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Reflections on a Journey of Exploration into the World of Clinical Nurses

We shall not cease from our exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.

T. S. Eliot, *Little Gidding* V 1944

My excursion into the world of nursing practice was a journey of exploration, a journey located in a specific time and context but which functioned as a revealer of fresh insights for myself and my colleagues who are nurses. I began this journey by posing the question:

How Do Nurses Think, Act, and Reflect on
Their Clinical Nursing Practices?

To undertake this journey of exploration required me to make decisions about a theoretical basis that would inform and challenge the emergent understandings and an appropriate methodology with which to attempt to answer this question. I decided to examine clinical nursing practices from the perspective of critical theory and feminist critiques. In order to do this I, as the principal researcher, collaborated with four nurses work-

ing in an acute-care public hospital to engage in a critical ethnography, a research process that is openly ideological in design and emancipatory in intent. Through this collaborative process of inquiry, we systematically collected descriptive accounts of nursing action as a basis for theorizing and critique.

Nursing is an occupation that is female-dominated in constitution but has traditionally been subordinated to the male-dominated medical profession; likewise, clinical nursing knowledge has traditionally been subordinated to medical knowledge. Medical knowledge is generally treated as objective, value-free scientific knowledge, a view that mystifies both medical knowledge and the work of the doctors who use it. This view of the value of medical knowledge has been legitimated by the state through legislation, which accords specific responsibilities and rewards to doctors while legally subordinating the roles and responsibilities of other health professionals to them. This view of the medical knowledge as objective scientific knowledge is an apolitical view that disregards the ideological component of medical knowledge and the way in which it is exercised as social control to reproduce and support the class and gender interests of doctors.

Nursing has supported this apolitical view by its oversubscription to externally derived understandings of nursing developed through obsequience to the dominance of medical knowledge and practices. Historically, nurse scholars and educators have accepted the superiority of the technical knowledge of doctors by appropriating both the forms of knowledge and the paradigm in which this knowledge is created. Thus, they have unwittingly perpetuated the oppression of nurses and of their clinical nursing knowledge. Technical knowledge with its capacity to explain and prescribe is used by doctors and nurses as the basis for instrumental action. However, both doctors and nurses generally ignore the fact that this action is ideologically embedded within the sociocultural world of healthcare practices, which is subject to values, ethics, traditions, and the subjective and intuitive understandings of the healthcare practitioner.

The changed understandings of the roles and capacities of women within the community have been mirrored within the development of nursing knowledge. Critiques of the handmaiden role of nurses and the explication of the doctor/nurse game has led to a desire to develop nursing knowledge that is distinctive to nursing. This emphasis on the need to understand

and to describe and explain nursing practice has predominantly been taken up by nurses who have worked to develop objective, value-free knowledge about nursing practice. However, a growing emphasis has been upon the need to develop knowledge about the practical knowledge that nurses have and use in clinical nursing practice. This knowledge is subjective, value-laden, traditionally formed, and contextually embedded in the practices of clinical nurses. Nurses interested in developing this knowledge have focused on the development of meaningful intersubjective relationships between the nurse and the patient, which disclose the traditions, rituals, and pre-judgements that each brings to the situation. This process develops practical knowledge enabling nurses to make deliberate choices between alternative courses of action by subjecting their values, purposes, and commitments to scrutiny in the light of the constraints and exigencies of the situation.

This approach has provided nurses with valuable practical knowledge of the intentions and meanings of their nursing actions. However, it neglects questions concerning the relationships between the nurse's interpretations and actions and the structural elements of the healthcare situation. It enables nurses to examine intersubjective meanings but not the socially constructed reality through which these meanings are created and maintained. The focus is on clarifying individualized interpretations thus ignoring the power relations at work, which shape and form the consciousness of the nurse and patient and which are open to contestation as a form of false consciousness.

Feminist critiques of male-created roles and structures have informed critiques of the male-dominated medical profession and the implications of this dominance for nursing. Neo-Marxist and radical feminist analyses have begun to challenge the power relations at work in nursing as a basis for the development of alternative perspectives, which value the knowledge and experiences of women. However, these perspectives have not been generally well received by nurses because the analyses lead to alternate views of women's health issues and health practices, which develop alternate structures that bypass the medical system.

Nurses are beginning to recognize the need to examine the relationship between the manner in which power is experienced and exercised within nursing practice and the kind of knowledge that evolves from and informs this kind of analysis.

According to Perry:

Nurses must discover ways to effectively challenge the taken-for-granted explanation that the individual is "responsible" while the system merely exists; and to challenge the taken-for-granted dominance of one form of knowledge over another, and one set of values over another. (Perry, 1987:9)

Through a commitment to feminist perspectives and the insights of critical social science, this research was an attempt to meet this challenge. In order to do so it was necessary to develop collaborative critiques of the forms of knowledge that are used in nursing practice and of the ways in which these kinds of knowledge serve particular interests. An examination of these interests can serve to uncover the power relations at work and the manner in which knowledge is socially constructed and ideologically embedded. This kind of analysis would have a deliberate and articulated agenda to develop an empowering and educative process in which nurses would be actively encouraged to reflect on their nursing actions, the understandings that inform them, and the contextual situation within which they work as the basis for transformation.

This reflective process facilitated an inquiry into the historical, cultural, and taken-for-granted meanings that informed nursing actions in order to disclose the interests being served by their continuance. Through critique we examined the relationships between power and knowledge and focused on the hegemony by which oppressive practices were maintained, accommodated, or resisted. Feminist critiques helped us uncover instances of transformative actions, which could not be analyzed using power/knowledge. This led to a recognition of the unspoken values of nursing practices, which differed from the explicit values espoused by nursing scholars interested in analyzing power relationships in nursing. These unspoken values led to emancipatory knowledge through an engagement in nurturance activities and helped to uncover the strengths and limits of critical social science for knowledge in nursing. The research did, however, demonstrate the potential for enlightenment, empowerment, and emancipation of clinical nurses through the pursuit of the dialectical relationship between power/knowledge and nurturance/knowledge.

The Politics of the Research Method

In beginning this research I took the view that nurses are not “cultural dopes” who are unable to participate in and contribute to a collaborative understanding of clinical nursing practice. Rather the research design was based on the premise that nurses think and act in meaningful ways within the rich tapestry which constitutes clinical nursing practice. However it was posited that these ways of thinking and acting need to be the subject of scrutiny and contestation in order to uncover the taken-for-granted habitual actions and the contradictions between intent, meaning, and action. This kind of critique endeavors to disclose the power relations at work, which perpetuate oppressive and hierarchical structures in nursing practice, and seeks to uncover the ways in which these power relations affect the daily lives of clinical nurses, constituting the limits and development of their clinical knowledge.

The research act was regarded as a political act because it assumes that nurses are capable of reflecting upon the processes of their own nursing practice, in the light of the processes of power relations, to uncover the ways in which they have unwittingly collaborated in their own oppression. The research process intended to bring about a transformation of nurses' understandings of clinical nursing practice and of their clinical actions. This approach is premised on the understanding that nurses not only collude in their own oppression but also engage in intentional oppositional actions in which they resist oppression and challenge hierarchical structures. The research examined the dialectic nature of some of these oppositional moments in order to highlight their potential for enlightenment and empowerment.

Collaborative reflection upon nursing actions, nursing understandings, and the socially constructed culture of clinical nursing practice was regarded as a methodological tool by which the researcher and the nurse participants can critique clinical nursing practice with an openly espoused agenda to facilitate emancipatory change in knowledge and action.

The Method: Critical Ethnography—A Collaborative Case Study

This study was designed to describe and analyze clinical nursing practice through the process of an in-depth long-term

engagement in case studies of the nursing practice of clinical nurses. This engagement was based on the premise that an examination of nursing practices that attempts to challenge the contradictions in knowledge and action, which have been systematically distorted by history and ideology, will need to begin with thick descriptions of nursing actions. The choice of methodology stemmed from a belief that self-reporting of nursing actions and their meanings, a fashionable methodology in nursing research, ignores the problems of self-monitoring within the reporting process and the problem of false consciousness. By ignoring these aspects the researcher becomes open to the charge of rampant subjectivity, and under the guise of disinterested interpreter of the data, the researcher may perpetuate and legitimate forms of cultural oppression.

In order to procure these thick descriptions of nursing practice as a basis for collaborative analysis, I chose to engage in an ethnography, a comprehensive case study. Ethnography, like many methodologies, can be formed within different understandings of research and knowledge development, and informed by different knowledge needs. The kind of question posed determines the types of appropriate methodologies for consideration. Critical social science, with its capacity for the identification and analysis of issues concerning power and knowledge relations in the social order, poses questions in order that the exploratory research process itself is predicated upon a transformative focus towards knowledge and action. An ethnography framed within this context of critical inquiry, predisposed to rationally analyze and change unjust and irrational social activity, was classed as a critical ethnography in order to distinguish it from ethnographies with no transformative agenda whose purpose is framed to describe and interpret cultural realities.

A key component in any critical inquiry is the capacity for self-reflection and collaborative analysis to effect rational change. This process necessitates not only a reflexive relationship between the data and the researcher as advocated by Hammersley and Atkinson (1983) but also requires reflexivity with the research participants. This means that research participants have access to the data and become collaborators in a reflexive process with the evidence of their own practice in their own social world, with the insight and understandings of the researcher, and with their own self-reflection as a form of self-critique and ideology critique.

The openly ideological nature of critical inquiry means that a critical ethnography of clinical nursing practice is research in and for nursing and not just about it (Carr and Kemmis 1983). This means that not only socially constituted nursing hierarchies need to be examined but the hierarchies of the research process itself. Research that claims an emancipatory intent needs to be careful that it is not perpetuating the oppression of the research participants by disempowering them in the research process. Reifying the theoretical constructions of the researcher over the values and understandings held by practitioners endorses the theory/practice gap. Emancipatory researchers need to engage in a dialogue of collaborative reflection, which poses questions about actions and subjects those actions to systematic scrutiny and debate as a basis for changed understandings and changed actions.

In this ethnography I compiled comprehensive descriptive accounts of the clinical practice of four nurses giving them back the research accounts for ongoing analysis and critique. This process of continually sharing the research data, and my emerging theoretical constructions, with the nurses required them to engage in collaborative reflection and theory development. The process of problematising the everyday taken-for-granted activities of nurses and the contexts in which these actions were embedded served to nurture a process of consciousness-raising of the nurses engaged in the study at the same time as it worked to inform and transform problems and perspectives about clinical nursing formerly held by the researcher. These changed understandings formed the basis of changed actions.

The process of problematising clinical nursing practice is not without its problems in relation to language use and interpretation. The development of reciprocity in collaborative dialogue is not a neutral exercise because the way in which the dialogue is formed and used depends greatly upon the agreed upon worldview of the researcher and research participants. Rational dialogue is not an objective entity but is enacted by historical and embodied human beings who are as capable of engaging in rationally constructed disagreements about knowledge and action as in rationally constructed agreements. Through the reflexive process of collaborative discourse contradictions in theories, values, and actions are identified.

The Significance of the Study

It is our belief that the "real" expertise of clinicians lies in their ability to learn to manage the complexities and multiplicities of every here and now situation which they encounter...Clinical nurses...recognize that effective practice requires skill in making numerous, complex judgments which effect idiosyncratic practices which appropriately are situation specific...Clinical experts have gained their everyday understandings from their engagement in and lived experiences of nursing. (Cox and Moss 1988:4)

Nurses are beginning to acknowledge the complexity of nursing knowledge. An International Nursing Conference in December 1988 took as the conference theme the title "Professional Promiscuity" in acknowledgement of the disparate, disordered complexity of elements that make up the sociocultural world of nursing practice. Cox and Moss (1988) have argued that promiscuous knowledge is reflected in the chaos of clinical nursing practice and that an acceptance of this chaotic nature brings with it the challenge to develop new ways of understanding the nature of nursing practice and the knowledge base of expert practitioners. They suggest that contemporary nursing literature represents clinical practice as based on principles and rules, which are orderly, logical, and systematic. According to Cox and Moss this orderliness can only be discerned in the routines in which nurses engage, and these routines themselves are practiced within a simultaneous multiplicity of events. Schön (1987) likens professional practice to a varied topography consisting of high, hard ground overlooking a swamp. The high, hard ground consists of the resolution of manageable problems through the application of research-based theory and technique. Schön claims that these manageable problems that occupy the hard high ground, while often of great technical interest, tend to be relatively unimportant either to the individual or to society.

The high hard ground is familiar to nursing scholars. It is also the area that clinicians often regard as irrelevant to the real task of nursing. For clinical nurses the contextual realities—the leaking tube, the atypical patient, the hysterical relative, the demanding doctor, the unrealistic roster, the continual interruptions, the malfunctioning technology, the bureaucratic bun-

gle, and the ethical quandary—combine to represent the swampy lowlands of practice. According to Schön this swampy lowland consists of messy, confusing problems that not only defy technical solution but are those problems of greatest concern to humanity. The challenge is for the practitioner to move from the safety of easily resolved but relatively unimportant problems and to take the risk of pursuing answers to the problems that are important for them.

Lather (1985:8) reminds us that “we are both shaped by and shapers of our world.” She argues for a process of research on practice that enables practitioners to empower themselves to change their understandings, their actions, and the situation in the practice setting. She argues that our choice of research paradigms reflect our beliefs about the world we live in and want to live in. Lather suggests that we need research designs that allow us to reflect on how our value commitments insert themselves into our empirical work. Our own frameworks of understanding need to be critically examined as we look for the tensions and contradictions they might entail

...the search is for theory which grows out of context embedded data, not in a way that rejects a priori theory, but in a way that keeps it from distorting the logic of evidence. Theory is too often used to protect us from the awesome complexity of the world. (Lather 1985:25)

To experience the awesome complexity of clinical nursing practice is to spend time in the swamp; to lay aside preconceived expectations and unexamined habits; to reject mythical thinking and easy solutions to well-known questions. Nurses need to put their role as a nurse, their nursing actions, and the clinical setting in which they practice under close scrutiny as a basis for critical analysis and reflection. The reflection process is demanding. It is easier to search for the high hard ground of problem-solving exercises. The way through the swamp, the way of reflection, requires an examination of the reality as it is. This pathway does not contain known problems waiting to be solved. Instead it poses dilemmas with more than one equally acceptable option; options that are consistent with different value stances and ways of understanding the world of clinical practice. Reflection does not begin with a search for answers but with a search for questions (Freire 1972).

The reflective process begins with a reconstruction of experience, which is recorded for analysis. This analytical process not only uncovers the personal and nursing issues and meanings at work in the situation, but uncovers the historical and social factors that have shaped both the nurse and the clinical setting. This analysis forms the basis of a problem-setting exercise where problems are posed to enable the nurse to question the tacit ways of knowing and practicing nursing. This confrontation of the experience, and of the meanings and assumptions which surround it, can form a foundation upon which to make choices about future actions based on chosen value stances and new ways of thinking about, and understanding, nursing practice.

Critical reflection on clinical nursing practice has been ignored for a long time. Nurse educators have continued to prepare nursing students in curricula processes that support and develop technical and, more recently, practical knowledge. A concern for the patient as the focus of nursing practice has led many educators to develop curricula based on positivist psychological research. This curricula is dominated by a desire to reduce human behavior to categories for description, classification, and theory building. This reductionist approach endeavors to develop theory to be applied by practitioners, while ignoring the contextual, idiosyncratic realities of nursing practice. Perry and Moss (1988) contend that nursing needs to reject the utilitarian concept of knowledge and explore the dialectical relationship between theory and practice. They argue for the introduction of transformative curriculum processes based on critical self-reflection and rational debate. However, to engage in education through a transformative curriculum is to assume that the educator has a knowledge of clinical nursing practice that is enlightened, empowering, and emancipatory. This kind of knowledge has not been documented in Australia, and it appears that this area of research has also been neglected overseas. Nurse educators interested in pursuing a critical approach have focused on curricula development in order to develop an emancipated nurse (Perry 1985a; Perry and Moss 1988; Cox and Moss 1988; Yuen 1987).

My experience would suggest that the more generalized critical analysis possible in a critical ethnography is a useful and possibly necessary methodology. The field of nursing has used methods, such as action research, in authoritarian and

nonliberating ways by not questioning the power/knowledge basis upon which nursing is structured before engaging in actions designed to bring about local, context-specific change.

I would suggest that this study is significant because it endorses the view that clinical nurses can pursue empowering knowledge and engage in emancipatory action. It focuses on the neglected area of clinical practice as a basis for a collaborative critical inquiry into nursing. It is premised on the belief that a critical examination of nursing practice is long overdue and is a necessary basis for a transformative curriculum.

Limitations of the Study

The limitations of this study pertain to its context of clinical nursing practice, the administrative practices surrounding clinical nurses, and the research methodology employed.

The study was pursued in the dynamic environment of clinical nursing practice, which, like most large structured bureaucracies, does not represent an integrated whole with power relations operating in clearly identifiable configurations. Rather, it has developed as a result of a multiplicity of unrelated decisions, actions, interrelations, emergencies, and unintended consequences. This multifaceted meshing of power relations worked at times to support the research, but often it worked to limit and shape the research. Access to the research site was well supported by senior nursing staff. However, other factors, such as nursing mobility throughout the hospital, last-minute changes to shifts, the needs of other individuals within the hospital, and other difficulties related to continually negotiating privacy and confidentiality with an everchanging group of patients and co-workers, meant that the data collected in an ethnography based on following around specific nurses is more individual and context-specific than the data collected from a stable unit such as a ward.

The methodology enabled the researcher to collect large amounts of data, which was highly specific to nurses in a large acute hospital, and as such it highlighted issues and generated questions for more structured and specific research into clinical nursing practice. Nurses used in the case studies were all very experienced nurses who were fully employed in nursing and intended to continue in the field. They were all female and white Australians. Although the hospital employs nurses from

European and Asian ethnic background, there were none working in the areas that I had access to. This part of Melbourne has very few blacks, and I saw no black staff or patients throughout the nine-month period of the study. The data is, therefore, contextual and specific to these kind of nurses in Victoria and not necessarily generalizable to, or representative of, neophyte nurses, part-time nurses, nurses from places with different cultural, social, and/or educational preparation or nurses in nonacute settings. Therefore, although the major issues remain the same, the focus and specifics could be very varied. The research problem, choice of focus, theoretical basis, and methodology represent the knowledge, skills, and interests of the researcher and the nurses in the case study and was therefore limited by the researcher, the participants, and the research process.

Any research design that claims to be openly ideological and emancipatory in intent using reflection and critical discourse requires examination. A critical ethnography is conducted by an "outsider," the researcher as participant observer, who collaborates with the "insider," the research participants, to engage in an in-depth case study with a deliberate agenda directed towards emancipatory knowledge and action. This research was limited to recording and analyzing the observable nursing actions and the outwardly manifested interactions as a basis for later discussion with the nurses. The researcher, who is not a nurse, was reliant on the critical interpretations jointly agreed upon by the nurses and herself. This differed from those other critical research methods, such as action research, where the researcher is also the practitioner putting her own practices under scrutiny. However, the power/knowledge and emancipatory focus required the researcher to critique both her role and actions as researcher in order to reveal the contradictions and dilemmas faced by researchers during the act of researching and theorizing.

The purpose of the research can govern aspects of the research such as the content, shape, length, complexity, and form of reporting. This research was being conducted within a particular time frame to meet the requirements of a doctor of philosophy degree. The research was designed to be emancipatory in intent, design, and conduct. It was initially intended that the research would be entirely collaborative and that the research participants would engage in coauthorship of sections

of the final report. This was a naive assumption, which demonstrated the difference in understandings held by myself, other academics, and the nurses themselves concerning the possibilities and the realities of collaborative research for a higher degree. The intention to engage nurses in sharing the writing task with me about issues in nursing practice demonstrated my naiveté in understanding the oral culture of nursing and the structured differences between this and the academic culture based on "publish or perish." It was not sufficient to encourage nurses to write about nursing issues, or to journal their nursing practices, because they saw no more reason to change from their oral culture and accommodate me than they did with the administrative injunctions to write up nursing care plans. The nurses engaged in the same passive resistance with me as they did in their workplace, and this passive resistance helped me to identify a telling contradiction in my own research practice. In attempting to develop collaboration based on coauthorship, I was imposing a collaborative style that disempowered these nurses, who were highly articulate within their oral culture but felt disempowered when required to document their own understandings. The nurses were always cooperative in their own ways, and it was only as I reflected in my journal upon the intentions of the research design that I recognized that I was intending to use my power/knowledge to bring about a change in their mode of expression in order to fit in with my research design. Through negotiation I was able to redesign the research to take account of the strengths of the oral character of nursing culture.

This put the onus for transcribing tapes, writing notes, and forming or systematizing arguments back onto me. I decided this also was appropriate because I was the one who would benefit from the award of a Ph.D. if the research was satisfactory. I shelved my cherished dream of coauthorship, which would have given the nurses an opportunity to publicly argue their views. I reflected that the Ph.D. would not be awarded to me unless I could demonstrate my capacity to research and theorize at a level that would not be expected of clinical nurses without undergraduate degrees, and yet I was committed to the view that these nurses knew best how to theorize about their clinical nursing practice. This commitment was validated by the capacity of the nurses to respond orally to my challenges, to theorize in a sophisticated manner concern-

ing the historical constructions and contradictions in clinical practice, and to enable me to learn from their cultural perspectives in ways that changed my understandings and the theoretical shape of the research.

The research was limited by a time frame that was deemed appropriate for the researcher's question and the needs of the nurses. The research was also conducted within a particular context within a large typical general hospital in Melbourne, Australia, during 1987. This was a time when many nurses were beginning to question nursing practices as a result of the 1986 nurses' strike and the subsequent inquiry into professional issues in nursing in Victoria. The research design enabled nurses to ask and pursue their own questions as well as collaborate with the questions raised by the researcher. The data was initially shaped by the actions of the nurses and by their comments and taped discussions. In these settings the nurses developed themes and issues of interest to them, and I raised those themes and issues that I was identifying in the data. However, the extent to which I had to organize and, therefore, select the focus of the research was a dilemma, particularly when individual nurses had other interests, such as nursing stress or the development of appropriate nursing care for geriatric patients, which also could be developed from the data but which needed a much more in-depth treatment than was possible within the research. I recognized my own role in the collaborative meaning-making process as the interpreter of the theorizing process and of the theoretical constructions and implications that were emerging from the data. My reflections upon the data and upon the nurses' reflections shaped the theoretical arguments to which they responded and engaged in further reflection.

A dilemma is faced by the ethnographic researcher regarding the amount of data that is collected through participant observation that needs to be focused and refined. The power/knowledge and subsequent nurturance/knowledge focus of the research could have been pursued through the data in many other ways. The seemingly disparate data was organized and constructed in particular ways that followed our research interests.

A further dilemma related to the impact on the research process of the evolving theory, which I was generating. There was an emergent recognition of a dialectical relationship in

which the nurturance/knowledge aspect challenged the power/knowledge construction of the research and challenged the way in which the research was being conducted. I realized that I could not only reflect on my own actions as researcher in the light of power/knowledge, but I also needed to examine them through the challenges of this nurturance/knowledge, perspective. Only when I really begin to recognize the nurturance/knowledge theory at work was I able to understand that I could change the conduct of the research to value the oral culture of nursing and use it in the research. This was an empowering experience for me. The power/knowledge focus left nurses disempowered through their lack of engagement in written documentation, but the nurturance/knowledge focus demonstrated the negativity of power/knowledge and the positive capacity for nurses to develop critique and contestation. The examination of the unspoken values underpinning clinical practice highlighted the rationales for action, which remained obscure within the power/knowledge grid and encouraged me to examine my unspoken valuing of the written code of academic culture over oral nursing culture. Reflection on these dilemmas helped further the research process, my own understandings of my theoretical biases, and the possibilities inherent in new questions and reconstructions of theory.

The processes of collaboration and negotiation themselves posed dilemmas for me because I had underestimated the difficulty of getting nurses together to discuss issues from their practice. Research that is conducted using students from university courses or from an employment situation where the researcher has an official status is much more manageable because the participants are required to participate through official or unofficial sanctions and power relationships. My only previous experiences of researching with independent volunteers was with social workers who were used to developing and participating in group work. They were predisposed to group work through their social work education and their participation in therapy groups and feminist groups. I soon discovered that the structuring of nursing practice and the demands of shift work meant that nurses generally have limited opportunities to participate in groups for sharing and collaborative reflection for either personal or professional reasons. My group work expectations were a product of my own middle-class personal and professional history, and this realization

challenged me to justify the necessity of the group work focus for the research. Although I still believe that the research would have been more effective had I acted as a facilitator and recorder of change processes during group work, I also recognized that group work would need to be a decision entered into freely by the research participants. These research participants were already giving generously of their limited free time and they scattered to different hospitals during the research; therefore, it was obviously not feasible. Nevertheless, collaborative group work is something I would consider carefully and attempt to negotiate into future research designs.

The questions of *when*, *where*, and *how* to end the research posed a further dilemma. I was keen to pursue more and more questions and found it difficult in this kind of interactive study to terminate the research. Essentially I opened up a number of areas to be pursued by myself and others. The interactive approach meant that I developed satisfying relationships with the nurses concerned. It was difficult to break off these stimulating discussions particularly when we had engaged in sharing experiences and knowledge in depth. I found that I was in the same situation as Oakley (1981) when she engaged in a reciprocity of sharing in her interviews with women, which led to the development of a few real friendships. McRobbie (1982) in her comments on Oakley's situation suggests that it was a measure of the powerlessness of these women that they did collaborate and form relationships with a caring, articulate researcher who was interested in them and in their opinions. I think that some of the nurses have continued to initiate contact with me because they do enjoy talking about nursing with someone who is interested in learning about nursing from them and who is prepared to take their views seriously as a basis for critique and reconstruction. If this process demonstrated the powerlessness of nurses, it also demonstrated the powerlessness of this isolated researcher pursuing doctoral studies who experienced the nurturance/knowledge construct at work when the nurses also took her views seriously and helped her make sense of their world of clinical nursing. I believe this demonstrates the nurses' commitment to nurturance/knowledge because the interactive process enabled us to provide each other with mutual respect, support, and knowledge through the process of critique and reconstruction.

The process of engaging in this research was enlightening,

empowering, and emancipatory for me as researcher. *Enlightenment* came through the development of my knowledge of clinical nurses, their working situation and the limitations of the power/knowledge theoretical framework with which I had chosen to examine clinical nursing practice. The processes of observation, critique, and collaborative meaning making enabled me to identify many theoretical constructs, such as accommodation and resistance at work, and through analysis I was able to develop new theoretical insights into nursing practice.

These insights were *empowering*, because they enabled me to move beyond the realm of recognizing and using methodological techniques and theory devised by others, into the realm of creating empowering collaborative research practices and theory development informed by the nurses and with which they experienced face validity. It was the initial "yes, but" responses of the interactive face validity process that facilitated the development of new theory and the affirming "yes, that's right" response. Interactive collaboration took away the power to reconstruct a lone view of reality, empowering participants and researcher through the process of contestation and critique.

Emancipation is demonstrated through action. An ethnography does not facilitate action for its research participants in the manner of more action-oriented methodologies such as action research. However, the nurses did respond to our collaborative critiques by actions designed to change the situation. Some actions were emancipatory, but many reflected the dominance of the technical model in nursing practice when nurses who had arrived at strategic action plans through collaborative analysis then attempted to impose them hierarchically rather than facilitate a collaborative process for contestation and negotiation among nursing colleagues. Nonviolent emancipatory change takes a commitment to ideology critique and negotiated collaborative strategies for change and takes time. This process involves self-reflection to disclose the historical construction, values, ethics, and taken-for-grantedness of habitual practices while accounting for the embodied and embedded character of social actors and the limits to freedom, rationality, and happiness, which constrain and shape their world of practice. This study was just a beginning.