the best care they could possibly give on any particular day. This feeling also applied to one another, an affirmation rooted in an understanding that it was 'a personal responsibility to get to know one another' (Diana, Vivien, and Lyn, T:7, p. 13). Thus each person was part of a community 'adding their own special touch' (Tinks, T:8, p. 1), attempting to make a significant difference in the life of another.

Was the significance of this experience conveyed in the subterranean of talk? Talk of the everyday; about patients—that Mr J had died and that 'death was not just a matter of patients dying, it was as if something personal was taken away' (Journal entry, early March 1997); what it was like yesterday when the fire broke out on the ward (Journal entry, early September 1997); families—partners, children, schools, kindergartens, and elderly parents and friends; cows, dogs, kitchen tables and tea. Was this talk contextualising one's being, a being-in-relation (Greene 1990, p. 31)?

Music: 'Ancient Mother', Track 1, (traditional) 1993, arranged by R. Gass with On Wings of Song Singers.

Talk ... at Tin Can Bay

Away for the weekend the group talk. Talk—natural affinities—waves tickle the toes at the edge of the shore. The cold water soothes the heat from the body, froth from the
waves still for a moment then dissipating as if the ripple has moved upwards bathing the spirit afresh. Imprints on the sand at Tin Can Bay mark momentarily one's signature, only to be washed away as the ripples of water surge forth rhythmically, changing the landscape yet again. You jump the wave; shrieks of delight fill the air as the water embraces your body; you stand up—glistening as the sun transfigures the body with its light—the rays enter and depart; the heat counteracts the cold sheen of the first and subsequent embraces. The warmth of delight fills the body as exterior meets one's interiority, bathed simultaneously in an ocean of being. And what of this being—the exuberance one shares with others? Is it the enfleshed experience encountered together, the rhythmical movement in one's life, a world that is different from the every day, but one that you inhabit and which I move towards? Is it about a sense of playfulness—openness, creativity, joy of being and experiencing (Lugones 1987, p. 158)?

And were you surprised as we revelled in the water catching waves, missing them too? 'Did I tell you that ... ?'; '... wasn't that wonderful ...?'; '... could you put some sun screen on my back?'.
Walking with another (others) in each other’s worlds, travelling in between them and mine? Do I experience connection through empathy, being able to feel what it might be like for you (Mansbridge 1993, p. 443)? Does my embodied experience of closeness (Savage 1997, p. 239) enable me to stand beside you? Is this an epistemic moment, a knowing that foregrounds the other(s) and the self (selves) (Pam, R:2, p. 5; Jenny, T:12, p. 8) in apprehending meanings of one's presence in one another's lives? Perhaps this travelling in and between worlds (Lugones 1987, p. 158) discloses knowledges of identities—you apprehending dimensions of my world I choose to share with you—and what you choose to share with me—a resonancing that echoes through journeys shared—knowing (Lyn, T: 8, p. 9).

Narratives are shared as they unfold; I listen as you do too. I hold your story—maybe it becomes part of myself. The understanding I have changes—our connection—yours and - mine emerges through the blending of stories, one's selves becoming transformed (Lauterbach and Becker 1996, p. 64; Baker and Diekelmann 1994, p. 67; Gilligan 1988, p. 6) through these insights.

Music: Dawn: sunrise across an ancient land, (Bark, 1995, Track 6)
For the spirit within

Talk ... of elsewhere places
Have you heard how the others are? Any postcards yet? Three participants plus a nursing friend had taken an overseas holiday to an unknown land. They had planned to take this trip for some time; preparations for the journey had been steady although interrupted. The three considered themselves to be part of the older ward staff members, having worked with each other for many years. Moreover as part of a larger group (of which I was one) who were older chronologically they occasionally spent time together bushwalking, finding a sense of sanctuary from being together immersed in nature ...
Tall trees surround us like guardians watching every step. As we stroll along the newly created paths the leaves crunch gently beneath our feet. We walk the terrain silently; now and then a stick breaks as you stand on it. The splitting wood reverberates, adding to your thoughts. Who else has walked this way, you wonder, and how long ago? The smell of eucalyptus exudes from trees. Bees hum ... Here and there long tufts of grass reach out to catch glimpses of the sun. Early morning dew like a crystal catches the light, projecting colours of red, yellow and indigo—gone as quickly as it catches my eye. Over there I can see other grasses, these are brownish green, their tall slender blades hide, from the less suspecting eye, a pink orchid shielding it from would-be prey. Your thoughts are interrupted: you stand still listening for the imitator; it's hard to pick the lyrebird in this symphony. The kookaburra laughs knowingly. We trek on, carefully and with reverence. Boot marks in the ochre soil signify our presence. One by one the line moves; weaving and dodging occasional bushes, wading through the sparsely scattered undergrowth to arrive in a clearing; you marvel at what you behold. We agree to set down for a while and have tea ... sticks are collected ... we boil a billy; I stir the tea with a eucalypt twig. You lift the billy from where it is nestled, stand and swing the billy 360 degrees to push the tea leaves to the bottom. The tea is shared, savoured, quenching the thirst and refreshing the spirit.

Quiet chatter intermingles with the sounds of others in the community here. Parrots fly by, their markings of crimson, greens, yellows and blues blend amongst the foliage and the escarpment of rocks that surround us in this dry creek bed. The odd wild heifer stands curiously at a distance watching us, the interlopers, walking on a land that might be ours, temporarily. Suddenly we can hear another noise, different from the rest.

A small whirly whirly (wind spiral) picks up the soil and leaves, jostling them here and there. It moves across the horizon towards us; we watch fascinated. Just like a top it spins, darting this way and that ... then it is gone as quickly as it had arrived.
Quietness falls amongst us as we sit together in a circle. An eerie stillness flows up from the earth as we share the overwhelming vastness of the land, soaking up the colours and shapes, the warmth in the air, celebrating the beauty as it stretches out before us—a land of ancient times that carries the stories of the never-never and one that now holds our stories too ...

'Dry creek bed': photograph by P.A. Cash.

We share it together ... an occasion that sustains one's wellbeing (Noddings 1989, p 135). Do these moments together rekindle the inner voice (Belenky et al. 1986 p. 145) and ground one's spirit. Do they enable the self to renew points of connection with others and develop new ones? Maybe it is in these times together that friendships are enhanced enabling a deeper appreciation of the other, their values, confirming in this relationship a sense of intimacy (Bowden 1997, p. 67). Are these times about gaining a sense of belonging in the context of others? Were these moments of solitude amidst women who would hold you while you wondered; as you saw yet again the despair in another's eyes, the sorrow, the 'hollow soul', as k.d. lang (1992, track 7) might suggest? Was this holding the something that lies at the heart of the caring the group were able to extend on the ward, all part of one's journeys in life? Engaging with
these women and in the hearing and telling of stories, in the creating of meaning and shared understandings, caring takes place (Baker and Diekelmann 1994, p. 67; Aristotle N.E. 1166a, 4-35, p. 153).

This shared journey is mediated by desire. It is reflected through foregrounding the patients' interests, about being in relation, an intention that arises from a desire to reach out to another or others and in doing so implicates some sort of action. It is thus not only a moral understanding that underpins practitioners' views (Held 1993, p. 52) but also action (Tronto 1993, p. 103) together forming a dialectical relationship. For these women, it seems as if both moral intention and engaging in care for and with others can best be understood in the context of the ward relations and the manner in which such relations affect the meaning of care (Greenleaf 1991, p. 72; Noddings 1984, p. 2). Responding to individuals in need of care by taking care of another might be construed as paternalistic (Hoagland 1988, p. 120) given that, in taking care of another, personal power can be usurped. Nevertheless in the taking care of a patient, nurses seem to construct this caring in a manner that enables the 'caree' to see its benefit. They do so with the intention of relieving the untoward, pain, discomfort, suffering: action directed in such a way that appears to facilitate the power of the patient but supports their growth (Pearson 1989, p. 25).

Care also seems to be about giving and receiving (Noddings 1984, p. 24) perhaps highlighting the reciprocal dimensions of care. One wonders whether in empowering the patient the nurse reciprocally enhances her own power? These areas are what Tronto (1993, pp. 105-108) describes as the caring process, a process that, for both historical and contemporary reasons, caries with it various forms of privileging. Where, for example, institutions purport to care they may reflect practices that act to disempower by taking 'care of' people, furthering subordination (Tronto 1993, p. 117) through revealing one's vulnerability to another (Hoagland 1988, p. 111) and augmenting one's woundedness. Likewise, because acts of caring on the ward take place with some degree of privacy, caring happens in private spaces contributing to its
invisibility. Other assumptions compound the invisibility of caring, especially ideas surrounding nurturance and the genderedness of caring work.

In many situations those in need of care may be perceived to be less autonomous and thus, for Held (1993, p. 53), issues of care emphasise concerns surrounding justice. Does the perception of individuals' neediness occasion a sense of weakness, and hence in 'being weak' that a person might require caring work, work that is ideologically othered (Hoagland 1988, p. 122) given its association with the less able? From this perspective it is possible to think that caring is not only a moral concern but also a political act as well.

Yet for Noddings (1984, p. 24) caring is about mutual engagement, a commitment that is underpinned by a desire for the wellbeing of the other. It is preceded by caring for the self and in the hermeneutical sense apprehending the other's situation as a possibility for me (p. 14) or put another way, participating in the other's experience (Pearson 1989, p. 25). This positioning has been described as empathy and requires trust (Baker and Deikelmann 1994). Noddings (1984, p. 72) also contends that, in caring for another, one works with a sense of engrossment, a focus that seeks to harbour the freedom of the other through support. In caring for someone do you become engrossed in them, subsequently displacing the self? Does such a displacement contribute to and enhance exploitation and powerlessness (Mullett 1988, p. 114) of both you and the person for whom you are caring? Instead, attentiveness or sensitivity might better express the moral location of feelings for someone else's predicament.

Developing this sensitivity might in part be understood to reside in becoming aware of the ways in which the self contributes to discursive practices and social relationships that both shape and are shaped by the self and selves of nurses. Whether such understandings are promoted by a bounded self (Jaggar 1998, p. 9; Held 1993, p. 61) in the context of self-in-relation remains questionable. Is it conceivable that feelings of
security in one's connections, plus the attentiveness that remains paramount to the enactment of care, help to sustain the energy needed to support transformations of this kind as a form of praxis? Do these connections create feelings of solidarity, nourishing the self, enabling one to act with courage to work transformatively? For Mullett (1988, p. 116) the question of caring as a praxis is more than raising one's awareness about one's caring. Rather, it is through the group's collective attempts to problematise the extent to which their realities have become distorted that alternative ways of seeing emerge as part of the struggle to transform the material world (Freire 1972, p. 60). Caring praxis takes as its starting point the view that thought and action in caring are dialectically situated in ethics, and as moral agents nurses can imagine and create new possibilities for caring (Falk Rafael 1996, p. 15; Watson 1995a, p. 83). Was this the implied goal of the group; part of a shared temporality (Benner and Wrubel 1989, p. 140), an imaginary place, a place elsewhere in which care might be extended more fully and deeply (Chinn 1995, pp. ix-xiii; Cash 1993a, p. 73; Chinn 1989, pp. 71-72)? Was this the location where one's connections with colleagues gave meaning to (nursing) life, one's feeling of belonging from which one felt grounded (Jaggar 1998, p. 9; Friedman 1992, p. 94)? Is it a place which one knows yet also imagines as quintessential to possibility—a new dawn?

Quietness

For Alan

Music: Grofé 1892-? Sunrise, first movement, The Grand Canyon Suite, RCA Reader Digest, Dynagroove, Track 1

By what metaphors do I speak to you? Those illustrative of hopefulness, of compassion? Are they metaphors of the authoritative text, or are they symbolic of something else, a different world of women's wisdom that illuminates one's understanding as a natural dimension of one's experience (Parker 1999, p. 23; Banonis 1995, pp. 89-90)? Metaphors of the symbolic act to transcend our locations as Ray (1991, pp. 182-183) maintains; rarely is caring understood. It stands as a 'thereness', a presence, a reaching out to the other in ways that exhort compassion, new possibilities in being held (Karl 1992, p. 6).
As Annette spoke, my thoughts wandered as I heard about the fellow who had been moved to the ward last night having been in intensive care for four days. Pam had looked after him during the evening shift before and was to do so again today. I was to work with Pam; we had the four patients between us, the bike rider, a woman recovering from a bowel resection who was due to have her tension sutures out today but remained very unwell; another woman in her seventies admitted via accident and emergency at about 1800 hours last night. She was unconscious, and clearly dying. The fourth person, another fellow about forty, and hospitalised because of his unstable diabetes mellitus with deep heel wounds. The story was that he had been in accident and emergency and had no-one to collect him. Apparently because accident and emergency had no money to send him home in a taxi (a distance of thirty-odd kilometres) he walked, his heels becoming bruised, swollen and sore. He was to be transferred to another area of the hospital later in the morning so that we could admit another patient coming to the ward via theatre.

What was it that was so different about these handovers in comparison to what I was used to years before? Was it the approach, and/or the process?

I walked with Pam down the corridor and we talked about the four patients that we were to care for that day. There was the fellow to be discharged, the one with the sore heels, not very communicative, requiring regular ‘gluc’ometer readings and obviously quite unstable physiologically—let alone his emotional status; Mrs K, unconscious, needing a considerable amount of care; Mrs Z who remained extremely unwell after a bowel resection, and the fellow she had looked after last night—the bike rider. It was clear that Pam and I
between us had the sickest patients on the ward. We talked about the best way to manage given the situation. I suggested to her that I look after the fellow who was going to be discharged and the bike rider, leaving her additional time to care for the other two patients. Although no words were spoken, both of us understood implicitly that we would be there for one another during the course of the day and that if we needed extra help we would be able to call on others.

(Journal entry, mid-August 1997)

And is this being held a sharing of the world in which one engages? For the group, the sharing of the 'load' stands out (T:15, p. 2) as the participants talk about practice and the mutual support that underscores their availability to one another. Annette, for instance, mentioned what a strain it would be carrying the managerial dimensions on her own; Jenny and Pam commenting that having their colleagues enabled them (just like the other participants) to cope. If they were faced with not having one another then 'it would be very hard on your own' (Jenny, T:15, p. 6) 'basically I'd freak out inside ... you would just have so much on your shoulders' (Annette, T:15, p. 6) and no one with whom to consult. 'Each staff member is a resource for information; we draw on each other's experience' writes Pam (T:12, p. 14) in the margin of the transcript. Indeed, participants expressed a sense of confidence in one another (T:15, p. 6), always knowing that there was someone else with whom they could share their day-to-day practice (Jenny, T:15, p. 6) and feel relaxed in doing so (Jenny, T:13, p. 12) given their mutual respect and concern for one another.

Clearly the group appeared to recognise the importance of relations of caring, trust, and concern (R:3, pp. 8-9). Caring involved each person having their own role as a team member while being acknowledged as 'put[ting] in what they can and are into the ward—good or bad!' (Tinks, T:8, p. 1). Was it through engagement with each other that participants were better able to value the self? In doing so, did they create for the self a better world (Held 1987, p. 126), one that valued the self as part of the collective interconnections in one another's lives, 'care [being] the extra—the sharing of
ourselves' (Jenny, margin comment, T:8, p. 14) or, as Vivien (R:3, p. 9) put it, even the 'physical presence [of one another] might be enough' to enhance meanings?

As the group teased out their relations they began to reveal the importance of one another in affirming their own identity as part of their resistance to the seductive and tyrannical depictions of the gender norms (Ferguson 1998, p. 10; Bordo 1990) and patriarchal ideologies embedded in nursing. Not only was the physical support vital but there were less tangible things, an air of confidence perhaps, that stemmed from feeling supported, 'knowing things were going to be all right ... when [a staff member] walked in and you were in strife' (Vivien, R:3, p. 9) or watching out for one another (Tinks, R:3, p. 10), which contributed to a shared endeavour. Somehow this shared feeling of possibility worked to unite the group.

Creating and sustaining bonds

The bonds that seemed to unify not only arose from the everydayness of ritual and routine (Starhawk 1982, p. 155; Aristotle N.E., 1166a, 4-5, p. 153) but from inclusion (Annette, R:1, p.,14) and shared visions, dreams of what participants imagine the best care to be. While not necessarily precisely the same, such dreams served to hold the group together, strengthening the bonds in mutual concern and acknowledgment for and about each other (Annette, R:1, p. 14). Diana (R:3, p. 14) believes it is their individual perception, their intuition in the caring for patients that by extension dialectically applies to each other. This relationship, Annette (R:3, p. 14) adds, pulls people together giving strength to purpose.

Sharing these bonds also appeals to a much deeper level, creating and holding the heart of the community. Moreover, it is not only the dreams that enhance the feelings of community, but times spent in wanderings, the fun (T:3, p. 17; T:5, p. 3; T:7, p. 9) but also participants' joint herstories of being with one another, creating a culture of resistance to outside threats (T:7, p. 12), all of which helped to ground the heritage of being in relation (Pike 1997, pp. 533-534; Cox 1995, p. 31; Friedman 1992;
Hoagland 1988, p. 154) and from which difference and heterogeneity stem. Perhaps it is here where one can be at ease within the self in the world one knows (T:8, p. 3; T:13, p. 11) and in which one is known. It is the mutual concern born of this 'at easeness' that gives rise to the ability to attend to, and be supportive of, one another. In attending one is 'lending support' to another to enable them to gather the strength from within, to focus one's power as energy in the gathering of that strength. For the nurse, such reaching out constitutes an engagement of the self with another like a guide who heralds the way, using her rhythms of being to enhance the depleted energies of the other. Without this support for the self it becomes difficult to care for patients (Boykin and Schoenhofer 1993, p. 62; Green-Hernandez 1991, p. 124).

**Sensitivity**

Again the metaphoric voice reflects on the dialogue in Appendix 9. To what extent is admitting that you are experiencing difficulties in handling the load a risk? Does it highlight for another your vulnerability and in being vulnerable offer a way of establishing closeness with someone else (Hoagland 1988, pp. 106-110)? Could it be that in choosing to reveal how one is feeling, one gives others access to the self, an ephemeral instance that, while it might be construed as a controlling one in which the self engages in manipulative strategies, may also be thought of in another way, when control is relinquished. Disclosing what might be of significance to another person holds with it risk. How does one respond to meaningful engagement when utterances reveal dimensions of the self that others may not be privy to? And what if the shared disclosure stands at odds with one's values? By maintaining my integrity, am I able to engage with you without falling prey to exploitation (Card 1996, p. 89)? Will I become complicit, rendering invisible my emotional work (Frith and Kitzinger 1998, p. 304)? How can I do this—can I be present only when I apprehend my own worth and the worth of another as fundamental to self? Do we see each other equally as you and I attend to what is said? Can I contribute meaningfully in such a conversation as you, like I, are immersed in a network of relations? Do we share deep thoughtfulness that acts to profoundly change both of us—imbuing in our relationship a sense of intimacy? Is our relationship one of friendship (Bowden 1997, Raymond 1986, p. 288).
218)? And where is the control to be found in this relationship (Hoagland 1988, p. 113)? Has it dissipated in the mutual recognition of trust? Is this relationship—yours and mine—reflective of an understanding that honours each other; sharing and self understanding that weaves new connections from the fabrics of one's lives ... ?

**Attentiveness**

Attending to one another reflects a focus on the other that captures the all of my self that I am in being with you as together we come to appreciate each other's situatedness and in doing so affirm the manner in which each of us experiences reality. Sharing what one feels about a given situation acts to support how one perceives the situation to be and having a colleague to share this with reduces isolation but at the same time confirms one's experiences (Hoagland 1988, pp. 125-128). Yet to what extent is this framed upon the ways in which others see us - as Sartre asks, is the person in the mirror (stillness) an image on whom I gaze or is it someone else? Such a position seems to suggest that being with another is dialectically related to the manner in which one understands and sees the self. This connection also enables nurses to pool their energy by making themselves available to reach out further in a connected knowing of the self with others. This kind of thinking, in which meaning is sought, is for Arendt (1977) fundamental. Such knowing is time honoured—meanings derived over the many years of experience in practice. It is a temporality to which participants continually refer and one that is underpinned by empathy (Belenky et al. 1986, p. 115). I began to ponder upon whether the group's being together in elsewhere places reflected a need to ground their caring in an ecological way perhaps, as Ginzberg (1987, p. 71) describes, in a reunification with nature as part of one's 'life force' (Trask 1986, p. 86), re-connecting with and enriching eros (Griffin 1984, p. 1), enhancing creativity, one's feeling of balance and inner harmony (Lorde 1984, p. 55).

And is this world which I walk but one; whereas I feel the other world from which I came is now moving beyond my grasp? Is the other world changing its focus to one in
which the ideologies speak to individualism—I yearn for a place elsewhere ... Are my
desires, in Gergen's (1991, pp. 8-10) sense, those of an affirmative postmodern
romantic in tension with modernist leanings? I cherish depth of engagement, meaning,
friendships, beauty, passion, harmony and nature.

As opposed to the 'youngies' or 'oldies', a description that annoys Vivien (T:11,
margin comment, p. 2) (as she notes, possibly because she falls into the older group),
the 'middle group' comprises women staff members who are very involved in family
life. This group are closest in time to momentous occasions: the pain of childbirth, the
joy of new life, the multiple transitions of the body, new connections, loss and grief.
It is a time when women feel particularly responsible (Lyn, T:11, p. 2) given children
and partners, and this has a tendency to generate restrictions upon one's sense of
freedom (Jenny and Lyn, T:11, p. 2). I wondered through these conversations about
women's multiple lives, their choices and their sense of having to juggle all the calls
upon the self. Did these women resist a bifurcated consciousness (Smith 1992, p.
306) in part because they had managed to transform their worlds to enable them to
share more equitably the responsibilities of parenting (Baines, Evans and Neysmith
1992, p. 23)? Was their professional world of nursing something that enriched their
worlds in intellectual ways (Jenny, T:11, p. 4) removed from tedium of the draining
repetitious work at home (Noddings 1989, p. 135) allowing women to create new
meanings through living in multiple locations? Their lives brought to others
remembrances, a thoughtfulness in a return to the rhythm of embodied understanding,
intuition emerging through different connections and in the travelling between various
worlds (Lugones 1987, p. 154).

Intuitiveness being together, sensing the other, is a knowing. It arises through
thinking—what Arendt (1977, p. 59) might call an 'inner sense' not given to
perceptual appearances. It is like the 'third eye', knowing beyond the immediate
sensing. Thinking may be what prompts this intuitiveness, a thoughtfulness that
grapples with meaning rather than reason (Arendt 1977, p. 57). What something
means encourages an inner searching. Unlike Kant, whose legacy was to distinguish reason from thought, Arendt (1977, pp. 63-64) suggests that thought arises through reason; a dialectical process which foregrounds the imaginary and places of memory. Thinking may distance the sensory despite, nevertheless, being embodied. In reading Arendt I began to wonder if one's reflexivity enabled this knowing, and whether participants' knowledges of one another engaged them with a familiarity of their embodiment. Was intuition a heightened awareness that prompted their attention? Greene (1990, p. 33) puts it differently, using the metaphor of an orchestra. The orchestra is finely tuned, able to detect elusive changes in one's being that to the ordinary person would be undetectable. Such artistry derives from an intense appreciation, maybe a passion of and for the whole, for the team. And then of course, as Lyn suggests, 'there's a camaraderie if you like'(T:2, p. 7).

But the notion of camaraderie as 'entering in ... [to] a sort of fellowship' (Hennie, T: 8, p. 2) suggests something more. What did it mean, to be entering into ...? Perhaps it reflects compassion, as Simone Roach (1991, p. 15) expresses it, 'an entering into the experience of the other ...'. Was this the something Jenny (T:4, p. 16) termed as the caring envelope, being held, being entwined in or bounded by strength. Is the envelope a metaphor about containment controlling the environment to promote healing, and in such circumstances healing is enhanced with the all encompassing energies of collaboration (Krysl 1998, p. 5). Vivien (T:11, pp. 5-6) wonders: 'it never ceases to amaze me that we do all get on so well'. She then writes, asking 'does this necessarily increase your survival chances in the hospital?'. Perhaps the metaphor of the envelope also suggests a space created by friendships (Raymond 1986, p. 239) reflecting a 'striving for the full use of one's powers [which meant] living life with a purposeful energy', enfolded by trust and respect.

While respect for another might be perceived to rest upon obligations (Dyson 1997, p. 197), Card (1996, pp. 84-85) eloquently writes, that respect may be far more important in relations of caring in a pluralist world precisely because respect underpins
an openness in caring relations that stems from a social justice viewpoint and which, Aroskar (1995, p. 136) contends, is paramount to a moral community.

In this moral community one might encounter respect and understanding, being with, listening to what another is saying, bearing witness to the testimony of the other. You listen with humility and as the story unfolds each word touches your flesh. This bodily experience, suggests Griffin (1999, p. 288), has been ignored, bodily knowledge being dismissed as erroneous. Understandings of the self left unspoken.

Quiet music: Morricone 1986, 'Gabriel's Oboe', The Mission, Virgin Records, Track 3
He had been hit on his bicycle riding to work.

Now with us on the ward he was in one of the single rooms close to the nurse's station so we could watch 'over' him.

From the corridor I peered in the windows of his room. He was lying there with a sheet draped crudely over him. I knew he had been to theatre, stitched up and put back together, his body traumatised by the accident and traumatised further by the body work necessary for his object survival. He was in ICU, ventilated, tubes in his chest, tubes hanging from his nose, shoulder, sacrum, penis; tubes in and out of everywhere.

He came to us following extubation; stiff, sore, tired, his body bearing the scars and the scares of the story ...

I walked quietly into the room, he looked septic, sweaty, discoloured, uncomfortable; he turned his head to see who it was entering his room. I sat down by his side on the chair next to his bed and introduced myself. He asked where Pam was. He wanted her to look after him, after all she had promised she would be on in the morning. I assured him that both Pam and I would be there for him all day, Pam was in the next room with another patient but she would be coming in to help as soon as she could ...

We began to talk, initially about his immediate concerns, he was sore—his body ached, he wanted to move. It was too
painful to even adjust the position of his legs. Together we began to figure out what might happen during the course of the day and how together we might accomplish each activity. I arose from the chair beside him. He muttered 'please don't go!'. Deep down I knew he was feeling totally alone, scared, wanting someone there with him. 'I'm just going to get the CD player and I'll be right back'. Pam grabbed me as I walked to get the machine. She needed some help next door to roll the woman and do her back. I returned to him and set up the machine and asked if he had any preference for the sort of music. He had none, nor did he care. I selected some quiet classical pieces and left him to rest after we had given him some analgesia.

(Journal entry, mid-August 1997)

What is it about being alone, vulnerable and realising one's mortality? Is it about facing the raw emotion of the everyday world of life and in living, death? Do nurses realise these moments, taking stock of them, or do they put them to one side? Is it about struggling with the living that nurses engage, each person's illness becoming etched in their being giving their life meaning almost as if their life becomes a metaphor for life itself and death too? For in death, one comes to apprehend the meaning of life. Meanings of one's existence are often contained in metaphors, metaphors themselves reflecting the deeply symbolic (Griffin 1999, p. 209) but also signifying and giving connection to other worlds.

These worlds blend as a unison of interests. Lyn (T:2, p. 7) writes to me that there is 'respect for ... staff members and their knowledge inside and outside nursing'. Such affirmations are commonplace but respect and trust exist in a triad with competence.

Being competent seems to be integral to the epistemic nature of virtue ethics in caring from a professional point of view. From an Aristotelian perspective, van Hooft (1999, p. 195) argues that caring from the moral location of virtue is not only a matter of 'feeling rightly', indeed it also involves 'thinking rightly', which draws on
understandings from, amongst other things, science and technology. It also implicates the interests being served in what constitutes rightness and the moral embeddedness of choices in decisions of this nature (Sandelowski 1997, p. 75), including the notion of rationality. In this comment what van Hooft seems to ignore is that these two may be dialectically related, informing ways of acting in care. Interestingly, Cooper notes (1993, p. 27) that even though a nurse may be technically competent, unless she acts sensitively her agency will not reflect the attention needed for connectedness in caring. Looked at more closely, perhaps the notion of competence entails apprehending the other as a way of seeing the abject as part of the self or the self's 'extension' (Cooper 1993, p. 27) as part of the embodied self (Sandelowski 1997, p. 78). Moreover the notion that competence may reflect understandings that are not necessarily related to technical constitutive interests but rather to practical or emancipatory interests (Habermas 1972) remains in question. Is the notion of competency about maintaining a larger relational climate in which mutual understandings of one another (Held 1993, p. 60) remain the corner stones of engagement, contributing to and sustaining the goal of empathy as an intersubjective meaning?

... and what do you hear? Tales of the past; the pain of my body—the bodied self, a body disenfranchised from my being? Responding with reverence you touch me by your presence ... restore that which is vanquished ...

While this awareness of one another might be construed as surveillance, paradoxically it increased the participants' ability to relax enabling a greater sensitivity to each others' idiosyncratic ways (Grams, Kosowski and Wilson 1997, pp. 13-15). Paralleling this awareness was an awakening and deepening of wider relationships (Koerner 1996, p. 74) helping to sustain the participants. It seemed to ripple through the ward, a thoughtfulness informed by a moral landscape that enhanced their passion in caring (Watson 1990b, p. 19).

... You with your shared courage, you exude strength. Are we one?
It was about half an hour later that I returned, having assisted Pam.

It was a day of firsts.
The chest drains had come out earlier that morning.

I removed the peripheral line, then the catheter.

We washed his body together. The washer glided over spaces between the wounds. His body was now the superficial site of invasion. He put his hands in the water, playing with it for a while and smiling back at me as our eyes met.
The water seemed to make him feel good as if cleansing his spirit.
He complained of sore legs and feet. At first they were so sensitive to touch. The warmth of the flannel and the immersion of his feet into the water seemed to thaw the pain.

Talk of his family began to surface.

I suggested a massage and he agreed.

The room was filled with quietness broken only by the soft rhythm of Vivaldi's returning bars of The Four Seasons. As I massaged gently he began to speak of what happened. One moment he was pedalling—the next in hospital separated from his family. He spoke—

of the wrenching in the separation ...

leaving his wife and kids ...

and in the fragility of his mortality.

The depth of emotion seemed to fracture his sentences into half—unable to be finished—the remaining thoughts diffusing...
as smoke does through a room, gently saturating the air with its heaviness. We breathed these thoughts together knowing in some other way we were also celebrating his life ...

We began to weep ...

silently the tears fell as if to wash away the past.
The rhythmicity of hands and breathing worked like waves seemingly transforming the taut painful body into the vortex of deeper and deeper relaxation and connection, a shared space ...

... time stood still the mutual realisation that the connection between us had transformed the physicality of caring to a deeper positioning; revelation of new meanings born through the pain, in bearing witness to the preciousness of life, vulnerability, and in life itself ...

a celebration of the spirit ...

What happened?

Later:
I sought Pam to get him up to a standing position.
Carefully, and with some degree of awkwardness we manoeuvred him to the side of the bed.
Stiffly he sat for a few minutes wriggling his toes, overcoming the dizziness. We held him; shoulder against shoulder against shoulder against shoulder on the side of the bed. Energy flowed into him and with one carefully adjusted movement his feet touched the floor. We lent our bodies to him giving him strength to stand.

At that very moment, Annette walked in. Spontaneously she came to push his knees together and with the agility of experience, in the one movement cleared the bed from behind us, and pushed his bottom in. There like the three stooges we stood—up straight—in a line—smiling.
It was like a victory, a milestone in recovery. We stood with him for several seconds glancing triumphantly one to another all of us with tears in our eyes. Now, opposite him, with a gentle smile and eyes glistening, Annette's face also told a story revealing her own depths of emotion—yes! celebrating too. Our line had now become a circle of shoulders. We stood closely sharing the energy, moments of vibrancy that sustain one's being; our being-in-relation.

He wanted to use the bathroom, so with his weight firmly upon our shoulders we walked him the five or six steps into the bathroom and lowered him onto the toilet. It took the three of us to get him onto the seat. It was a wonderful moment that we shared, another two firsts!

As I reflect on these specific moments, spaces in which time stood still, I am met by a profound sense of the enormity that these few moments held for each one of us.

Perhaps they speak to our selves in the complex web of life itself:

a tide the ebb's and flows; of our smallness in the context of a larger unknown; of a sense of spirit that transcends the immediate to other spaces in which one might dwell, be, or become; of the boundaries that are created and broken by moments where we are ourselves and then not—broken, bound, blurred ...

And my not speaking bears the marks of the inexpressible, the horror, the sadness, for the you that was you but the same you as is here with me now, the you, you bear and the you which I try to bear with you ...

I try to imagine the me in you—

And what were you seeing?
... in the standing up—the mind's eye retracing what was; the rippling through the phases of distress, frame by frame a stark reminder—the journey to where you are now and to where you might be ...

(Journal entry, mid-August 1997)

How do nurses live with these worlds—these day-to-day horrors of mutilation; the pain, the joys of new life even in life in death? In each moment do nurses find within themselves untouched locations of compassion? Is it a situation one recognises as having gone before, perhaps in the depths of another world—in dreaming? Learned from another place in their worlds of life: 'letting go', as my sister Dodie once told me, is the mother's grief, discovering time and again the feelings of compassion you must endure or the humility as your life is transformed with the inner wisdom that arises from encounters that mystify. Are these moments in which 'bodies and spirits are being traded, and by this transaction your soul is allowed a larger breadth' (Griffin 1999, p. 243)? Or are they moments of consequence in which the unification of energies arising from the depths within meet, connecting momentarily, only to be transformed, dissipating in linear time? Connection, caring and compassion. Yet one moves to another space in which one tries to find meaning in what were once bodies as the skin which formally contained them no longer does. It has become broken, as if letting the life blood ebb, weakening the fragile boundaries within a mortal existence and life in death and death in life. So too perhaps, is an implicit realisation that this is also the me that lies here. Maybe it is the enfolding of the unified bodies of the selves that enables our healing work to proceed. To stand together, to be in touch with one another/other in these ways, is I believe, an act of love.
Chapter 11

Outside - Outside?

Standing outside now and looking back

Now separated physically from the group I still have many questions. Trying to achieve closure on a project such as this is a monumental 'ask'. It is a contradictory moment when the researcher who has worked with the participants in developing the data, negotiating and reaching mutual agreements along the way now stands alone in a somewhat singular enterprise, working amidst the voices in the data and organising the texts into a coherent form, as well as those that are lying in between (Smith 1999, p. 47 and p. 53).

Perhaps closure is never achieved; rather there is a moving on, a holding of the memories, meanings and understandings that have left an indelible imprint upon one's life, informing the way one is and the ways one might be or become in the future. There are lots of things about this journey that have not been told in this piece of work. Questions for instance surrounding leadership; views on/of feminism; more detailed discussions in accessing the group; in-depth conversations on change and technology; thoughts about the legitimate knowledges and specific institutional arrangements which augment authorities. Then there are the very rich stories of practice, some that arouse despair, others joy or hope and others still convey a sense of beauty—the aesthetic. Amidst all the narratives lies a playfulness, like the 'artful dodger', the self invisible and visible in appearance(s). And then there is nursing, in which a multiplicity of ideas become intertwined in notions of caring. Sadly, some of these and other areas, while crucial to the project as a whole, have by necessity been excluded. What I have therefore sought to accomplish is to bring together the main ideas, drawn primarily from meetings. The ideas surfaced are the things the group articulated as critical to their relationships in the 'being of the team'. In making these relations visible the ontological and epistemological dimensions underpinning women clinical nurses'
constructions of their relations have been illuminated, exposing a crucible in which connection, caring and compassion enfold the many selves.

Mel, Lyn, Pam and I stood in the clean utility area drawing up the IV drugs. Mel suddenly said 'It's been really good this study!' the others agreeing with Mel. Lyn inquired how I was going to write it up, to which I responded I was not sure yet. Mel then said: 'start at the beginning—tell it how its happened, make it visible so people can see the difficulties you had getting started and what you have found along the way. This is supposed to be about women caring for women—nursing. Do we really care about one another - women caring about each other? ... If you can't care for each other then can nurses care—and can nurses care about nursing? Yeah, it needs to be visible! We are so used to seeing nursing in the past as something you never talked about. Now it's time to do that!'

(Journal entry, late October 1997)

The reader is now referred to Appendix 10, dialogue that summarises some thoughts related to participants' involvement in the project.

The research involved thirteen women clinicians (of whom I was one) from one acute care surgical ward in explicating, problematising and critiquing their 'collegial' relationships in order to begin to fathom how and in what ways these relationships informed the ward culture, but especially practitioners' relations with one another and the effect these relationships might have on caring for patients. New meanings were derived through the sharing of knowledges, the self becoming more evident to one another (Vonnie, T:13, p. 7). Vivien reflects in the margin of the transcript 'it has made us dwell on our relationships, which has been a positive thing' (T:14, p. 1). Maybe the power of this research also lies in the meanings and possibilities that this project has had for all involved and to an unknown extent, perhaps in the spaces somewhere inbetween.
Ethnomethodology informed by a critical feminist approach was used to access and grapple with the various epistemic and ontological realms of the everyday material worlds of the women participants. The work sought to problematise the women participants' locally held embodied commonsense understandings, to unravel the interconnections between these knowledges and to make visible the manner in which meanings are continually shaped by and shape women's understandings which are in turn tied to social contexts, practices, discourses and social relations in which meanings are constructed, negotiated, deconstructed and transformed. It has valued, made visible and privileged some of the marginal knowledges that might be said to reside in otherness. Throughout, attention to 'gender sensitive reflexivity' (Smith 1999, pp. 4-5; Chodorow 1995, p. 521; Olesen 1994, p. 165; Jaggar 1989; Harding 1987) particularly in the sharing of one's feelings and emotions, has enabled the women to develop a more penetrating understanding of their lives as women nurses.

The research has been political. Not only did the topic itself generate tension, but it has also teased out multiple meanings that have emerged from the various voices, intersubjective meanings, struggles and sites of resistance in which these women engage. From the commencement of the project the participants entered into a shared space in the form of meetings or get togethers, as they were more commonly termed, that served as a major source of data gathering. Coupled with these meetings, I kept a journal throughout, which contained field notes. Notations comprised such things as descriptions of practices, information on the agency and organisation, documentation of conversations, rituals, commentaries on the social worlds, informal interviews, meetings, and social gatherings, impressions, recollections, interpretations and questions. Often conversations comprising field notes were conveyed through stories, narratives of the self or selves in relation. But stories also featured in the meetings, contextualising many of the ideas being conveyed. Sometimes they served as punctuation points; in a metaphorical sense they marked a place in the sand; epiphanies, when one began to think about things differently. Now and then, the women's narratives spoke to issues concerning power, often of disempowerment. It
was almost as if, in the telling of the story, the participant, as the author, was able to
reclaim her power. However power located within the dominant ideologies was ever
present. Issues involving power were embedded in discourses, practices, social
relations and organisation, often reified and hegemonic, taken for granted and
embodied in the everyday lives of practitioners. Awareness and concern about the
dominant voice(s) increased during the research, perhaps as much through the sharing
of understandings as through the strategic moves to further commodify health. Thus
the broader politics of health economics and participants' concerns for issues of justice
were being felt in the participants' lives at the time. The group dealt with these
ideologies in several ways. The participants tried to confront them, work with them or
resist, occasionally placing them at a distance, holding onto and/or shifting their
(invisible) boundaries where necessary. Sometimes they would play the bureaucratic
game: use the dominant language but reinterpret it, constructing alternative meanings to
prevailing discourses, while in other instances they would engage in subversive
tactics.

The conduct of meetings evolved as a natural process in being together. Initially I
adopted a facilitatory role which dissipated over time but, on occasions, was evident.
Perhaps I picked up this role when asked a question pertaining to the specific issues
surrounding methodology or method, or when I asked a question in order to clarify
meaning, or perhaps a query to refocus the conversations just as others did as well. In
some circumstances I asked about a situation or topic that had been raised previously,
encouraging a sense of reflexivity. Generally speaking ideas were covered time and
time again, interconnecting with other thoughts, peeling away meanings to expose
deeper and deeper understandings. Progression of this nature was encouraged at first,
but then became part of the natural stream of inquiry, a transformative process, a form
of conscientization (Freire 1971, p. 224) in which openly dialogical inquiry exposes
deeper and deeper meanings. It has involved a commitment to the histories of the
women participating, as these histories intersect one another's lives giving meaning not
only to how materiality is understood but also to how and why they know the world as
they do. It has also engaged the group in a form of liberatory praxis, one that has mediated the (object) world with one's interiority, the self becoming conscious of her own freedom (Greene 1988, p. 122). Perhaps it has re-awakened a desire to embrace a sense of fulfilment that arises from a longing for what might be possible, or for what might be a better way, towards a multiplicity of being, a praxis located within a moral community from and with whom one shares in a sense of goodness, of healing and of dreaming ...

The flow of dialogue was always haphazard. Unfinished sentences were commonplace, as if the group were completing sentences for each other. Was this because there was an intuitive feel, a knowing that stems from the many years these women have spent together, or was it something else, an eagerness to speak out loud the meaning making they were experiencing through another's insights? Or was it about the opportunity in being together, enjoying the richness of dialogue and in sharing one's worlds with another? However, in reading the transcripts several of the group were embarrassed, commenting that they were unable to put a sentence together coherently (Annette, R:1, p. 2) or as Vivien (R:1, p. 2) put it '... it makes us look like a bunch of prep kids!'

Diana wrote her reflections in a post script:

We are not really articulate finding it difficult in looking at our own nursing. Either objectively or subjectively felt, sometimes the questions put were not always totally understood. **BUT** as sessions progressed, analysis of the problems and verbalising skills became (or appeared to become) easier. Could this be due to greater awareness or confidence in each other? Common problems and inadequacies were aired and shared which has encouraged greater bonding. Support was a word used often for those helping and being helped. Largely we can rely on each other. The 'so busy' is used as both an excuse for not meeting one's own ideals of nursing care and the need to support each other. All agree that Annette is a great leader and a 'tow setter' for the ward. All felt they tried to help/support each other and felt they were helped. All appeared to feel our ward is unique and
special from the staff's perspectives. People's personal lives were shared and this appeared to enhance team spirit and interpersonal relations.

PS. Collegiality is an extension of the feminine/caring phenomena in nursing.

(Note from Diana, late October 1997)

What became very obvious to the participants was the importance of the past as it informed the present and the possibilities that might lie in the futures of these women. Conversations acted to illuminate, make visible, confirm, and expand many taken-for-granted dimensions of their material world of relations. Questions were raised, alternative meanings were sought in an ever increasing vortex of deepening understandings, connections and multiplicities. Knowledges were shared, serving to inform one another, adding new light to their understandings and the meanings one another's relations held for them. There is little doubt that the participants have come to understand one another better (T:13, p. 13), often revealing information about themselves which was not necessarily known beforehand.

In other cases the conversations not only affirmed the presence of one another in their acts of caring (Jenny, R:1, p. 7) but also the importance of mutual support, providing help, listening, being sensitive and acknowledging one another's contributions to the being of the team. For some of the women, working with one another over the years had enabled their self esteem to develop (Lyn, R:1, p. 7); for others it was knowing you could depend on staff (Pam, R:1, p. 8), trust them, trust their judgement (Lyn and Tinks, R:3, p. 8) and also know they were competent in helping you to carry the load (Tinks, R:3, p. 8; Annette, T:15, p. 2). The feeling that individuals were not alone but rather, in an intangible way, together and secure, present—in a 'being the team', was palpable (R:1, p. 9 and p. 16). But this not-aloneness (R:1, p. 12) was also infused with being involved, having a sense of personal control, aspirations, hopes (R:1, pp. 11-12) and dreams. Other feelings such as being comfortable together, being happy inside (R:1, p. 9), having a sense of camaraderie, a 'pulling together', 'jelling',
'having a sense of worth' (Diana, R:1, p. 3; T:8, p. 4 and p. 8), a feeling one was contributing towards a commonly held goal, all acted to bond the group together.

To share how you felt at any one time (Pam, T:15, p. 3) was acknowledged as a valuable thing to do. It affirmed the importance of emotion in terms of understanding one's everyday world (Annette, T:15, p. 4). What seemed to help the participants to deal with their complex material lives was their happiness and enjoyment in being together (Vivien, R:1, p. 1; Tinks, R:1, p. 6; Jenny, R:1, p. 7) in being part of a team and in being the self (Donna, T:15, p. 4). Listening to the self and one's emotions comprised a significant dimension of caring (T:5, pp. 8-10). Annette (T:5, p. 10) commented that once you let go of the professional veneer and felt, you could then learn from these emotions and grow.

That these women believed that the care they offered to patients contributed meaningfully to both the patient's life, and by extension enhanced their own, reflected an ethos grounded in their empathic approach to care (Annette, T:17, p. 15). Being attuned to patients, apprehending what it must be like for them, was also paramount in the group's relations with one another and to the goal(s) of caring on the ward. In caring for the self one was then able to care for/with/about those women in relation to the self, and this further enabled one to care for/with/about the patient. Each of these notions stands in a dialectical relationship with one another. Whether the participants' relations could be construed as friendship remains questionable. Mel was the one who overshadowed the idea of friendship by saying 'we've broken down the barriers somewhere along the line with each other ... we worry about [each other] we look out for each other ... we look into each other's faces and think 'oh, are they happy today? Oh yes, they're happy' and we don't worry any more; that sort of thing ... we could tell straight away ... when I'm dealing on this level of friendship—we're deeper, we're like family, that's what we are ... on a different level of communication' (R:2, p. 13).
Conversations during our times together supported the self to be privy to one another, sometimes speaking of things other participants took for granted, things that were held deeply as part of one's interiority rarely shared with, or for that matter known by, others. Making the self vulnerable, taking risks as one revealed the invisible contributed to an ever increasing sense of mutual respect (Mary, T:17, p. 5) and understanding. The respect accorded to each woman remained central to the common bond(s) of caring grounded in connectedness and compassion, a credo that seemed to be shared with the full complement of ward staff.

Participants acknowledged the importance of a balance of ages contributing in some way to the collective understandings of the life worlds of women; lives rooted in the richness of nature in the transcendent rhythms of the embodied selves in their everyday realities. The many and varied gifts each women brought to the group and to her practice were valued and affirmed. Valuing of one's unique contributions enhanced the diversity of the group in a heterogeneity that can be brought to bear in practice, yet paradoxically, can also undermine.

In highlighting these areas and delving deeper into the ontological meanings surfaced, there were many understandings woven time and time again in a curious fabric that now comprises the chapters of this work. It took a long time to come to an understanding that many of the thoughts are echoed through issues concerning, for example power, in bracing the self or being poised, in traversing the landscapes, in genealogies, multiple subjectivities, the corporeal self, the stranger within, how and in what ways the self is understood not only by the self but by one's colleagues, and the meanings contained in caring and connection with others. Together they contribute to a dialectical ontology—a way of being, a way of becoming in the enactment of care that is first and foremost in relation.
**Authenticating this research?**

Throughout the chapters I have endeavoured to maintain a moral commitment to the various authors who participated in this project. I have tried to find a way that weaves the interconnections using different positions, the voices of participants, my voice, metaphorical voices, maybe your voice too, in playing with different tensions, contradictions and multiple locations at any one time (Emden and Sandelowski 1999, p. 4; Lather 1994, pp. 42-44). Indeed, it has meant trying to create a polyphony within the various representations of one's realities. Take, for example, the notion of standards to which the group refers. Standards work as a simulacra, a representation of reality which is foregrounded by participants, yet behind the notion of standards lies the invisible—amongst other things, concerns about empathy. There are many simulacra which form the rhizomes and from which the rhizomatic interconnections within the subterranean texts constantly interrupt, rupture and intersect in and amongst the multilayered texts. At times, lines worked to segment the dimensions of the rhizome. Again, using the notion of 'standards' or 'genealogies—in control? a segmenting line such as 'coping' might work to territorialise, whereas 'understanding one another or the self' might suggest a line of flight leading to another plane, revealing ontological questions. The chapters therefore are somewhat arbitrary and conventional (Smith 1999, pp. 45-69; Rabinowitz 1998). They need to locate the writer and the reader outside but inside the contexts of the research. At the same time, however, you have been invited to develop parallel texts whilst also enabling the emergence of epistemologies and ontologies that are fluid, open and always becoming (Alcoff 1999, pp. 73-74). In trying to reveal the complexities of the various texts the work conveys a sense of the nomadic (Braidotti 1994, p. 60), a movement in and between the many layers of the complex and varied lives participants live. This nomadic style has, to some extent, usurped the framework of location (the outside, inside, etcetera)—positions articulated early on but necessary for me to see where I was standing or moving towards at any one time.
The outside - in - inside
Locations were ones in which I found myself constantly moving, reflecting, relocating myself and thinking about what might happen next! It therefore reflected the preparatory work: moving into the field and getting to know the group; of the many and varied struggles, and the playing with locations along the way. However these locations were much more defined in terms of what they represented, clear lines of territoriality existed in one's imagination. But these boundaries became blurred as I moved into the inside, traversing the landscapes, as I listened to, and shared in, the heritages of what was before, what were then or now, the stories of one another, the patients the women cared for/about, and the understandings that arose from all these various connections. It was almost as if I slipped into this life in the ward, 'unknowingly' becoming a part of it as an insider. This movement was something that I realised latently, well after it happened. Perhaps it was prompted by the sharing of my despair when my 'little dog' was ill? Looking back it may have been an acceptance of self as the person I am before or at the moment when I was invited to work on the ward. It may have been something else, or perhaps a culmination of many of these things. These are details about which I can only surmise.

The playfulness with locations continued in the context of being inside and gazing out to the other worlds, yet participating in the realities around and within the group. Again this location is also a deception but one that generated a feeling of being 'inside'. Nevertheless, it was also here in the context of the ward that the nomadic voyages in and between the segments of the rhizome became much more evident, the lines and interconnections more tangible, constantly moving and re-emerging in different spaces and locations.

As my time with the group lengthened my connections with each person strengthened. I too had some knowledge of other women's contributions, and I began to wonder what they saw my contribution to be ... or there again what this has been? I became privileged to enter a landscape of meanings and understandings that might not have
been possible otherwise. For example, I was privy to apprehending the importance of
the varied age range and the interests of each participant in each other and in the team.
It seemed that these women's lives were/are constructed around moments embedded in
some of the sacred iconic depictions of women and nature, or as Starhawk (1990, p. 10) puts it—power from 'within'. This power arises from one's embodied spirit, the
self becoming nourished by one's connections or bonds within the spaces in which
one metaphorically stands. Thus locating the self and nourishing the spirit appeared to
be gained through feeling the rhythm of being through the sea and the attendant
pleasures this offers; mothering or nurturing work—possibly the rhythm of the body
and finally (at this stage anyway) the rhythm of the bush/earth. With time I began to
really appreciate the depth of these knowledges, understandings of the self,
apprehending the parts but also cognisant of the whole. It was if the participants had
double vision, seeing the self-in-relation.

Outside?
What has struck me about this group of women is they are all so different and that
such differences are celebrated. When I started this research I was concerned about
the ward's prevailing images which constitute an almost immortalised mythology set
against a culture of heterosexism, racism and misogynist attitudes. The participants
remain, as it were, untouched by the horizontal violence stemming from the outside. It
is a testament to the women involved that they have now a growing reputation that
speaks to their place as a 'holding environment' (Cox 1997; Karl 1992), one in which
I have felt 'held' over the past years and one that sustains me now.

Standing together

... Now, with the curtains drawn, seven staff stood surrounding the bed with Mrs P and Kim. The two at the head
of the bed hold Mrs P's hands. Her skin was drawn tensely over her knuckles signifying her anxiety about what might
happen next—bracing the self as if ready to resist any pain as
the tension sutures were removed. While conversation flowed in and between the staff and Mrs P, there was an undeniable gaze of support for Kim and also for Mrs P. It was if the staff were linking the two together in the telling of their own experiences to which both women could relate. Kim began to remove the sutures. 'Hold, cut, pull, out' a chant had begun. 'One down' someone says as Mrs. P mentions 'it was not as bad as I thought it might be!' ... 'Two', several members begin to share the count, 'that one hurts a little' Mrs P says. Kim stops and contemplates her technique. 'Pull slightly this way' Tinks suggests, as she reveals what she means in the air; the next one slides out gently—'three'—as all but Kim in the circle join in the count ... Mrs P more relaxed now, smiles, enjoying the group around her and participating in the chant. She comments how nice it is to have everyone here with her. Finally the last suture is removed. The group cheer! We celebrated together!

(Journal entry, mid-August 1997)

Outside - out ... Have I really finished and gone?

There is a lot to be said for standing back, seeing this work from yet again another location. The various positions outlined immediately above have worked as another
collection of simulacra which, while helpful initially, have become ruptured and displaced. What is left instead is a horizon of multiplicities, many and varied partialities in a knowing that is at once contextual but relational. The whole experience has been a very important period in my life. It has been a time of great joy, immense pain, of feeling vulnerable, of being cared for and of caring about. I have engaged in reciprocal relations, felt and been part of a team who have cared, nurtured and shared their public and private worlds with one another. I feel I have walked with my 'colleagues' through the various moments in our shared histories and this has been a time of connection, renewal and healing not only for me but I think for the other participants as well. It has engaged us all in looking towards the future with some sense of hope and thus possibilities, which have arisen from a collective endeavour to value one another's contributions. I might add that I don't want to give the impression that this was necessarily an outcome of our time together for it may have happened anyway. But I do want to note that differences were marked, yet these were transcended by mutual commitment, a respect for and a belief in one another in the being of the team.

Taking stock now as I sit at the computer and reflect, I have tried to depict some of the many and varied dimensions of the journey(ies) the group have shared, their being in relation. The work is not finished—nor will it ever be. Rather, this like other moments of significance in one's life serve as punctuation points, points that inform the self with a new sense of freedom as one walks on. What I have attempted to convey to you is the richness of this work; some of the struggles and the passionate feelings I have about it all. To say that it has had a profound affect is perhaps an understatement, for it has been a gift to each of us as we have worked with ourselves and with each other in a space that transcends our time. Each of us carries these stories ... we share them with you as a gift of love.

Penny
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Appendix 1 Painting the (self) portrait-Speaking on the self:

Annette: I've been working at The Hospital since 1965; I've been away to do a couple of courses. I've been in charge of the ward for I suppose twenty-five years. I'm getting to the stage where I'm starting to doubt how much longer I've got to go. Things aren't too bad at the moment, but it is actually a younger person's job and things are getting a bit grim at times.

laughter

Vivien: My name is Vivien and I've worked - here most of the time since I finished my training in the early eighties.

Jenny: I trained in London - started in 1966. I did a staffing year there and then we moved out here [Australia] and I worked here [at The Hospital] for about 8 months. Then I left to have a family and came back seven years ago and I've been here ever since!

Tinks: I'm Tinks and I did my training from 1989 to 1991 and then I did my graduate year here and that was in 92 and then I've been with this great group of girls since.

Lyn: I trained here [at The Hospital] in 1970, left in 1975, worked in Geriatrics part-time for a long time and came back here in 1987; then seven years of night duty on this ward. I've been on day duty for over two years; I always used to do part-time ... I'm a mother ... [there] seems to be five other people pulling me different ways!

Pam: I'm Pam and I started here at The Hospital in 1986 as an enrolled nurse. I went overseas, came back and went to Uni and train [to do nursing] finishing in 1993 and did my graduate year in 1994. [After that] I worked and I got a part-time job in a ward I didn't particularly enjoy and then I was fortunate to get a full-time job on this ward. That's it.
Vonnie: I'm Vonnie. I started my training in 1992 at Deakin and finished in 1994, did my graduate year last year and was lucky enough to get a full-time job here.

Donna: I'm Donna and I did my training in 1988 to 1990 at another University; did my graduate year here, and then when that finished I went to another city for 2 years, got married, came back and did annual leave relieving here and then when the ward changed [its location] I got a job here full-time.

At this point in the circle it was my turn to introduce myself. I spoke of my own history, getting into nursing, about my political involvement within nursing, sharing aspects of my nursing background that I hoped would enable the women to better appreciate who I was and what my interests were.

Mary: My name's Mary ... I have worked on this ward for a long time. I did my training at The Hospital - started in 1977 [and] I've worked in a few other places mainly in another city. I did a gynaecological nursing course at a hospital in another city, in - 1986; most of my working career has been spent where I have chosen to work.

Diana: I'm Diana, like Mary [I] trained a long time ago - that was interrupted by 12 years child bearing then I came back, returned to nursing with different expectations and different ideas. I've just completed a Bachelor of Nursing [post-registration] which was done off-campus over a four-year period. I had a smattering of medical, surgical, orthopaedic when I returned but I've basically been part-time in this ward - laughter - ten years part-time.

Hennie: I'm Hennie ... I was 8 years old when Mary started here in 19... laughter

Mary: Thank you very much Hennie! ... laughter

Note here the interaction between participants. It is a typical example of the life in the data and offers some clues about relationships.
Hennie: I started in 1990 I worked in [a midwifery ward] for 3 years and I've been here since 1993; I trained here as my first position and I always wanted to get back to this ward ...

19th August, 1997

Mel: Thanks for guiding me here, I feel really special.

Penny: It makes me wonder if there are other people that might want to participate.

Annette: Others would be happy to come but I guess somebody's got to run the joint [the ward] too don't they? I think in a way sometimes they feel a bit - left out.
Appendix 2 Beginning conversations: being together

Penny: I guess we need to establish some ground rules about talking - would you be happy with that? Ground rules? ... I'll put it in this journal noting the heading 'ground rules' in the group journal ... What are the ground rules that you think might be important?

Vivien: Always go counter clockwise!

Penny: I was thinking that you couldn't ...

Annette: be talking about them in a derogatory fashion.

Lyn: That's right!

Penny: So what transpires in this space is the property of this group? So we don't talk about it outside the group. Is that a fair thing?

Lyn: ... maybe people can tell others to shut up if they go on too much.

Penny: ... feeling comfortable enough to say what they have to say.

(T:1, p. 2)

Annette: I'll tell you two things that have come back to me ... I've been concerned that the reason why people are here today is because I suggested it would be a good thing; people are not here because they want to be here, that's one thing that troubled me. I realise I've got quite persuasive powers. The other thing is wouldn't it be a shame if doing this [it] somehow or other altered it, what we have. Wouldn't it be a shame if all of a sudden there was some sort of rift.

Jenny: I don't feel pressurised, but I think quite a few of us, have all said 'wouldn't it be awful just by looking at what we've got under the microscope it actually disappeared'.
Tinks: I sort of thought well - Annette thinks it's a good idea, why would she think it a good idea; so it really makes you think about it a bit more.

Annette: There are many ways that I'm good at my job but I find it very difficult to get the staff together and talk to them so I don't. I don't say to people you do a good job. How I'm successful I'll never know because they're the mistakes that you [make]; in management. Maybe I'll just bite the bullet and do it once a year or something ... we were joking one day and [one of the staff members] said remember you said one Christmas I had said we've done a good job and everyone nearly fell over. The fact you [Penny] said we'd do this makes me feel good. I haven't got the confidence or the ability to look at their practice so you're filling a gap and that's why I suggested we do it ... I feel it's beneficial.

Lyn: I think we are are all still a little unsure of exactly what we are supposed to be doing ... and we need the leadership from you to probably draw what you want out of us.

Jenny: Do we need to actually define collegiality? I mean really ... teamwork; I mean are they the same thing?

Penny: The literature talks about collegiality as teamwork, then teamwork is seen to be just tasks or rituals that you do in a ward situation. It's not that in my view; I'm really interested to know how you people think about it ...

Annette: One thing about teamwork ... I know for a fact that I wouldn't have the confidence to come to work every day if I didn't feel supported by the staff and it would be much too daunting a job to do on your own. I can't imagine any of us coming to work on our own; [without] ... that support I would go under immediately.

Jenny: Half the time you need to ask somebody to actually physically help you do something, turn the patient or help them out of bed or something like that ... you're always bouncing ideas
off each other, I mean even if it's something really basic like some observations that aren't quite right.

Vonnie: Everybody's really approachable; they don't mind [helping]

Tinks: When I did my graduate year some of the places were awful; so then when I did my six weeks on 13 West I thought hooley dooley people are helping me ... I think because we've got such a high standard of care ... everyone works on that same level.

Lyn: ... when you come on a shift ... you just look around and think who's here today? If you've got extras or if there's a lot of young ones [new graduates] you think - 'oh dear!' If there are all these familiar faces you think - 'oh! this'll be a good shift' because you can trust people. [If] people let you down you don't trust them.

Tinks: If you'd like somebody to give you a hand and you say please do that for me and you come back and it's not done then you think I'm not going to ask again!

Penny: Trust is very complicated - I find it very difficult to trust - I suppose everybody does.

Lyn: I don't think we do here though do we?

Annette: ... Trust might depend on whether or not you're independent so I feel I'm quite an independent person. I can afford not to trust people; I feel I'll manage on my own.

Lyn: But you said before how you couldn't manage alone.

Annette: As a person that's me as a person I don't trust anybody - but at work I do, because of ... the nature of people working here - about how people maintain good teamwork. I do have confidence in the team, even though it's against my nature.

Lyn: We all bring our histories with us ...

(T:1, pp. 7-10)
Appendix 3 Changing worlds

Penny: And how have you adapted to that [pace]?

Jenny: Work faster! You go quicker!

Mary: You don't know the patients as well as you used to for a start; particularly the person who's in charge of a 34–bed ward ... you tend to know the sickest ones.

Vivien: The grads [graduates] don't get as well looked after any more; we don't get as involved with pre-op education any more.

Jenny: A few weeks ago we were talking about a letter of complaint from a patient. I think that scenario was a result of the ways things are; you know it's rush, rush, rush! There's actually two changes that have taken place over the last couple of years: we became a 34–bed unit ... and there's been a great increase in short stay surgery - like having 3 patients in one bed over 24 hours. We're really busy!

Mary: People are expected to go out of hospital as quickly as possible. A few years ago they'd have a chance to wee post-op, today they don't! They whack the catheter out and away they go.

Lyn: Now you're expected to teach 80-year-olds with arthritic fingers and bad eyesight to find their clitoris not their clitoris - their urethra they didn't know about that; finally we taught 'em!

Lyn: ... there was this old lady and that's what she was poking it into, that's why I said that ... down a bit further!

Penny: Do you think there's a change in knowledge about women's bodies?

Vivien: Nuh!
Reflecting on spaciality

**Jenny:** It's a bigger area to cover, the person who's in charge might be up there at room 1 or down there at room 13. It's harder to find people; whereas the other place [13 West] was just sort of a square and everything was very, very accessible ... I mean that back corner is so far away from the kitchen! When somebody just says that they want ... you get back with it - and then the person in the bed next to them says 'oh, can I have some too?'

**laughter**

**Mary:** Good exercise though!

Looking within

**Annette:** Often it was very difficult because the staff weren't my staff; I understand what it's like to have my staff and other staff. Over the years I have actually been the one who's hired the staff and as time's gone on these people have then become my support because they've been put on for a job, they seem to enjoy their work and it's team business, I mean I understand deep down what it's all about, I find it hard to put it into words, but I understand the team.

**Penny:** You're much more conscious now about how you feel the importance of the people?

**Annette:** Yes. I feel so supported [knowing] now that the staff will look after the patients whether I'm on the ball or off the ball on the day. The staff are consistently there looking after the patients; I am very aware of my - the sense of responsibility for the end product, the standard of care. I don't look after the patients, other people do; I'm very conscious of this. When I first started, I struggled and nearly drove myself crazy knowing what I wanted but I had nobody, that's the thing, and I guess I sit in these afternoons and I realise my
God I'm lucky - look at what I've got now, look at what you had 20 years ago or whatever or when you started in charge, and I had to work very hard and long and you know pull the daggers out of my back every night when I was ... I used to work 10 hours a day every day until I got on my feet. I started to warm me up!

Mary: I think we're probably getting used to having different people working here, replacing people on holidays, or when they're sick, because it's such a big ward and there are so many people. When we used to be on 13 West it was very closed shop.

Lyn: We like it when we are all here though.

laughter

Mary: But I think we're all better now with having other people come and work with us, as part of the team, and I think we accept them better than we used to when we were on 13 West.

Penny: What do you think has made the difference?

Mary: We're more used to it! I do try a lot more now than I used to to make people feel more comfortable in the place. I talk to them a lot more, find out about them, you know; I try to look after them while they're here.

Lyn: ... but I think in this place, because it's so big we try a little bit harder, don't you Mary; because it's so big we realise that people can get a bit lost and stuck around the corner or down in room one or somewhere, and they could be floundering or could be not getting their work done properly if we don't take a little bit of notice.

Penny: What do you think about large wards as opposed to your experience of being in 13 West?

Tinks: ... it's just that you can give people more care - can spend a bit more [time] and get to know the patients better.
Appendix 4 Standards?

Pam: [Here] everyone's got the same [standard] whereas when you go on other wards it's hard working in an environment when your standards are not the same as others.

Annette: I tell you what I think's fascinating and I don't know where it starts, finishes, or what the cause is, but I don't ever, I really don't ever have to say to people look you will work is just not good enough. I think it's interesting that all the staff seem to keep each other on their toes. This is what we're talking about, this teamwork business. I don't have to say to people look, your work's not up to scratch, because chances are one of the other staff already told them last week.

Penny: So somebody else does the telling?

Annette: Yes but not necessarily just Mary, that's just an example, but I think each person has their say about what they think is right and wrong and if they see something that's not right then other people are told that's not the way it's done; it's not done like that.

Penny: So what's the standard then?

Lyn: I just think that one thing that people would have in common in the ward that have a similar standard of care would have a similar amount of empathy with their patients.

Penny: So it's empathy?

Lyn: I think empathy's got a lot to do with it; I think often you find somebody and they might be quite a good nurse, but for some reason their empathy isn't the same as the nurses you really admire.

Jenny: ... We individually have got to give above a certain standard. You said something about we will lift the standard of each other; I think everybody here wants a certain standard for
themselves to give to their patient, I don't feel it's what other people are egging me on to do, and I don't feel that I'm egging anybody else on to work better; I think everybody here does work well, basically they’ve got the best intentions of giving really good care at heart.

Annette: So when standards and things like that are mentioned I mean it really means nothing.

Jenny: Some days the standard is better than others because some days you're not so busy. It doesn't necessarily follow that when you're not busy you give the best care but sometimes when you're pushed that bit harder.

Annette: Well as you all know I don't actually do much in the way of bedside care but I guess it was like a penny dropping for me. I mean I’ve always been a late starter and a late - slow learner whatever but ... empathy was always just a word I guess, you know I was hospital trained ... never thought about it ...

Penny: So was I.

Annette: ... We had such task orientation when I did [my training]; the penny dropped and I started to understand about how people felt when they were sick. It was like an absolute revelation and that completely changed the way I looked at things because we weren't bought up to be empathic were we?

Penny: No.

Annette: It had to be a learned thing and I guess it doesn't matter which way you trained. That's the key to nursing really and once you know you're able to empathise with your patients then nothing else really matters - you're understanding how that patient feels and how they like to be looked after; that is the key to your daily work. It doesn't matter about tasks ... you stop and think about if you were sick how would you like to be treated - and that's your answer to nursing basically ... it's an easy job, simple. making light of the last part I guess I'm trying to point out its so individual too. Everyone's saying
it's like teamwork and standards, everyone wants to do standards, but basically I think it is a very individual thing. Each one of you presents yourself differently to the patients and OK you all try to look out for the patients but it's a very individual thing, how you care for your patients, nobody else does it like you. So when you talk about standards, what are you talking about?

Penny: Another issue is the tasks - and the notion of basic care and you know, other care, I'm not quite sure what basic actually means....

Annette: I talk about basic care all the time in order to highlight to people that the basics are the most important thing. I guess my idea is a nurse's job is to care for someone while they are unable to care for themselves; if they can do that then they are doing basic care, anything more is over and above ...

Penny: I don't know if everyone's aware of this—that a lot of places have basic nursing care [and] advanced nursing. The basic care that you're talking about is often I think seen as unimportant and de-valued, whereas what you're doing is you're valuing it.

(T:1, pp. 9-13)

Annette: ... one of the things that I've learnt over the years regarding the standard - we should be providing for the patient the care that the patient wants; like washing people. Now other people do not have a shower every day, a lot of people at home don't; now we think somebody's strange [if they] don't, right? But old people - they do not shower or bath every day; they can't, it's too much trouble, they get up, they walk into the bathroom, they wash their faces and hands, do their teeth, comb their hair, and that is it for the day, and they are happy. We're in here and we're dragging the poor old buggers off to the shower -

Mary: every day -
Annette: ... and they don't want to be, but they're getting dragged off and we should be doing other, more important nursing; we could sit down and talk to them or sit and help them with their meals or something; and they're not enjoying it anyway, and they didn't come here to be showered, they came here for something else, to have an operation -

* * *

Mel: [So] - ultimately the structure of this ward means that only the best possible nursing care ever gets done.

Vivien: Oh what - just let me stick my fingers down my throat - the best possible nursing!

laughter

Mel: I've worked in another hospital where people do whatever care they feel appropriate and don't get picked up on it ...

Vivien: We do an average job and we get by.

Annette: I think it's nice that people have aspirations; that people have got to aspire to something better. Unless you actually aspire to improve then you never will.

nods of agreement

Vivien: ... we do - not the best job possible. We do the best we can on a certain day!

Mel: No, we do the best job possible!

laughter

(R:1, p. 12)
Appendix 5 Coping

Annette: We've had a busy morning we've had all up 14 patients doing to theatre today - I've been a little bit manic!

ha ha - laughing

Jenny: Yeah! Well when the boss's off everybody goes ...

laughter

Penny: Obviously it's a good day for - discussing coping, given the number of patients going to theatre. Why we feel we have to cope?

laughter

Annette: I don't know what the alternative is? I guess I'm from a different era. We had to cope! What are the alternatives to coping? I don't know ...

Lyn: It's a sort of part of your nature. Your parents and your teachers sort of yelled at you 'there's no point in doing anything unless you do it properly' ... you were never allowed to be too emotional about anything and you just did cope, and I think it's a hangup about having to cope all the time.

laughter

Diana: Are you talking [about] coping emotionally or coping with the whole gamut?

Penny: What's coping emotionally?

Pam: When you've got to draw that line—about getting too involved with your patient - stand back.

Vivien: I spend most of my days here not coping.

laughter

Vivien: I didn't cope last night, I probably won't cope again tonight.

Jenny: I always feel I must cope because otherwise I'm admitting defeat!

Jenny: ... just sometimes if I'm vulnerable emotionally - I mean I you don't cope emotionally just occasionally - tears may get
get the better of me perhaps, from a patient or something like that, or from another person you work with and you go off.

Diana: ... if they're competent to deal with what's expected of them, then they're seen to and feel that they are coping

Penny: I create those expectations upon myself that sort of pushes me into doing things that I wouldn't necessarily do. I guess it's the same in a ward situation, you're trying to do the best for your patient; if you are unable to do that, then you feel as though you're not coping ...

Annette: Ultimately we've all got to realise that's there's a limit to what we can do ... I must say I try to do the job the way that I think it should be done. We're not super human! I mean you run around like maniacs; we've got 14 people going to theatre! When it all boils down how many of them are dreadfully sick? None of them; they're just having these procedures, which could have been done next year if the truth be known, so why the hell are we getting so stressed? - Relax!

laughter

Jenny: So, what are we going to do, just say sorry that patient's not going to theatre?

Annette: Yeah but I mean the pressure's all put back on us - we're just the mat to wipe their feet on - eh?

Lyn: Pawns.

Annette: Yeah! Just pawns in the system!

nods of agreement

Jenny: But in amongst all that there are - sort of amongst all that, there are these really sick people who actually do need looking in great detail and at great length.

laughter

Lyn: Even if they think it's slight procedure, it's the biggest thing in world to them!
Diana: Do we as nurses have greater expectations than other professions because of the very nature of our work?

Jenny: We've had to provide this wonderful service, be above reproach, do everything on time, perfectly all the time!

Annette: Says who?

Jenny: Well I dunno - that's - we've been brought up and conditioned this way, haven't we?

Lyn: But if you went to the doctor's surgery and sat for half an hour you'd think you were jolly lucky, if you're here and sat for half an hour before the nurse came up and said I'm ready to admit you now, you're the world's worst because the public have incredible expectations of what goes on in here.

Penny: Why do you think the public think that way? I see it as partly due to things like ER and Country Practice. How much do you reckon that's affected people's perceptions?

Diana: They did have that nurse one with the short skirts and the boobs. laughter

Penny: So what's that say?

laughter

Vivien: That we're tarts

Tinks: Tarts! laughing tarts!

(T:4, pp. 1-3)

* * *
Appendix 6 The Complaint

Annette: ... the general public don't see what we do.

Penny: So, how does that impact on yourselves in terms of coping?

Annette: ... last week we each got a two–page written complaint about the nursing care, we are still reeling.

Penny: Can we talk about it?

Annette: I can bring the letter in if you'd like laughter kept me awake for an hour last night, I don't want to talk about it ...

Annette: I've been quite cranky today - most of us try to do the right things for the public but you can't please everybody all the time and we did actually get this complaint. I try very hard to accept that the care we give is not seen to be up to scratch. Once you get a complaint there's no going back, it's in black and white, it's on paper, you can't do anything to change things, the damage is done.

Penny: Have you all seen the letter?

Annette: I only saw it yesterday some of the others saw it late last week and I only clapped eyes on it yesterday and Lyn and I read it and we just slowly passed it around so people can absorb it.

Penny: What impact has it had on you - tentatively tell me if I'm asking things that you don't want to talk about.

Lyn: Well I really ... kept on saying it's not my fault laugh I don't mean that! I didn't have a lot to do with this woman, but I happen to know her husband so then I copped it at the pool from him, and I did feel a bit embarrassed about it cos I hadn't read the letter at this stage. I wasn't quite sure what her complaint was. I only know that she was very unhappy and then he kept telling me these things and I kept saying
'what am I supposed [to do]?’ So and in the end I just thought, 'just shut up, Lynette, don't say anything!'; I mean I know these things happen, I know people don't get any sleep in hospital; I've actually been in hospital; you don't get a lot of sleep in hospital! That's one of her complaints, but that's a minor one -

quietness
Annette: Her major complaint was that there was no care.

Donna: That makes you really angry, knowing how hard we all work!

almost dismissively
Annette: Big Fizz

Vivien: Can't you see some truths in her letter though? I don't think that we want to see the truth. I can see some things that would happen that she's not happy about! I can imagine her sitting here for half an hour with no one coming to see her.

Annette: I was the one who took her down to her room and said sit on the chair and somebody'll be with you soon.

Vivien: That's the sort of thing that I can imagine happening, I can imagine people coming in, not introducing themselves, [those] sort of things. By the time she left here she was quite a crazy over the top woman who I had to deal with on my own without help ...

laughter
Annette: Now Vivien - did you feel that you coped very well?

Vivien: As I say I don't cope - not very well at work - I mean even on a good day I'm not a good coper -

laughter
Vivien: But no! I didn't cope very well with this woman. I was left here trying to deal with this crazy lady, but I could, we hadn't meet her expectations, except for one of us - Miss Diana - so someone had given her care that she thought was up to scratch and the rest of us had let this woman down!
Annette: ... I mean you can get angry but we just have to take it on the chin!

Vivien: We haven't done a good job!

Annette: ... and learn from it too!

Vivien: Learn from it?

Annette: Learn from it!

Jenny: It'll make us look at what we do.

Vivien: Yeah I've thought a lot about different things since - um - everyone nicked off on that day and left me coping with it.

laughter
Annette: But Vivien that would ... that would ... be a growing experience -

Vivien: Oh it was Annette! Pigs after that laughter

Lyn: What do you teach the student in terms of coping, do you say they must cope, don't even talk about it?

Penny: I don't talk about coping ...

Annette: I guess it is old fashioned isn't it? I feel it is a bit old fashioned but mixed in with that coping is also a growing thing too; you've developed a skill now in dealing with an irate, complaining patient, so that if it happened again you are like, forewarned and forearmed.

Vivien: Yeah. I'd be the person - send them to me—no worries!

Lyn: It just leaves a really [bad taste]. I mean I agree with Vivien now, especially after I read the letter. I thought she was bit strange but then -

Vivien: She is strange, Lyn -
Lyn: But then I agree with what you've said. Somebody met her expectations! Diana met her expectations so if Diana can do it why can't all of us?

laughter

Vivien: If Diana can meet her expectations, everyone should be able to you'd like to think!

Annette: Yeah - don't be unfair to Diana.

Vivien: Oh no - I don't mean to be unfair to Diana.

Penny: So, are we talking about physical expectations now?

Vivien: Well none of us would meet their mental expectations probably, but physically we should be able to, everyone of us here!

Annette: ... if somebody could tune in emotionally to her then she would have been more satisfied with the physical care.

Vivien: Diana tuned in, but the rest of us haven't!

Diana: I only dealt with her once ... it was absolutely nothing special - normal everyday care! ... in fact I have to be prompted to remember who she was.

laughter

Annette: It was over 3 days. She came with the expectation too; she was concerned about how she was going to cope before she came. There was some strange things though. The first morning after her operation she hadn't voided since her operation and when I went in I said to her 'have you had something for pain this morning?' and she said 'I'm not having an injection, they make me too drowsy', and I said 'well you're going to have to have an injection because we're going to have to get you to pass urine fairly soon', and I went out, met Jenny. We drew up some pethidine, gave it to her and then we were busy and I didn't actually get back to her that day but I had to actually encourage her to have an analgesic. Well she's saying one of her problems is that she wasn't given an analgesic. There are strange things in her
story, I do accept that she's complaining, I think she wants to when it comes down to the nitty gritty.

Jenny: I didn't feel she was strange at all that morning.

Vivien: God you should have seen her Friday. laughter

Jenny: But by that time, things had gone from bad to worse, and when we get that roll on, it gets stranger and stranger.

Jenny: When things don't go well with people, they're not themselves! We have to make allowances for that! I wonder about a patient like that - but it was her operation, I think sometimes we forget that and [I] hate having to admit it, but she probably possibly did get second rate care perhaps.

Penny: What's the difference between first rate and second rate?

Jenny: I don't know.

Vivien: A letter! ha ha laughter
Annette: We probably give them quite a bit of second rate care and don't realise we're doing it!

Lyn: Oh that's just the way it is!

Annette: Yeah she seemed like quite a sensible girl, I thought, when I met her, something changed; anyway we'll use it, we'll take it as a learning experience.

Donna: I never met her, yeah, never introduced myself.

Annette: Well never mind, you're included with the comments, you've been accused as well.

Vivien: How dare they complain!

Penny: What do you feel about it?
Donna: I just think, after the day we've had today, and everyone on this ward works really hard and I think a complaint like that, it does give you a bit of a kick in the teeth. I know it is a learning experience and we all learn from it but I think, like we were saying before, the public out there are unaware of how we work and how hard we do work.

Penny: See you're it seems that like what you saying is that you're experiencing the whole ward scenario and she has experienced only the the care and that she has absolutely no understanding of what's going on around her.

Pam: In a way that's probably not her fault - she's not aware of what goes on out in the ward; she's not expected to know, but we all know what goes on. She's just focussing on her operation and we should be there for her, but that's not the whole picture.

Diana: You're saying it's unjustified criticism!

Pam: It could have been a busy day.

Annette: Maybe it was that day that that man died.

Penny: Diana you know how you just said unjustified criticism, it is criticism and it's coming from her point of view, but because you have had all those other things happening, I'd see that to sort of balance it. Her lack of being able to see is reasonable justification of her writing a letter cos she's feeling as though she's been (in inverted commas) neglected. You're quite justified in acting the way you did because in your mind, there was not another choice because there were so many other things happening - does that make sense?

Annette: You've got to wear it on the chin, and use it as a learning experience, I think, the fact that we are not everything to everybody, we're not really as good as we think we are. I mean some people have got an inflated view really of what the level of care is; we all make mistakes and we have all got a lot to learn. It is a long day. I guess we can't sit back and
think yes, we provide good care, we have to keep working on it and a jolt like this won't do us any harm - once we get over the ...

Lyn: Just keeps us on our toes you reckon?

Vivien: I think we'd be very surprised at the number of people who leave and aren't happy with the service.

Lyn: I think there's lots of people.

Vivien: It's just that she's the one who gets up and writes the letter. We feel very upset and as if she's betrayed us almost but I'm sure that we have got inflated egos about our care.

Annette: Because we've gotta hurry people out [of] hospital it's not like, finished off, that's what worries me, there's a rush ... I'm guilty of trying to help this process. Now, we've got 'em sitting out of bed and in the TV room waiting, and putting other people into that bed before they've left the ward. You talk to the powers that be about it, they say there is nothing else for this is a business, and they are not here to be pleasant. We're here to get the job done! It's very difficult when we, on one hand, are supposed to be a caring professional, we're asked to be so businesslike, it's very hard to combine the two, business and caring!

Lyn: It's true, because it's the pressures on us that then put the pressures on the patients.

Diana: But we're not going to be able to change that, that's only going to get worse and worse so you have to learn to cope with that or get your patients to cope.

Vivien: Here we go again - cope or else!

ha ha ha: laughter

Penny: Well if the image is so far behind, how do you prepare the public for the next ... ?

Annette: I think the patients are having major operations, they get the good old fashioned care, people spending time with them,
educating them, being there for them, understanding that they've got emotional needs. These minor procedures people that come in and out on the same day, or in today and out tomorrow, we just treat them factoryish, they are the ones that are neglected; but you know these sick people in the centre rooms here I'm sure that we are spending more quality time with them; they're not the ones who are going to complain, it's these in and out jobs that are going to complain. It says many things for us, one is that we can prioritise and spend our time where it is actually warranted with sick people who can't look after themselves, but what do we do with the other problem, of what's left over, we will have to give it some thought.

Jenny: Well I think we have to make it clear to them this venture into hospital, this day or two days that we understand that it is important to them, and we have to remember that. Well I think we'll just have to sort of take it on board and do it one way or another, especially diagnostic procedures. People who zip off for colonoscopies and D & Cs and hysterotomies, and there are a lot of them, all those people have actually got malignancies and they know that the results of this little procedure - the procedure that they're having. It will mean a huge big operation and probably change the course of their lives.

Penny: Yes - so where does, where does the whole question of coping sit in here then?

Vivien: I've said I'm not coping now, I can't.

Jenny: It's easy to sit here, take a bit of time out in here and talk about being better nurses for our patients, or coping better or whatever, you've got a doctor wanting this sort of swab that we haven't got on the ward, we've got our lunches arriving, nobody's free to take them around, we've got the machine beeping with the TPN (total parenteral nutrition), the physiotherapist wanting to have somebody take a patient for a walk, bla bla bla bla
Annette: But don't you think we've all got our own individual way of coping?

Vivien: That I'm upset inside, a lot of the time, on my shifts here, that I know that I'm not managing.

Annette: So that is what it is for you, not coping is feeling you're upset inside?

Vivien: No not being able to get around and do the physical work as well.

Annette: See for me, feeling upset inside can be from the time I wake up in the morning until I go to bed at night and I often feel upset inside but to me, I don't see it as a coping thing, I guess it's how they're different.

Vivien: But you do cope at work, I mean you do rant and rave and you let off steam and you do cope!

Vivien: The rest of us all have to cope with you coping!

laughter

Vivien: ... I don't cope! Mrs Hurry picked up as quick a wink last night that I wasn't coping and I haven't looked after Mrs Hurry before in all the time she's been here. I was looking after Dad when she was sick last time; Mrs Hurry said to me last night, 'Vivien, you're running around like a blue arse fly'! Now she knew! I mean the rest of the staff could tell as well! But I didn't cope last night, I had a terrible night trying to manage with my people, and she knew straight away, standing and walking slowly around the room that's why I walked so slowly down the corridor, so I looked calm and composed.

laughter

Lyn: Do you reckon she thought you weren't coping or she thought you were just busy?

Vivien: No she knew I wasn't coping - I was very busy.
Tinks: Or is it just that you were thinking you weren't coping because she mentioned it?

Vivien: She could tell, straight away. She watches other people, the other staff who've looked after her, and she knows that they're copers but not Vivien!

Tinks: Oh rubbish!

Tinks: I think trying to cope is trying is to show yourself that you can do it!

Pam: It gives you a sense of satisfaction which I think you need after a hard day and you think yeah! I did cope! When you don't cope you want to try and sort of reach out, get someone to help you, but I think it's hard to maybe say that you aren't coping.

Tinks: Sometimes you can get the workload done but you know yourself you haven't done a good job - you haven't cared—you've done tasks and ten or three-thirty, but it's just things had to be done ...

Jenny: Sometimes it just boils down to just asking that question - have the patients had everything they needed and yes, they've had time.

Tinks: But sometimes you feel I - didn't do this and this - there's something missing -

Jenny: You've done it in in a distracted way.

Penny: It must have an affect on you as ... being unable to care for these people over a short time, and ... that has implications for the way you relate to them?

Vonnie: I try though, to build up some form of relationship with the short-term patients, but you're not going to open up to someone within a few minutes. They might be going to theatre in ten minutes and they've [just] arrived on the ward,
they're off to theatre, they're back and they're out, I mean it's very difficult!

Annette: I think in that sort of situation we've got to rely somewhat on the way that we handle people, in a competent manner, and a caring manner. Quite often you can walk in - just twig with where they're at. We're talking about a brief - little interlude. [It] has to encourage us to use our perception a bit more ... you just have to learn to hit the nail on the head straight away really.

Penny: What is it? How do you know what it is?

Annette: You don't - at the time it comes to you - doesn't it?

Lyn: It's experience.

Annette: I don't know what it is - everyone would've experienced it at some stage, how they just cot[ton on to] a patient immediately. You say something, you start off on the right foot - or alternatively - things start off on completely the wrong foot; I've done that too!

Lyn: [One old lady] said they wouldn't give her a taxi; you know how you can apply for taxi things for medical reasons; she's got stress incontinence - she can't even go on a bus or into town. I said 'you must know where every toilet is in town'; I said 'I'm going to follow you around!'; chuckle Oh God, anyway, I can just imagine I'll be like that when I'm old, that's all I'll need to know where every toilet is before I get from the main drag to the ... anyway that was fine so there are ways you know.

Penny: Was that the point that you won her over?

Lyn: Then we were laughing and joking about it - really I wanted to bring the daughter over, I thought I'd get the old lady on side fairly easy, it was the daughter I was more worried about, who was glaring at me chuckle so we all sort of got into a conversation.
Penny: So it's really - relating to her experience - going back to her was probably the trigger for winning her over.

Lyn: Yeah!

(T:4, pp. 3-15)
Appendix 7 The self within

Annette: ... remember I said last time, I mean I feel supported all the time; I don't think I could ever come to work each day if I didn't feel supported by the staff.

Diana: ... coming from nights to days, I was very fearful, I had spoken to Lyn not knowing how days worked. Lyn took the trouble to write down a routine for both shifts. We actually met for lunch and she went through a few of the accepted protocols of this ward. I'm still learning but that really helped a very difficult transition period and I was very grateful!

Jenny: A year ago I had a fairly major back problem and when I came back to work - um - obviously lifting and moving people was really difficult to ask for help, I hardly even had to ...

Tinks: One patient a man with Ca larynx - I could've passed out - he haemorrhaged. Annette and Pam came running in and helped me out - I thought I had blood flicked in my eye. I was ready to faint - this man's looking into my eyes trying to get help from us - [asking] save me! silence I felt supported - I had help around me when I needed it.

Vivien: My father died just recently and it's been quite a traumatic time for me and I've been inclined to be a bit teary at work every now and then. People have been wonderful and very understanding ...

Penny: I had an old dog a couple of years ago and she ended up with epilepsy and died. The support of the staff then was just magnificent ... and at the moment I've got another very, very sick dog at home so I'm a bit fragile.

Penny: Can you think of a narrative where you were unsupported? What happened in that sort of situation?
Diana: I can think of one. My first shift back after 12 years absence from nursing. I was given a quick orientation right through the ward and the next patient that came through the door was thrown into my hands and [I] had to deal with this. I didn't even know where anything was, I was totally at sea.

Annette: When I was doing mid[wifery] [it was] a very negative thing at the time but I've turned it around to be a positive thing; I was on nights out in an admission section on my own, my job was to admit people off the street in varying degrees of labour, shave and give an enema. I was to ring on the intercom if I had any problems ... This woman came in, who was considerably intellectually disabled, well into labour - she was beside herself and in a very short time, so was I! I'm ringing on that intercom and nobody would come ... I was screaming so loud the sister from the ante natal ward heard and came out. She helped me get this lady up on the bed and between us we delivered this baby. The wretched sister from labour ward came around when we'd almost finished and just stopped [still] leaning on the door and not saying a word; and I was absolutely furious! It took me many years to get over the feelings of that woman coming and not being at all supportive ...

Vivien: I had had the same patient for a long time and I'd become quite friendly with this lady. One of the other staff on the ward, who I was always very, very nervous of, came up to me one day in front of this - this lady and asked if I'd been doing my job properly and giving her pressure care. That was back in the days when everyone had their bottoms rubbed every couple of hours. I was just so mortified that I'd been asked in front of this lady. I felt as though I was being questioned, my whole nursing, I mean it was just something so basic and here this person was asking me in front of this patient, who I really quite liked. It's always something that plays on my mind that I never go and ask people in front of patients, whether it be positive or negative things. It's always upset me, that incident!
Penny: So you've obviously learned something pretty major from that too.

Vivien: Yeah, it was such a trivial thing really - I can still remember exactly where I was standing, where this other person was standing; it's just so vivid and it's 9 or 10 years ago ...

Penny: Does anyone else have a story like that, that you feel that you've come to look at it differently?

Tinks: When I first started here at the hospital, and they were so cruel and it was an awful ward, I hated it. [It was the] first time in the hospital, first shift, didn't know anything, didn't know the paperwork, didn't know this and that. I felt really lost for the 3 months I was there. I never forgot that place and I said I never would forget the way I felt there and how uncaring they were to others ... So I try to make it an easier transition for the grads when they come up on to this ward, to [help them] feel part of the team and to try and work out when they need help, if they're coping, are they stuck - so I'm always trying ... looking out for them.

Annette: But people who come in to work the odd shift here and there, they don't work in the same manner ... but that's probably a fault on our part because we've got unreal expectations of people who come in here, we should be more charitable.

Vivien: Well - a girl came up here to work last week and she was told from the ward she was coming from that we were very, very strict - she came up and she said what a lovely shift she had, and how everyone was so friendly.

Vonnie: A lot of people say things like that about us.

Annette: Where's it come from, then?

laughter

Vivien: I think because [we] used to follow protocol ... laughter
Vivien: ... we have a lot of fun at work - [though] I can't remember when I laughed last night.

Diana: But that's just a perception others [have]. Once they come up here they finally realise that it's not all these things we've heard about.

Penny: I do know the students love coming here, they think it's terrific because they feel as though they're supported.

Vivien: Annette makes us try very hard for the students, and the grads.

Annette: You know how I was saying about [that] experience when I was a student midwife, that still comes to my mind when students come; what a horrible experience it can be for people.

(T:7, pp. 8-10)

Annette: Perhaps these negative things that happen to us are probably good in a way.

Vivien: It's so humiliating at the time though.

Annette: Yeah, but one small bit of humiliation might actually change the course of your nursing.

laughter

Penny: Any other stories that you feel that you learned from - you've turned around?

Vivien: It was the end of first year when we had to give injections. I had someone I should've looked after ... she (Sister D) came screaming up the corridor looking for Nurse Vivien wanting to know why this person hadn't had their analgesia. I think ever since I've had a thing about analgesia because I had that shit at work in front of all the other staff. I was very very upset - I didn't know this person needed analgesics. I was out of my depth. I like to think I give reasonable analgesic cover now, that's something I've got to thank Sister D for.
Jenny: We were just made to feel we would cope, and manage.

Penny: Have you got examples of that sort of thing where you felt that you were made to cope?

Annette: ... I think actually a lot of the way that I feel about the staff now comes from the negative ways that we were treated in a way. I mean I know everyone would probably find it very hard to imagine that I was quiet and shy and very introverted when I first started. I was a very sensitive little thing from the country, it was a real trauma growing up and surviving in those days, but I think in some ways it's been a positive thing too - I've turned it [around] all those very negative years.

Lyn: Never be put in situation where you don't feel that you've got enough knowledge to cope [or] you feel inadequate.

Annette: Don't you think, though, generally we're better prepared to cope now? ... Now we expect people to care for the whole patient, come onto a shift and it's total patient care and I think that encourages people to be more thoughtful. We didn't have a chance to be thoughtful and that in days gone by, we just had to come to work and do what we were told ... it's the new nursing basically.

Penny: Any other comments?

Lyn: In those older situations we're talking about, people never told you that you were doing a good job. You were still learning all the time by trial and error, without anybody really offering [or] giving you direction or maybe a pat on the back.

Annette: I don't think we were actually encouraged to be individuals. At work now everybody works a little bit differently, but that's to be encouraged, whereas in the past I think we had to fit into a mould. When I was a first year I used to look at the second years and I used to think they were all just as I am, I used to think they knew everything and all the rest of it but you'd fit in to the first–year mould, the second–year mould, third–year mould and then at the end, you turned out; whereas
now people are individuals from the start, and I guess they're encouraged to be individuals really.

(T:3, pp. 8-11)
Appendix 8 Tense relations?

Lyn: At times it's been a little bit difficult. We've felt that we've alienated ourselves a bit from the others because we've left them out there to do the work while we've been in here doing nothing and the week we had cake they were a bit cross with us.

Lyn: But it was all just difficult wasn't it Hennie?

Jenny: I know - because the cake was out there for them to have and they didn't want it.

Donna: Who was it for, the cake?

Jenny: It was Pam's birthday and if we'd only thought we could have done it much better but it is sometimes a bit of a rush to get in here and you don't always go about things the best way.

Penny: So how could you do it differently next time?

Hennie: We didn't intentionally do it ... I think some people are already a bit peeved - it's not just the cake, perhaps [it] reiterates their feelings of alienation.

Penny: Do you talk to them about what happens in here?

Penny: ... One of the things we talked [about] a little in the last few weeks has been what have you got out of these sessions; have they been any help to you as a group? Um - what has happened within [the group]? Have there been any notable changes within the ward?

Lyn: Yeah, well last week we did discuss the occasional friction. I don't feel that it's something that's been all nasty.
Annette: Perhaps the fact that people have their say here, everyone has a different insight into how people see things. I walked in the other day and somebody was saying they like to hear what I think about different things right? Normally I don't say anything. They thought it was interesting but you've also heard things I'm sure that have surprised you.

Diana: I'm sure! Anything that gives you a bit of insight into people around you is going to make you more aware of things.

Annette: Penny, you know when we talk about friction - I haven't thought of them and us myself until just now. We have actually created something. You've got to take that into consideration: the fact that the people who have chosen to come in here each Tuesday, we do walk off and sit in here and discuss whatever we're doing and we think it's worthwhile. The other people for whatever reason chose not to - they're the people who are excluded now, they don't know what we do basically, even though we talk about it; but they don't know what we're talking about. The fact that usually during double shift time, well we're not helping there, we're seen by the other people as sitting around not doing anything while they have to carry the can. And I can see what they're saying and I know where they're coming from but somehow or other we've got to be reasonable too. So we created something by doing this and maybe we should have spent more time explaining what we're doing and we may have defused that ... they go crook.

Penny: How do the rest of you feel about Annette's comments?

Mary: It's probably true! I mean you can understand if you were really busy during the morning and it comes the afternoon and half the people disappear off the ward and you're left ...

Jenny: It's created a bit of a rift actually.

Annette: I don't think it's too bad; it's just that those people are using that as a lever I think for me, you know throwing crap.
Jenny: I must admit I sometimes get out and feel slightly guilty; I’m actually feeling better about it now than I was at the start.

Tinks: We talked about it actually on Sunday morning at 'Tin Can Bay'. It just happened, to come up I don’t even know why; we talk about all sorts of rubbish when we get there.

Mary: I would feel the same, that I was excluded. Is everything resolved?

Pam: We talked about it in here ...

Annette: ... well how would we have managed though [name of the Nursing Director] thought we would do it [the research] in our own time.

Jenny: It's fine to say do it in your own time ... it's never going to be the right [time].

(T:14, pp. 1-3)
Appendix 9 Standing together

Penny: ... How do you care for one another?

Diana: We deal with life as very raw stuff; I think pain and suffering are great levellers ... an analogy comes to mind is the disasters, you know when people fight fire altogether, like it's that sort of pulling together ...

Mel: I think we've broken down some barriers - that you have when you say - have to go to the kindergarten to pick up your child ... all the initial getting to know each other is now deeper; when we see each other we worry about her ... we look at each other and think 'Oh are they happy today?'.' 'Oh yes - they're happy' and you don't worry any more, that sort of thing laughter it's the truth!

Penny: How do you know other people's goals?

Jenny: I think we've all got roughly the same goals. We all want to provide good nursing care ... so you're sort of fitting in a lot of care that you want to get done with doing things with other people. That's a lot of what teamwork is on this ward. And then along the way we seem to ask each other how we all are, find out what we did yesterday and all that sort of thing as well. It's amazing isn't it?

Lyn: But I think coming from doing nights to days I wasn't aware that this ward was very into education and post-op ... sort of physio - I had to learn that ... I knew that it was important ... but it was very important to this ward! So that was a goal that I then saw that this whole ward knew about.

Penny: Do you think going back to this goal that you all seem to have in mind, can you actually pin that down a bit more ... how do you know it's the right goal?
Diana: It's in the best interests of the patient ... the outcome.

Jenny: The crunch is if you don't do these things, if you start saying 'oh if I have time I'll do this or that', it doesn't get done ... the worst scenario a clot in the leg - a chest infection ...

quietness

Tinks: I think the goal was first set by say Annette because she's the one who's taught me what needs to be done.

Jenny: If I toddle along and say can you come and help me get Mr Bloggs out of bed you wouldn't say I haven't got time, don't bother about that, you'd say OK and off you'd come.

Tinks: When I first started here ... they showed me the ropes and what needs to be done and the importance of it, not just because it's done, it's beneficial for the patient.

Penny: Is it routine?

Tinks: There's no routine ... there is no set time as to when you need to do it but it is part of your daily routine that these things need to be done for this patient ...

Mary: ... in fact a lot of things are routine, for example a hyster, there are a lot of routine things that are done like physical preparation, all [the] psychological and physio[therapy] that is a routine; and when she comes back there are a lot of things once again that are a routine in a way; we do follow a routine ... to get to that goal, for the patient to get better and go home.

Penny: So do you think that [the routine] has an impact on teamwork?

Mary: Well if you've got a routine of sorts it's easier to get through your day; to know what you have to do.

Donna: If someone is getting bogged down with a sick patient somebody who's not so busy will come along and give them a hand. That's when you're teamwork.
Penny: How do you know though ... when to step in?

laughter

Tinks: I don't know, you just keep an ear out all the time.

Hennie: Not everybody's tuned in though ... you have to have a big picture, you can't be focussed on your own. Not everybody is a tuned in person - people could breeze right past you; this person could [say] 'Oh do you want a hand?' because they're more tuned in, but [this is] not to say that person who walked past [might not be] but it's ... it's not always the same.

Lyn: I guess that's ... it's already been said there's a certain intuitive ability ... we ... we tune in to caring to patients and to meet those patients' needs ... we use the same skills for each other ...

Lyn: ... and there's a camaraderie if you like.

Penny: Diana, what do you think is the basis of the camaraderie?

Diana: Respect! Understanding!

Penny: What's the basis of the respect?

Hennie: ... you don't just walk up to somebody and they respect you, you have to show them ...

Vonnie: you can pull your weight ...

Hennie: ... show you are a team person and you are interested in the big picture and what everyone's trying to achieve.

Penny: So, you're saying that there's an interest in others?

Lyn: I respect a lot of the young 'girls' because of their knowledge cos we trained so long ago. If I have a bit of a technical problem or - what's this drug's about, I asked ask the young ones, they're likely to know.

Penny: You're saying that it's a recognition of other's knowledge ...
Lyn: Yeah and where they've come from ...

Penny: ... their background ...

Jenny: ... and competency!

Lyn: Competency is very important ...

Diana: cos some have got skills others don't have because of experience or extra courses ... [They are] respected over and above for that extra knowledge.

Penny: What other dimensions can you tease out?

Lyn: Approval! They meet your ideals of care ...

Penny: ... about how I'm treated ...

Lyn: ... there's got to be respect for the patient.

Hennie: To be committed ... dependable, have that understanding -

Vonnie: Reliable.

Vonnie: I guess if someone's let you down before you're not going to ask them again to help you out.

Lyn: Until they redeem themselves.

laughter

Lyn: ... dependency ... the whole team to work ...

Penny: Diana was just saying then about this inter-dependency.

All: Oh yeah!

Jenny: It's a confidence in each other ...

Pam: and sort of tuned in ...
Lyn: I think just being there for one another and providing that support ... 

Diana: Listening.

Lyn: I think a lot of the ACNs on this ward are very aware of our capabilities so they then give us people that we can cope with. The other day Vivien gave me this young 16-year-old boy and I thought 'oh I don't really like sixteen year old boys' ... 

laughter 

Lyn: ... cos I've got a 19-year-old and two 14-year-olds. She said I gave him to you cos you've got all those boys at home and I said well yeah actually we did get on alright, so it was OK. So that was Vivien knowing a bit more about me and that made that work.

Mary: I get mothers with babies now. 

laughter 

Tinks: I get the Turkish speaking people ... another language ... hey I can speak every language!

Diana: We'd better analyse who we get! We'd better analyse the patients we get from now on, there's a bit of stereotyping!

Tinks: I admire everyone that works in this ward. I think everyone sort of admires each other for what we do. We all know what we're to do which makes it a bit easier even though it could be an absolutely shocker of a shift, but we all pitch in, tuning in to each other, not just working, not just looking straight ahead but our eyes are always open and always looking out for others, trying to make it easier for everyone else because there are days where it's just awful and everyone wants you, everyone wants a piece of you so you try and help each other and make it easier, to get through the day and get towards what we want to achieve.

Hennie: I feel guilty now - that's good - people are willing to be open, and willing to talk about [things]; it makes me look at things in my own nursing practice and my own personality. I
think areas in me that I can change or about me and about my practice that will benefit our team. There's always [areas] where we can be better; I'm very pleased that everyone's talking and we're laughing and having a good time and it's really exciting to think that we can be forthright [about] what you think and we can be open about it, it's good, it's healthy!

laughter

Appendix 10 Looking back and forwards

Jenny: But you've been working with [ideas from college] ever since because I always remember you saying what I learned at college was  da da da da

Annette: I think people in this session here, as time goes by, they'll have these flashes where they recognise where we've come from - you know - about collegiality - you know - the implications of it. Without this forum perhaps we would never have highlighted some of these things and I think people will actually grow a bit in the future as a result of it, because you'll always think back every now and again, think things through ...

Lyn: [It's] made us think how important it is - we probably didn't put such a big thing [on it] - we didn't think about it, I suppose, so it's made us realise well it is important this there was important.

Vonnie: I think it's something we've taken a bit for granted actually.

Annette: It's like most things, you know, you don't miss it unless you're out of it.

Penny: Yep. Yep. Cause that's what really put me onto it, I went from working in a hospital where - um - I always felt like you people that you're supported, into what I would call an extremely alienating environment ... the loss that I felt after having experienced all those wonderful things was quite immense.
Lyn: It didn't get you back into a hospital environment?

Penny: No it didn't, but it enabled me to move to an environment [elsewhere].

Hennie: We will still have [these] sessions when Penny's finished, more of [these] opportunities.

Annette: Yeah I did say [yes], and that hopefully it would be nice if you put it out maybe somebody else would like to do it, somebody else would like to sort of chair a group, doesn't have to be me, does it(?) perhaps you could make sure that happens.

Hennie: Certainly; I'll be quite happy to do that!
Appendix 11 DUEC Approval
Appendix 12 Plain Language Statement

DEAKIN UNIVERSITY ETHICS COMMITTEE
PLAIN LANGUAGE STATEMENT FOR NURSES

My name is Penelope Cash (Penny) and as a Registered Nurse I am currently undertaking a higher degree through the School of Nursing at Deakin University Geelong. During the period 1994-1996, I will be undertaking a research project to explore the shared meanings underlying the notion of collegiality in clinical nursing contexts. I am also interested to know how, and in what ways, collegiality affects nursing care. To undertake this project I need assistance from female Registered Nurses who would be willing to participate in sharing their knowledge within a group situation and allowing me to work with them in their clinical setting.

The approach taken in this study would involve you in:

- keeping a personal/professional journal to document your practice;
- meeting with other participants to discuss practice issues as a way to uncover meanings contained in collegiality, and
- keeping of a group journal which arises from those insights derived from shared personal accounts of practice.

It is anticipated that group 'get-togethers' would be weekly, and last approximately one hour. An initial involvement has been set for a six months, while the maximum period of participation will be twelve months. During this time, I will be working with you in your area and gathering data through field notes. Group sessions will be audio-taped, but you will have the right to switch the recorder off if you so wish. You will also have the opportunity to comment upon or correct accounts of the meetings, and the 'group journal'. As the audio-tapes will be transcribed by myself or a person not related to the research, confidentiality will be maintained through the use of pseudonyms (unless you elect to retain your own name) and then only I will know your identity. All keys to the pseudonyms used, all consent forms, and all recorded data, will be stored in a secure place to which only I will have access.

If you would like to become involved and then decide to withdraw, you can do so at any time. If you wish to participate in this study and/or you would like further details please do not hesitate to contact me at Deakin University (052) 271009 or 272610 and leave a message for me to contact you. Thank you,

Penny Cash
Appendix 13 Consent Form

DEAKIN UNIVERSITY
ETHICS COMMITTEE
CONSENT FORM FOR STAFF

I, ____________________________, of ____________________________, hereby consent to be a subject of a human research study to be undertaken by Penelope Cash and I understand that the purpose of the research, as described in the Plain Language Statement and discussed with me by the researcher, is to explore the shared meanings underlying the notion of collegiality in the clinical nursing contexts.

I understand that the final work will be presented as a thesis, and that parts or sections of the work will appear in books, journals, conference proceedings, or possibly other art forms (e.g., a play) and that I will be offered the opportunity to receive a summary of the thesis.

I acknowledge that:

1. the aims, methods, and anticipated benefits, and possible hazards of the research study, have been explained to me;

2. I voluntarily and freely give my consent to my participation in such research;

3. individual results will not be released to any person except at my request and on my authorisation, and

4. I am free to withdraw my consent at any time, in which event my participation in the research study will immediately cease and any information obtained destroyed if requested by me.

Signature: ____________________________ Date: ____________________________