Making Sense of Change in Primary Health Care: A Complex Responsive Processes Perspective

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Abstract

This research arose from my curiosity about change, and my dissatisfaction with models and tools which do not explain my real life, messy, and sometimes disappointing, experiences of trying to instigate change. My aim, therefore, has been to explore what is it like to experience and make sense of change *as it is happening* in my working life as a Nurse Practitioner and Primary Care Trust Board member, in primary health care in the National Health Service.

Essentially I argue that the dominant way of thinking about change assumes it is a "thing" to be planned and then applied. I believe the error is in thinking we can produce change as if we are in control of a system. An alternative way of thinking about change arising from my experiences is that it can only express our *intention* for the future but is not controllable in the way often implied. I also suggest change is experienced as *movement* in the present where, often with hindsight, we experience a shift in patterns of how we speak about or experience something.

Early on, my search was for a way of explaining my experience of change by initially drawing on the theories of complexity, which point to emergent pattern which arises spontaneously from local interaction, without any external blueprint or plan. I then turn to the theory of *complex responsive processes of human relating* (Stacey et al, 2000) which views human interaction as itself inherently pattern forming and therefore ordinary everyday interaction as the source of change. I take the theory of complex responsive processes as the foundational theory for my research by asking *"What is it like to experience change in primary health care from a complex responsive processes perspective?"* My methodology, which is consistent with this perspective, focuses on my own experiences, as *emergent exploration of experience* (Stacey and Griffin, 2005). In other words I am reflexively exploring my own experience by using narratives, stories and analysis intertwined, to reflect as closely as possible the messy reality of the way we are continuously making sense of experience and change.

My experience seeing patients in primary health care; managing a nursing team; and sitting on the Board of a Primary Care Trust highlights the emotional, fantasy laden aspects of experience which are often disregarded or viewed as common knowledge. Similarly, there are feelings of anxiety surrounding any change where my identity feels threatened and there are changes in power relating between people (Elias, 1939). I argue that tools, models and labels serve to relieve feelings of

anxiety, by providing an illusion of control, but may in themselves also increase anxiety and block the potential for change.

During the research, my own practice has changed by becoming more reflexive as I focus on my own participation, whilst adding further dimensions to the theory. Firstly, I argue that focusing attention in this way implies a heightened awareness of responsibility and potential for one's own actions. I cannot know the result of my actions but know that they may have some effect, large or small. Secondly, I argue that the dominant discourse may perpetuate the way change is viewed as a "thing" external to every day experience. Rather than focusing on control, process thinking conveys a different reality of continuous sensemaking. Lastly, I argue that focusing attention on feelings, emotions and the environment as simultaneous rather than separate aspects of experience becomes important when experiencing and making sense of change from this perspective. I argue, therefore, that a complex responsive processes perspective challenges the dominant perspective on change by providing a way of understanding which resonates with my experiences, has significant implications for my own practice, and validates paying attention to ordinary everyday experience in which change is continually emerging.

Contents

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Chapter 1: Introduction; "Coming home"

I first became concerned with the idea of change whilst studying on a nursing degree course, and working as a practice nurse during 1995-7. The course focused on promoting healthy lifestyles with patients, and introducing change, for example, by setting up a new clinic. Feeling enthusiastic about newly learned ideas about change and leadership, I had discussions with a health visitor colleague who was doing the same course. We were keen to put our ideas "into practice". We initiated a meeting with other nurse colleagues, and talked about how we could work together. After several meetings and conversations we ran a series of "Elderly Health Workshops" providing `flu vaccinations, along with the opportunity for patients to see a range of other health professionals, whilst also having the opportunity for a cup of tea and a chat (Poole, 1998).

Fired up by my perceived success, I applied for a "Nurse Development" post at a larger practice, where my role was to work as a nurse practitioner, and to "Integrate the Nursing Team". At interview I remember naively telling the panel how I had already achieved success at my previous practice and how I would go about promoting teamworking at the new practice. However, when newly in post, I began to suspect that this might not be as easy as I had first thought.

I arranged a meeting where I asked the nurses to talk about their own areas of work (for example health visiting, district nursing and practice nursing). My intention was to find common ground and develop a "vision" to improve care by working on a common health initiative. However, there was little enthusiasm for this idea as my new colleagues expressed their despair at previous interventions and away days with facilitators, aiming to promote teamworking. There was hostility between people at these meetings. I wondered where was I going wrong? I felt frustrated and anxious that I had failed and reasoned that I needed to get better at "managing change".

I was influenced by common organisational development approaches, based on agreeing common goals and visions and setting objectives to achieve the desired change (Berwick, 1996). However, I sensed a dissonance between the theories of change studied on my degree course and my real life experience. In a subsequent role as a Primary Care Group[1] (latterly Primary Care Trust) Board Nurse, my experiences of trying to instigate change in a new NHS structure (DOH, 2000; DOH, 2002; DOH, 2004a) similarly proved frustrating. What seemed to be lacking in my tools and

[1] For a glossary of terms used throughout the thesis see Appendix 1

models was a recognition of the context and history of what had gone on before for these people. There was not a strategy that could be lifted and applied to all people in all contexts in a rational, planned or orderly way.

Perhaps it was these difficulties and frustrations which fuelled my curiosity as to why I was unsuccessful, and my openness to other ideas to help make sense of my experiences.

At about this time, my partner (an organisation consultant) returned from a conference where he had felt inspired by new ideas emerging from the complexity sciences[2]. Initially skeptical, I later read books by Waldrop (1992), Capra (1996) and Goodwin (1994) which struck a chord with my experiences, by suggesting how patterns arise spontaneously from local interaction. This seemed to explain for me how change depended on the interaction of agents - sensitive to small fluctuations which can produce patterns which are never exactly repeatable - and therefore was not just about me!

The opportunity to explore these ideas, and what it means to experience change from a complexity perspective, later became realised by undertaking this PhD. I remember returning from my interview for the studentship feeling excited and emotional at the prospect of exploring further what this might mean – it felt like "coming home". My journey with this process follows with my exploration of the literature, and my own narratives and sensemaking in this thesis.

Changing tack: what do I mean by change?

Since completing my degree in 1997, I have returned each year to the University to talk to a group of degree students, who are required to write about a change project as part of a module on leadership. As we explore our own experiences of trying to initiate change, there are nods and smiles as people recognise the messiness of change, how difficult it is to "implement" and the sense of frustration and failure when things don't always go to plan. Despite this, nurses are still expected to demonstrate their knowledge of models of change and write about their experience of managing a change project. I wondered why it is, that despite intuitively knowing that change doesn't happen as models suggest, we keep using them or pretend that they work in the way they are supposed to? What purpose are they serving us? I hope to shed some light on why this might be so in this thesis.

I have also come to realise that change has a number of meanings that I was not previously concerned with. In particular this became apparent when people asked me what sort of change I would be studying – was it about imposed, external change, by the government; structural change in the NHS; cultural change; or how to "manage" a change process or initiative? All these categories imply that change is something that can be controlled in some way by someone outside a "system". Indeed mechanical metaphors used to describe change are evident when talking about human beings and organisational change– such as "forces", "resistance", "drivers" and "levers" (Lewin, 1951). The implicit assumption is that you can design a change and make it happen. It seems that ideas about change have been applied to human interaction in the same way that they are applied to objects or things which have been manufactured by humans. For example, I can pick up my chair intentionally and move it (control it). However, when we speak about organisations or teams as if they are "things", reifying and sometimes personifying them, we transfer the same ideas about control to ongoing processes of human interaction. In other words we make processes into spacial wholes which we then believe we can manipulate.

Initially, I became excited by the ideas suggested by the complexity sciences, as they suggested that change or patterns emerge spontaneously from local interaction without any predetermined plan. I felt this helped to explain why I couldn't be solely responsible for "managing change", but it also depended on the complex interactions with other "agents" I was working with. However, as I explored the increasing amount of literature amongst organisational and management theorists aiming to use these insights in organisations, I began to realise that they were actually saying very little new (Pascale, 2000; Lewin and Regine, 1999; Wheatley, 1992). They seemed to be maintaining an outsider position of trying to control and predict change albeit with new complexity metaphors, such as choosing the simple rules for people to follow, in order to create desired change (see Chapter 3). In other words, they maintain the position whereby organisations are systems open to manipulation by someone such as a manager supposedly outside of the system.

Reading the work of Stacey, Griffin and Shaw (2000), however, I felt that they *were* saying something new about complexity and change. Using ideas from the complexity sciences, they draw analogies with human interaction, within the domains of process sociology and relational psychology. They argue that interaction itself is inherently pattern forming (Stacey et al, 2000) and patterns or themes emerge spontaneously and unpredictably as we interact with one another. Furthermore, we can never step outside of these processes of interaction and observe or change

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[2] see Appendix 1

them as we are always part of that process. Global patterning (or themes such as "the economy", "health" or "holidays") emerges from local interaction of individuals at one level forming and being formed by the social at the same time.

> "The potential for transformation arises in the capacity for spontaneous individual responses and the amplification of small differences in iterated habit from "one" present to the "next". The natural complexity sciences demonstrate the possibility that nonlinear interaction has for amplifying such small differences into completely different patterns which are unknowable in advance" (Stacey and Griffin, 2005, p.17)

This is the perspective I will be taking, by paying attention to my own experiences of the continuous and unrepeatable (and therefore non-transferable) processes of relating, and thus what it is like to experience change as it is emerging. This differs from taking a detached view of what is happening, like much research on change in organisations, which offers propositions for changing the whole (Weick and Sutcliffe, 2001; Lewin and Regine, 1999). I began to make sense of this when I saw a journalist reporting on the Tsunami disaster. As he flew over islands destroyed by the tsunami he was able to see a bird's eye view of the disaster and report on what he saw. However, he commented that this did not help understand what it was like to experience what this meant, until he landed and spoke with the survivors. Whilst it is possible to take a detached view, my experience suggests that it is not possible to directly change or control the whole with predictable results. My purpose, therefore, has been to make sense of my experiences of change as I have increasingly worked with concepts suggested by the theory of complex responsive processes. My contribution is to provide a unique perspective on change *as it is happening*, in the context of primary health care, which I believe to be previously unresearched from a complex responsive processes perspective. I hope that this will resonate for others working in primary health care and help them to make sense of their own experiences (see Chapters 3 and 4).

Focusing on the theory of complex responsive processes as the foundational theory for my research has implications for what research and practice mean from this perspective (see Chapters 3 and 4). Research and practice have become intertwined as a process of making sense of experience or, as Stacey and Griffin more recently describe, as a methodology of *emergent exploration of experience* (Stacey and Griffin, 2005). Rather than being an introspective account, a complex responsive processes perspective sees experience as referring to "interdependence, to the social, as the fundamental human reality" (Stacey and Griffin, 2005, p.23). In this sense my "self" emerges from

the many interactions I have with others, as individual and social are simultaneously forming and being formed by one another. My experience reflects many conversations with many people as I am participating in change as it is happening and therefore reflects the wider context of primary health care.

This approach therefore validates focusing on one's own experience or "taking one's own experience seriously" (Stacey and Griffin, 2005, p.35). The thesis comprises reflexive narrative, or story, and analysis intertwined, rather than viewing "narrative" as a separate "thing" to be analysed. Although I have sought to produce a logical sequence or structure which feels acceptable I have also wanted to show the messy disjointed way that things happen and themes emerge spontaneously. This reflects the "narrative-like" way we are continuously making sense of experience. These stories and narratives have reformed as I have revisited them and are a record of my sensemaking process which is inevitably ongoing. Over time, the quality of my reflection and awareness has arguably developed in response to this way of thinking.

Writing in this way inevitably raises ethical questions such as what I can reveal in my writing without disclosing confidential information or causing offense or harm. When writing the narratives I was initially keen to capture my feelings and perceptions of what was happening, without "holding back" in any way. I wrote frankly about my feelings and interpretations of what other people may be thinking and feeling, including the rather more uncomfortable aspects of human nature such as blame, gossip and fantasy. However, I later faced uncomfortable feelings concerning who might read my work and who might be offended by it, despite attempting to disguise people's identities. At the same time, if I leave out or modify my narratives too much, I may lose exactly what I am trying to capture about the "real life" experiences and sensemaking as a participant in these processes of interaction.

I began a process of reading the thesis as if I was one of the people represented in the stories – i.e. from the eyes of the "other". Would making my stories "safe" lose any real meaning? How far could I risk telling it as it is – or as I saw it, without causing offense or embarrassing myself? After taking all the names (albeit changed names) out – the narratives felt flat. Instead of feeling alive with real people, referring to people as "someone" or "a receptionist" seemed to depersonalise the stories. I was the only person present. I decided to add changed names again although writing sensitively to how others may feel if they read it. Colleagues are aware of my research, and I have written in a way which protects their identities. I do not attempt to speak for others. What I write

can only be the way I see it – I would expect others to see things differently. Whilst the narratives including patients are based on my experiences, the patients' details are fictitious. I have also given key people, such as the Assistant Chief Executive of the Primary Care Trust, the opportunity to read my work. Ethical concerns have arisen throughout writing the thesis and I continue to take them seriously.

I began to think about how I am continually constrained by and yet enabled by the risk of saying something and the risk of saying nothing, whilst preserving my own integrity or identity in my role at work. This is something we all face in day to day life as we continually choose how to respond whilst not knowing how another will respond. Perhaps this is what is reflected in the thesis overall – and in the themes surrounding health and primary health care. The balance is in the constraining – or feeling safe enough to take action - yet with enough flexibility to allow the potential for change. And this is a dynamic process as we relate to one another. I hope, therefore, that this ongoing thread of being ethically responsible will become clearer throughout the narratives as is has for me in the process of writing them.

How I have compiled the thesis

The thesis reflects an ongoing process, of numerous conversations with supervisors, colleagues and reading of relevant literature over several years. I aim to show how my sensemaking has *evolved* with an increasing understanding of the theory, as I make sense of aspects of my experience working in primary health care. I also aim to show how my thinking and reflexivity has developed as I have increasingly refocused my attention on my experience from a complex responsive processes perspective. This includes my work as a manager of a team of practice nurses; working with patients as a nurse practitioner; and working as an Executive / Board Nurse for a Primary Care Trust. I also include references to other aspects of my personal experience, which has helped to make sense of this new way of thinking and acting. Whilst including aspects of my own unique history, I am also providing insight into a number of areas previously unresearched from this perspective, in a primary health care context in the NHS.

Chapter 2 shows my early sensemaking as I am living with changes at a general practice, where various tools and models are being used to try to effect a change in culture at the practice. Evident are some embryonic ways of relating my experience to the theory, which initially relied primarily on metaphors from the complexity sciences. I also include experiences at the Primary Care Trust in relation to themes of control and structure change. My curiosity about the messiness of my

experience led to my initial research question *"What is it like to make sense of change in primary health care from a complexity perspective?"* Turning to the literature, I explore how change is viewed in the National Health Service in the UK. I am also struck by the emergence of the themes of responsibility, emotion and language, in rudimentary form, which become evident throughout the thesis.

In Chapter 3, I explore in more depth how *complexity theory* has been used to make sense of organisational life, in particular in the NHS. I argue that these ideas sit firmly within a systems paradigm, where the position taken is an observer perspective attempting to change organisational "wholes". Arising from this way of thinking, I also discuss my initial approach to methodology, where I was aiming to discover what assumptions other people had about change. However, my internal disquiet when interviewing colleagues felt similar to my disquiet about models of change, where both assume the perspective of an objective observer of an external reality.

In Chapter 4, I turn to the theory of *complex responsive processes* and what this means for making sense of change and the implications for thinking about research and practice. I discuss how the theory of complex responsive processes has emerged, and how a complex responsive processes perspective on change is different from systems thinking and other interpretations of the complexity theories. From this perspective change is understood as simultaneously recognisable and yet changing identities and ideologies emerging as people relate to one another. Linked to this is the associated anxiety this brings. Establishing my methodological stance, I focus on these intertwined areas in answer to my research question *"What is it like to experience change in primary health care from a complex responsive processes perspective?"* as I refocus attention in my daily work, in the next three chapters.

Chapter 5 focuses on my experiences of working as a nurse practitioner, reflecting on my sense of identity, or role, emerging as power relating, and how this is both recognisable and changing in relation to my work seeing patients. I discuss how the notion of time, from a complex responsive processes perspective, challenges the way I think about reflective practice and educational methods. I also consider how a complex responsive processes perspective provides a different focus for what I am doing in medical consultations with patients and how I am increasingly viewing them *as emerging relational processes.*

In Chapter 6, I explore what it means to live with the ideology of Patient and Public Involvement in the context of my work with the Primary Care Trust. I reflect on how ideological themes simultaneously enable us to talk about something, whilst also conforming or rebelling. Ideological themes also enable me to choose not to do something. I also experience ideology as feelings of being included or excluded, in relation to a meeting surrounding the theme of the Expert Patient.

In Chapter 7, I turn to the theme of anxiety, recognised as inherent in experiencing change, which was a strong theme evident throughout my experiences. Faced with my own anxiety about being ill, I notice how "labels" act as a temporary relief from anxiety, whilst also sometimes increasing anxiety. Relating to others became a way of containing my anxiety, whilst sometimes increasing it – anxiety was individual and social at the same time. I discuss how anxiety may be amplified more widely in health care with life and death situations and scandals. Management of risk then becomes a way of containing fears of the unknown, and fears concerning survival individually and socially. I argue that some of the constraints we use to reduce anxiety may block the potential for change. Rather, by living with and acknowledging anxiety the "containing" is in the ongoing processes of relating to one another.

Chapter 8 draws together strands of themes which were apparent throughout the narratives of my experiences. Ongoing themes arose from the implications of this way of thinking in practice. Firstly, there is a sense of responsibility for what I say and do, rather than blaming the "system" or someone I perceive to be "in control". Furthermore, there is a heightened awareness of responsibility for and potential of my interactions which are paradoxically transformative (creative and destructive) from this perspective. Secondly I notice the theme of process language, as I pay attention to how I am speaking and writing to convey the ongoing, transformative nature of experience rather than talking in terms of "wholes", or "inside" and "outside", or fixed states. Thirdly, I pay attention to the feeling, emotional and environmental aspects of experience which are simultaneously affecting how I am thinking and acting.

Chapter 9 focuses on answering my research question *"What is it like to make sense of change in primary health care from a complex responsive processes perspective?"* and includes my contribution to knowledge. I argue that although the concepts require some depth of understanding, they do resonate with experience. Furthermore, by refocusing attention I make sense of change as expressing *intention* and feeling a sense of *movement*. I summarise key themes emerging and how they contribute to the way I am now making sense of change.

The final chapter draws together some concluding themes. Firstly I provide an exposition of my method, including how my approach is similar to, and different from, other qualitative approaches. Secondly, I compare a complex responsive processes perspective with other organisational perspectives in the literature, focusing also on the theme of anxiety. And finally, I explore what is generalisable about my research, including the implications for change and policy in the NHS, and what, if anything it is possible to do globally.

This introduction has summarised the background to the research. I will now continue the thesis by exploring in more depth how my thinking and sensemaking has evolved as I have worked with these ideas.

Chapter 2: How I am making sense of Change Management at a GP Practice and the wider NHS

This chapter records embryonic ways of making sense of my experiences, from a complexity perspective. I use narratives and stories interwoven with aspects of the literature on change in the NHS and the theories of complexity. The narratives reflect the messiness of change, and the complexities of concurrent issues emerging in the everyday conversational life at the general practice where I work as a nurse practitioner and nurse manager, and my work with the Primary Care Trust. Also evident is how my sensemaking changes as I reflect on my experiences, and I grapple with a developing understanding of the theory. Some of the themes emerging in rudimentary form continue throughout the thesis, and I will expand on these in later chapters.

This is inevitably an on-going story. Events at the general practice could be likened to an on-going "soap" story. There are disputes; in-fighting; stories of disasters; stories of overcoming something against the odds; stories of heroes and villains; even fairy stories. They may be recognisable as typical "goings-on" in many work settings. However, in my experience we rarely pay sufficient attention to what we are doing in ordinary everyday experience, which I am suggesting is the source of change. The purpose of this chapter is to enable just that.

Setting the context

I don't ever remember feeling that nursing was my vocation. I feel quite sad about that – as many of my colleagues say they always wanted to be a nurse, and I wished I had felt the same. However, I was interested in animals and people and wanted to help them, so it seemed "good enough" - until I "got married and had 2.4 children" – which was the message I heard from my parents. After training to become a nurse in the late 1970's, early 1980's, I quickly got on with the business of marrying and having...well one child, before my intended future took a different turn. After my divorce in 1993 I needed to reconsider my career. I joined a General Practice, and found I thoroughly enjoyed my work as a practice nurse. This led to a counselling course, a degree course and a search for further employment to develop my skills.

I joined Fairview Practice in 1998, having recently completed my degree in Specialist Nursing Practice. The "Practice" can be regarded as the people who work within the practice premises. At the time I am describing this comprised 6 General Practitioners, 4 practice nurses, reception staff,

administration staff and attached staff i.e. Health visitors and District Nurses (a total of approximately 30 people). Although employed by the Primary Care Trust, I was responsible for managing the nurses employed by the practice, and trying to improve "integrated team working" with the district nurses and health visitors.

The general context to working life in the Fairview Practice is a time of rapid change, including imposed "structural" changes. General Practitioner (GP) Fundholding, where GPs held budgets for purchasing secondary (hospital) care for patients ceased in 1998. Newly formed Primary Care Groups and latterly Primary Care Trusts – commissioning bodies made up of local GP, nurse, therapy, social services, and lay person representatives, were charged with commissioning (purchasing) care for patients; improving the health of local communities; and developing primary care services. This meant a change in role, or even loss of job for some practice staff whose role was primarily linked to Fundholding work. Decision making on budgets and purchasing of care for patients had also shifted from the GPs to the Primary Care Trust.

The Fairview Practice was undergoing its own changes with one practice manager leaving and another taking over, and implementing new appointment systems, in line with government targets, for patients to be able to see a GP within 48 hours (DOH, 2000). In addition to this, there were ongoing conversations about the need for a change in culture and the promotion of good teamworking at the practice. A considerable amount of time and energy had been put into team away days with facilitators and the GPs had been working with a management consultant. It appeared that there was a concern that the prevailing culture was seen as detrimental to productive working relationships.

Change at a GP Surgery: Tools and more tools

In November 2000, I attended a "Managing in Complexity" module run by one of my supervisors, Dr Dorothea Noble, at the Business School. Along with a group of MBA students, I learned about the theory of complexity in relation to other management theories. What seemed to be different was the emphasis on paying attention to one's own experience, from where order or change emerges spontaneously, without anyone being in control. This contrasted with a traditional perspective, which concerned designing strategies and outcomes. We were asked to write a reflective piece about our experiences at work. I found this an emotional experience thinking about what had initially been a difficult time for me. My initial perceptions of the Practice were of a "blame" culture, where I was warned to "watch your back". A large notice in the waiting room

warned patients that any "verbal or physical abuse would result in them being removed from the doctors list".

Furthermore, the nursing team seemed to me to be fragmented and the nurses blamed one another or worked in an isolated way. I was told that I had been brought in to "manage" the nursing team, as previous management of the nurses "had not worked". However, I felt my attempts were criticised by the practice manager, and I felt under scrutiny. The nurses also told me of numerous away days with facilitators, aiming to improve teamworking with the district nurses and health visitors which "hadn't worked".

Away days for the whole practice team began again. Some people told me they thought it was a waste of time. I was more optimistic, hoping that it would be possible to talk about some of my unpleasant experiences. Trainee management consultants were brought in as a training exercise. I was interviewed as part of this process, however the trainees only appeared to be interested in the systems and processes we had in place and I felt the relational aspects were ignored. At one of the away days we worked to agree a vision of "a surgery where the staff are happy, the patients are happy and we have enough money to go around". We were then asked to say what we thought made a good team. A senior GP, near to retirement said "kindness". There was a spontaneous round of applause, with some people obviously moved, including myself. It felt as if this was something we all desired but was somehow lacking in our experiences.

The GPs were having continuing discussions with Sarah, a management consultant and it was decided to introduce 360 degree feedback[3] for all staff, to help us to become an "excellent team". I attended a briefing session where we were told we could pick two people from different departments and ask them for feedback. The appraisal scoring had to be devised from questions relating to what we had all decided were important elements of a good team. A group (of which I was a member) amalgamated a list of words and circulated it to all staff to ask them to fill in what they thought each word meant e.g. "understanding" or "information".

I asked the reception staff if they had filled their forms in. They said no, and they "weren't going to either". They said they thought that 360 degree feedback was a way to get at them, and that they

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[3] 360 degree feedback is an appraisal system whereby all members of an organisation appraise one another. For example, "subordinates" appraise their bosses and peers, as well as bosses appraising each other and their staff.

wouldn't be able to give genuine feedback to a GP – their employer. They seemed anxious and angry, and I found myself empathising with them. At the next small group meeting we were to discuss everyone's responses on the forms. Jan, one of the receptionists, told the group that the receptionists were not filling their forms in. Andrew, one of the GPs said, OK, he would discuss it with them further at the next receptionists' meeting. I realised that although this seemed like a setback, they had actually been able to speak up and had made their point. This to me was a success!

Despite the lack of enthusiasm for the idea by reception staff, we carried on with the process of developing the questions for the appraisal form.

During November 2000 I attended a four day "Leadership Course" along with three other members of Practice staff, run by Sarah, the management consultant. This was an intense, and at times emotional, experience, during which I began to feel I had a better understanding of my colleagues who were present. I was also able to disclose uncomfortable aspects of my experiences at the Practice. I was amazed at how widespread the problems now appeared, and how they were increasingly being talked about.

Some weeks later I interviewed Joan, one of the Practice staff, as part of my research. The focus was on her experiences of change at the Practice, but she quickly turned to the difficulties she was having with another member of staff. She also recognised that this may be due to the uncertainties surrounding the end of Fundholding, and what this meant for the future employment of some members of staff. It seemed possible that this person's job was under threat.

How I was thinking about my research at this time

Initially my research question concerned "change" as "external" to everyday experience. I wanted to focus on people's "assumptions" about change, and to offer a different perspective. I was concerned to capture others' truths, which were "out there" to be found. Hence, early on, I decided to interview people to reveal what I thought would be their assumptions about how change happened.

However, my experience of interviewing colleagues was, I felt, disappointing. I was concerned by the hesitance of some people to speak to me openly about what I believed were the key issues at the Practice, preferring to speak in more abstract terms about change in primary health care. I felt

something was missing from this sort of interview. Other people at the Primary Care Trust volunteered to be interviewed, however, and on one occasion I felt this enabled them to disclose personal difficulties they were having with other members of the Trust. I reflected that a research interview led to a feeling of formality and preconceived ideas about what it means to be a "researcher", and "interviewee". Issues about confidentiality, ethics and power relations became evident where I was interviewing either my boss, or a member of staff where I was their manager. Issues surrounding the power of the researcher have been recognised by feminist researchers, in particular, who have criticised the research interview where the power resides with the interviewer who interprets the interview as they wish (Hollway and Jefferson, 2000). This increasingly troubled me.

Initially I included quotes from transcribed interviews woven into my own narratives and stories. They initially felt like truths which enabled me to justify my own experiences as accurate interpretations. I began to feel uncomfortable about this, as it was I who was choosing what to write – seemingly in order to "fit" what I wanted to say. Even more disturbing to me was the very transient nature of the interview, as things "moved on apace" as someone said during one of the PCT meetings. My quotes seemed to be very detached from what was currently going on and lacked the contextual feel of the interview, when written as words on paper. Seen out of context, a quote also missed the richness of the experience, for example body language, the physical setting and the context and history of what was being spoken about at that time.

Despite obtaining formal ethical approval and permission from the PCT Board and the Practice in order to proceed with my research, issues continued to arise in my experiences as a practitioner / researcher. Ethical considerations for researching one's own practice traditionally involve commonly recognised principles such as doing no harm, confidentiality, consent etc (Martin, 2004; Christians, 2000; Hollway and Jefferson, 2000; Hertz, 1997; Field and Morse, 1996). As Hertz (1997) raises - do we need permission from our family, friends or work colleagues before we write about them in our stories (Hertz, 1997)? I have had to respond to these personal and ethical considerations as they arise in each context.

On one occasion, a member of staff at the practice agreed to my request for me to interview her, despite expressing some concerns about what it would involve. On the day of the interview she was off sick. She later apologised saying we must set another date. However she didn't respond to my

email asking when would suit her. I decided not to pursue this, as she may have found it difficult to refuse, being a colleague at work.

It was this internal disquiet about who and what I was representing which led me later to abandoning interviews. I continued to keep a diary, however, which I initially colour coded on my computer, in order to distinguish between PCT, Practice or PhD stories. I felt concerned that I would miss something unless I recorded everything in chronological order. As my thinking has evolved further, now viewing historical "facts" as reconstructions in the present, these "categories" have become less important as I experience the inter-relatedness of everything.

Meanwhile work was continuing to develop 360 degree feedback, to "improve teamworking" at the Practice. I attended another meeting to produce the questions for the 360-degree feedback. It was a much livelier meeting I felt, although the two representatives from reception were rather quiet. There was some reference made to personality types i.e. "J"and "P" on Myers Briggs[4] (based on individual preferences for structure or flexibility). One question was around commitment and people "clock watching". Some were suggesting that people shouldn't clock watch and rush out of the door dead on their leaving time. I felt that the principle behind the question was more to do with how much energy they put into their work when they are there and how flexible they are if work needs to be done, as opposed to merely watching the clock. The focus of the questions was changed after I kept stating my bit. I noticed it wasn't possible to predict what happened in the meeting beforehand.

Also at this time we started to have "Thinking Partnership" (Klein, 1999) meetings. This was a new idea introduced by Sarah, the management consultant, during the Leadership Course. It involved a process of pairing up with one person and talking about a troubling issue, using a format of questions about limiting assumptions which might be blocking the person. The idea was that if you found your limiting assumption, you could change it.

At one of these "Thinking Partnership" meetings, we were unable to think of an "issue" to talk about. As a foursome we talked around this and said we felt less comfortable doing this at work where our roles were more evident and we feared what we may "uncover". We were also aware of

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[4] Myers Briggs is a personality profiling system derived from the work of Carl Jung. This is based on a series of 8 preferences of behaviour:- introvertion or extroversion; intuition or sensing; thinking or feeling; and judging or perceiving, and thus 16 personality types

a hierarchy. However, Andrew, the GP said he didn't believe in hierarchies. I said I felt the same and gave the example of St Luke's (an advertising agency where all the employees are shareholders (Law, 1998)).

There appeared to be some confusion about how the different developments would come together to improve things. I said that the mere fact that we were all meeting like this and speaking to different people in ways would inevitably have an effect even if we couldn't predict what. Joan, an administrator said "Scary!" I found it interesting that if things couldn't be packaged, and a clear result seen, it was scary. We discussed how we might share the ideas with the rest of the practice. I felt all the staff should be able to do Myers Briggs and to talk afterwards about how we could work better together. Although I felt guilty and uncomfortable for not "practising" our Thinking Partnerships, I noticed that we were having a different sort of conversation about how we were all feeling. I noticed Andrew was making furious notes. I also thought about how it did not feel safe to carry out these Thinking Partnerships in this environment at work. What I might reveal could be "used against me" in another situation.

In January 2001, we had another "away day" at the surgery. The theme was giving and receiving feedback – using Transactional Analysis[5] and other techniques, with the "right" motives of wanting to help someone. I made an effort to speak to Jane, one of the community nurses during the breaks. In one of the "practising giving feedback" sessions we shared our experiences of working in different ways. We agreed we needed to communicate better on issues where our roles overlapped. During the feedback to the whole group I said I felt we had had some "crossed transactions". I said I believed we were both doing our best for our teams and didn't intend things to go wrong. I felt much better after this. However, I had often felt angry, upset and frustrated with ongoing disagreements between our teams.

I was very much viewing that good teamworking was necessary for the healthy functioning of the practice and felt that tools such as transactional analysis and Myers Briggs personality types helped explain differences between people.

The feedback from the away day was generally positive – although the receptionists seemed to have found it uncomfortable. I accidentally bumped into Andrew in the car park the following

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[5] Transactional Analysis (Berne, 1964) explains interaction (transactions) based on stimulus and response and subsequent game-playing in terms of ego states of Adult, Parent or Child

week. I told him I thought it was excellent and how the nurses had found some common ground and understanding. He looked genuinely pleased – he said it was worth it then. However, I think he was concerned about the receptionists.

It amazes me the different conversations held with people in informal locations. I met Ruth, a Health Visitor on the stairs. We discussed the away day and the aim of getting people to work better together. She said she was used to calming people down in her job and I felt the same. I have learned to be quiet and calm and realise now that that is why maybe I find it difficult to be lively and passionate about things in other situations. I thought that my "free child" is more evident in home situations.

At a clinical supervision session the next week we chatted about the away day and appraisals. Towards the end of the meeting I said I would be on holiday for the next meeting. It proved difficult to find another date, so someone said let's leave it two months. I found I was agreeing in a mischievous childlike way as if we were being naughty. One of my Practice Nurse colleagues, Sue and I looked at each other and I realised that we do this quite often at work. I was aware that if I had said something different, the conversation could easily have taken a different turn and we might have been meeting on a different day. I thought about how sensitive conversation is and how things can change due to something someone says – but this also depends on how others respond.

The continuing theme was of a need for good working relationships, to function as a team, and I certainly had visions of a happy working environment as being the ideal, or something to strive towards. Ideas about vision statements, teamworking and leadership were familiar to me – from studies on my degree course, and also from my partner, an organisation consultant. I hadn't questioned how these ideas had arisen until I felt myself as if they "hadn't worked". I turned to the literature to try to understand why we think about change in this way.

Changing perspectives on change

Approaches to change in the NHS draw heavily from organisational theory arising from schools of management, psychology, sociology and economics over the past 50 years. Many traditional approaches to change are derived from systems thinking. These ideas are based on assumptions of science and engineering to do with controlling either mechanical systems, or systems in equilibrium. Systems are complex networks of interrelationships which have positive (amplifying) or negative (balancing) feedback on each other (Senge, 1990).

Systems approaches to change often involve analysing the causes of presenting problems, designing a change programme, implementing and evaluating it. (Ferlie and Shortell, 2001; NCCSDO, 2001; Isles and Cranfield, 2004; Berwick, 1996). The focus is on changing the whole and looking for cause and effect relationships among elements of the "whole". For example, one approach frequently advocated is derived from the work of Lewin (1951) and involves a three stage process of unfreezing the equilibrium, moving to an new position by reducing resistance to change and re-freezing in a new position. The idea of "whole systems thinking" is evident in the NHS where the "whole system" is brought together to develop values and visions in order to move in a desired direction, such as to provide seamless care for patients (NCCSDO, 2001). I recognise this way of thinking is evident in my experiences of trying to produce "teamworking" at the Practice.

Whilst systems thinking helps us to notice the patterns emerging in organisations and realise what we do may have wide reaching effects, the tendency, as seen above, is to imagine that it is possible to control and predict what these changes might be. However, this perspective assumes the position of an objective observer of a "system" made up of interdependent parts, which is viewed as a whole. This is unproblematic when there is a clear boundary, as in mechanical systems, but less clear with human organisations, and human interaction. Reifying, or personifying organisations, allows us to speak about something and observe patterns emerging. However, this also gives a false sense of being able to determine those patterns for the imagined whole.

More recently, advances in computer technology have allowed scientists to study the nature of complex adaptive systems. These are non-linear – or apparently disorderly systems in nature such as the weather, ant colonies, the human brain or evolution. The complexity sciences originate in diverse disciplines such as biology, physics, mathematics, economics and chemistry (Arthur, 1998; Holland, 1998; Kauffman, 1995; Goodwin, 1994; Waldrop, 1992). Complex adaptive systems (see Appendix 1) comprise a number of agents which interact with one another. Where agents are different from one another (microdiversity) and there is enough interconnectedness, they have the capacity to change spontaneously and unpredictably to form emergent and coherent pattern, without any blueprint, or external designer. In other words they take on a life of their own. Change, or novelty, and destruction (there is no guarantee of survival) happen in conditions where there is simultaneously stability and instability at the same time (often termed the edge of chaos) (Stacey, 2003a). I will discuss how these insights have been used in relation to organisations in the

following chapter. However, despite recognising the complexity of health care, these ideas have received less attention by those concerned to find ways of effecting change in the NHS.

The National Co-ordinating Centre for NHS Service delivery and Organisation Research and Development (NCCSDO) was commissioned by the Department of Health to provide a comprehensive literature review of change management (NCCSDO, 2001). The reviewers distinguish between planned and emergent change; episodic and continuous change; or developmental, transitional and transformational change. Primarily the focus is on ways to attempt to produce "a fundamental change in thinking, practice and delivery of health care over the next decade" in order to meet the proposals of the NHS Plan (DOH, 1997). They posit that the NHS Plan will require that the NHS becomes an organisation which can embrace continuous emergent change, and needs people skilled in handling change in a complex environment.

Reviewing the tools, models and approaches for intervening and achieving change the authors admit that plans may not deliver what is expected, however, they continue a search for a change initiative that will deliver the results that are needed (NCCSDO, 2001). There is a proliferation of models described, including Weisbord's 6 box organisational model; Peters and Waterman's (1982) 7S model; Pettigrew's model of eight factors showing the receptive contexts for change; soft systems methodology with its inquiring and learning cycle; process modeling; the theory of constraints; force field analysis; Total Quality Management; Business Process Re-engineering; and learning organisations, among others. There is a brief mention of the theories of chaos and complexity – suggesting that a systemic rather than reductionist approach to studying change is beneficial. As complexity ideas suggest change is largely unpredictable, then it is perhaps not surprising that the findings from studies using various approaches to try to effect change show disappointing results in terms of meeting the desired outcome (ibid).

More recently, a study to systematically review the literature on dissemination and spread of innovation in health service delivery, was described by its authors as a "conceptual cartographers nightmare", initially reviewing over 6000 abstracts (Greenhalgh et al, 2004). The 340 page report, whilst thorough in approach, is perhaps enough to leave most managers bewildered with all the models and approaches described and advocated. Similarly a 280 page resource document aims to help managers develop change management skills and apply change management tools in the NHS (Isles and Cranfield, 2004). The focus on tools to manage change again focuses on the desire to

control, predict and manage change from the position of an observer, and if the tools fail then what is needed are better tools.

However, in practice it is recognised that managing change is far from easy, if at all possible (Davies et al, 2000; Ferlie, 1997; Ham, 1995,) as Ferlie suggests below

> "sometimes an over-rationalistic and mechanistic view has been taken of the change process, given that organisational change does not always proceed in a planned or linear manner. The research reviewed here typically questions such a mechanistic and rationalistic approach and poses a more behavioural perspective..... organisational change may be as much unplanned as planned. There is here a rich theoretical and empirical field for future work in the NHS" (Ferlie, 1997, p.183)

Reflecting on my experiences at the Practice, I was struck by the proliferation of models and tools used in relation to change, which perhaps "hadn't worked" in the way that they were intended. For example, 360 degree feedback, Thinking Partnerships, Myers Briggs, and Transactional Analysis, were a few of the tools employed to understand and facilitate change. I found I quite enjoyed using these tools as a way of having different sorts of conversation which allow a recognition of difference, and a feeling of certainty about who I am and that this is OK. However, my experience of using Myers Briggs personality types, whilst helping to understand that people behave in different ways, may affect how I relate to them. For example, I felt critical of what I saw were judgmental and controlling "J"'s (Judging "type" in Myers Briggs), whilst also being accused myself of "being on another planet". Furthermore, I behave in different ways in different situations with different people. By paying attention to my "type" I may focus on that way of behaving, using it as an excuse for behaving in a particular way e.g. "introverted". I find a better explanation of who I am is that I am emerging and changing in response to others, based on my own history, and the context I find myself in.

Introducing the tool of 360-degree feedback provoked a strong response. This was viewed by some staff with suspicion and mistrust as a way of controlling or criticising members of staff. The assumption seemed to be that "one size fits all" in terms of the competencies chosen for the feedback. It was perhaps a permissible way of expressing dissatisfaction or a desire for things to be better. It may also have been a way of distancing from uncomfortable feelings such as blame and mistrust. For example, my focus on transactional analysis as a way of speaking about difficulties with the community nurses kept feelings at a distance by talking in an abstract way about "crossed transactions". However, I notice in particular the response to the call for "kindness" by the senior

GP – which was perhaps a risky "touchy feely" thing to say. Feelings of rebelling against the "tool", and feeling "naughty" or "guilty" for doing so also emerged in relation to practising the "Thinking Partnerships". These messy, emotional aspects of human experience are often ignored in what are seen to be rational decisions about change.

I began to think that tools used to facilitate change are perhaps a "safe" way of speaking about the unspeakable, such as issues of power or emotional aspects of experience. Focusing on the tool as something "out there" to be managed, perhaps distracted from unspeakable issues such as differences in roles and status. We were also ascribing "expert" status to the management consultant, presuming she had the ability to help us change the culture. Using these tools did enable different sorts of conversations at the practice, which maybe reflected a desire for change. However, the tools in themselves did not result in change in an intended way. Although a complexity science perspective points to how change emerges spontaneously from the interaction of agents, this does not explain the aspects of my experience which concerned feelings, anxiety, fantasy, or rebelliousness. A complex responsive processes perspective, however, recognises these aspects of human experience and suggests that changes in power relations between people is inherently anxiety provoking (Stacey et al, 2000). Perhaps feelings of anxiety arising from shifting power relations at the Practice, or fears of losing a job, or a sense of things not being "right" – also created the dissonance that was necessary for a shift in the patterns of relating. The talk about culture change and the use of tools were perhaps expressing intention for the future and allowed different sorts of conversations to emerge, whilst at the same time constraining the sorts of conversations we were having.

Looking for other ways of making sense of organisational tools, I came across the work of organisational psychologist Ibarra (2003), who although recognising some merit in personality-based and development approaches, argues that

> " a static definition of identity - as an 'inner truth' or 'inevitable essence' - and the corollary change process stemming from the idea that we are (or should be) on a quest for a knowable right answer are wrong headed" (Ibarra, 2003, p. 37)

She argues that the "true-self" approach is misleading, in the way that the focus is on "up front and diagnostic", following which implementation is then "easy". She proposes alternative models for viewing the self as "possible selves" – always changing, with more selves developed or appealing than others. A "test and learn process" whereby we are shaping and revealing the self through

testing and learning from direct experience to recombine old and new skills, interests, and ways of thinking about oneself, allows the creation of opportunities that correspond to that evolving self (Ibarra, 2003). Ibarra's work resonates in some respects. However, there is still an allusion to a linear test and learn model of change and the discovery of many selves rather than the emerging sense of self that I experience. Mead (1934) describes the self, or identity, as emerging in processes of gesture and response, or continuous relating between people. Who we are is therefore changing depending on who we are relating to and aspects of our own history at the same time. I will expand on Mead's work in Chapter 4.

I will now return to the Practice and theme of culture change.

New Manager: new culture?

I felt dejected. The security of the environment during the Leadership course had gone and I felt we would be back to our old roles and ways at the Practice. I gave some articles to Andrew including my "managing in complexity" narrative. I thought that showing this to Andrew might continue the themes talked about on the Leadership course about difficulties at the Practice.

The following morning Andrew rang me at home to say he had read my complexity narrative, which described my experiences at the practice. He had been affected by "seeing it in black and white". He wanted to arrange to meet me next week to discuss it. We arranged to meet on the day that the GP partners were having a strategy meeting in the evening.

At our meeting Andrew talked about us needing a different culture at the practice and also wanted to know more about complexity theory. I said I would write a short piece for him. I felt anxious but excited and said it feels as if we "are on the edge of something". I said it was about increasing returns – the positive things generate more positive, and negative can lead to a downward spiral. I was rather loosely using metaphors from complexity science, talking about increasing returns, which is a cybernetic idea from mechanical systems. I was also taking a rather idealistic perspective. Andrew also told me in confidence that the practice manager would be leaving. He was also toying with the idea of whether to show my piece of writing to the other GP partners. He needed to convince them that things needed to change.

Andrew appeared to feel responsible for trying to produce a culture change at the Practice. The assumption seemed to be that culture change is possible to "manage". Equally, I saw him as

someone who would be able to make such changes. I believed then, as I felt he did, that we needed to facilitate better working relationships.

When the practice manager left the surgery it appeared there would be an opportunity to change the culture at the Practice. I sensed from the conversations I was having with people that there was a feeling that things would now be better. There were also discussions about who would replace him, and what sort of person was needed to facilitate this change. I felt that problems at the Practice were now being attributed to this one person and I also held out great hopes for a change in "culture" with a new manager. It felt easy to blame the problems on a "scapegoat". However, while a decision was being made about a replacement manager, Andrew took on the management of the practice.

Over the following weeks, I began to notice the reaction of people to Andrew's leadership, after the practice manager had left. At the same time as feeling that someone was now at the helm as a leader, I was surprised by stories about mistrust, checking and blame, which were similar to the sort of stories being told previously. Feelings of mistrust were evident for me when a colleague suggested we have a Thinking partnership together, so that I could talk through my anxiety about whether to apply for the Executive Nurse position in the new Primary Care Trust. I rather apprehensively agreed to talk about this, as I was concerned that there may be another motive to do with wanting to know what my intentions were, which might affect the Practice.

I was concerned about what I saw as a prevailing culture. I was sure it wasn't intended that way but the norm seemed to be "don't trust anyone and mind your back". I had hoped this would disappear– or at least had the potential to change when the practice manager left. I grappled with ways of making sense of this in complexity terms – wondering if this "stuckness" was because of a strong organising principle, "attractor" or "rule" which kept us subconsciously behaving this way (Appendix 1 and see below). I needed to find another explanation for the apparent continuation of the themes of blame and lack of trust.

I began to attribute great importance to the recruitment of the new practice manager, and I felt the staff should be able to have a say in the process. I managed to persuade one of the GPs to introduce members of staff to the candidates, so that they could give their views. However, I only met one of the four candidates who were interviewed by the GPs.

The following month I was talking to Andrew in reception when the new Practice Manager, Beryl, came in. I hadn't met her before. She looked nervous (it was only her second day at work). Andrew introduced us and also mentioned I wasn't employed by the surgery. I commented that it didn't make any difference to me (I felt like I belonged to this team at the surgery, more than being an employee of a rather abstract "Trust"). Beryl, the manager replied that it would make a difference to lines of accountability. I noticed that this was obviously something she thinks about.

Later I met Carol, one of the administrators in the coffee room and asked how they were getting on with the new manager. It seemed that there was some anxiety about how their work might change with this new practice manager, who had said she wanted to know what they did "every minute of the day" (she wasn't sure if she was serious or not). Carol told me how she tried to convey a sense of the practice being like a family, amidst concerns that a culture of "checking" may prevail.

I felt disappointed, and concerned that things might not change. I wrote in my diary that I also had the feeling that unconsciously that is what we, or the "surgery" and the doctors want. However, I thought that maybe Beryl, the new practice manager, also felt unsure of her role and how she fits into this new culture. Maybe she will be adapting in relation to us. I was due to see her in a few days to tell her about my role – however, our meeting was cancelled several times. I attributed this to her being too busy, disinterested or feeling threatened by something she perhaps knew little about e.g. nursing.

There was considerable anxiety from the administration staff about the new manager which I made sense of as power relating. I too was anxious and disappointed that I didn't meet with her to explain my role, despite several attempts on my part. I had hoped that I would be able to influence her in some way and felt my status and position at the surgery was being threatened. My own perception was that similar patterns or themes of conversation were still predominant in the organisation. I was assuming that the "surgery" had a mind of its own.

Using metaphors from the complexity sciences maintained a belief in some sort of system that was controlled by a leader or manager, or alternatively by some "force" which maintained the culture of the whole. I notice how I refer to "rules" or "attractors" which are ideas from the complexity sciences describing global patterns of behaviour. Using these terms can lead to thinking that there is a "force" outside of human relating controlling that relating in some way. I have heard people (for example www.plexusinstitute.org) speak about introducing new rules or trying to change the

attractor (for example, making money, or patient centred care) in a predetermined way. While the analogy for human relating may be helpful in noticing patterns or themes, I was beginning to understand that Stacey's (2000) notion of organising themes explains what *is* emerging in a self organising way, without the need for external control.

> "If one takes this perspective, that an organisation is a pattern of talk (relational constraints), then, an organisation changes only insofar as its conversational life (power relations) evolves. Organisational change is the same thing as change in the pattern of talk and therefore the pattern of power relations. Creativity, novelty and innovation are all the emergence of new patterns of talk and patterns of power relations...Change is possible when conversational life is free flowing and flexible and impossible when conversational life remains stuck in repetitive themes (Stacey, 2000, p. 376).

Thinking about organisations and change as patterning of talk and power relating therefore provides a significant departure from traditional systems perspectives. The focus is on interaction which is ongoing, not repeatable and simultaneously stable and changing in the movement of the present (ibid). From this perspective, what I am viewing as an "organisation" (the Practice) exists only as patterns of conversation between people. Human interaction, which includes verbal and non-verbal communication, is seen as a continuous iterative process of gesture and response, rather than interaction forming a whole or "thing" or "culture" out there. It is therefore impossible to step outside of processes of human interaction to design them or control them in any way, as we are always participating in these processes of interaction (Stacey et al, 2000).

This certainly explained my experience of not being able to control what seemed to be emerging as similar and yet changing patterns of how we were relating together. My experience can also be explained in terms of changing power relations. I notice fantasies about persecutors, rescuers and victims in my language surrounding the recruitment of a Practice Manager. I talk about the new Practice Manager as if he or she will come and rescue us. I also notice my own fantasy about rescuing everyone, to save the practice from itself – in particular when I give my narrative to Andrew, one of the GPs. I was keen to prove myself and identify with one of the GPs in trying to "make things better" at the practice – for my own sense of identity and self worth. I later read about how fantasy and gossip are recognised as ways of coping with anxiety and feelings of exclusion (Elias and Scotson, 1994). I will build on this theme in later chapters. I wondered about the theme of culture change and what "culture" I was experiencing. I again turned to the literature on culture change in the NHS.

Several writers, including NHS policy documents, suggest that for improvements in quality, the NHS must undergo cultural change (McCormak et al, 2002; DOH, 2000; Ham, 1992). The assumption is that it is possible to change the "culture", in a desired way (Ferlie and Shortell, 2001; Davies et al, 2000). Culture can be defined as the inherited ideas, beliefs, values and knowledge which constitute shared bases of social action (Davies et al 2000; Schein, 1985), in a similar way to a definition of ideology as the "basis of the social representations shared by members of a group" (van Dijk, 1998). A common belief is that despite policy change, the underlying culture remains, with powerful groups (such as managers and doctors) who legitimate the prevailing view, and sustain the status quo.

Davies et al, writing about health care policy recognise that " much of the prescriptive advice aimed at organisations from the management literature assumes that cultures are an attribute of organisations that are open to manipulation. Indeed the current NHS reforms in the UK also embody this view"(Davies et al, 2000). They go on to say

> " an organisation's culture is an emergent property of that organisation's parts - that is, the culture may emerge somewhat unpredictably from the organisation's constituents (making it not necessarily controllable), but nonetheless characteristics of that culture may be described and assessed in terms of their functionality vis a vis the organisation's goals.....recognising that cultures do change need not imply that cultures can be changed in a predictable manner by policy or managerial interventions" (Davies et al, 2000, pp. 112, 118)

Whilst Davies et al (ibid) go some way to asserting that cultures are emergent phenomena, they believe that they can in some way be measured and assessed as a "property", rather than a process, against the organisations goals. Implicit is the view that culture emerges as an "it", "out there", rather than arising as we are continuously relating to one another. This relates to my narrative where I describe the feeling of a "force" of some "other" or "whole" which keeps the Practice behaving in a particular way. Alternatively, I was ascribing Andrew, the leader or manager with the ability to change the culture.

In a similar way, Schein (1985) stresses the centrality of leadership in the ability to see a need for change and to make it happen. He argues that "culture is learned.... and can be changed if one understands the dynamics of the learning process" (p. 8). He goes on to say that artifacts and values are surface levels of culture but not the essence of the culture. Quoting Argyris and Schon (1974), he suggests values can be stated but may only be "espoused values" which may predict what

people will say in a variety of situations, but this may be out of line with what they actually do. Assumptions are what Argyris calls "theories in use" which can be changed by resurfacing them i.e. double loop learning. Schein (1985) says this is "intrinsically difficult because assumptions are, by definition, not confrontable or debatable" (p.18). This idea is recognisable as the one adopted by the idea of Klein's (1999) Thinking Partnerships whereby one is supposed to be able to change one's limiting assumption. Despite feeling I may have identified my limiting assumption, I wasn't quite sure how I was supposed to change it.

Writers on learning organisations (using the ideas of Argyris and Schon), suggest that an organisation needs shared values and vision, whilst also advocating that individuals change their mental models or assumptions in line with the organisations goals (Davies et al, 2000; Garside, 1999; Senge, 1990). For example, Rushmer et al (2003) promote learning organisations or "learning practices" as the way to make improvements in primary health care, with cultural values of celebration of success; absence of complacency; tolerance of mistakes; recognition of tacit knowledge; prioritising the immeasurable; openness; trust and outward looking. This way of thinking again splits the "individual" and the "system", and implies it is possible to prescribe values and goals for an organisation to follow, while individuals change their values in line with the organisation's goals.

A complex responsive processes perspective recognises paradox, thereby removing the need to think in separate terms about the manager, or individual, and the organisation or the system, as they are seen as aspects of the same process of human relating at one level. As suggested above, this is in contrast to dominant ways of speaking, in the way organisations are viewed as an "it" (e.g. the NHS), which may then lead to an implied assumption of a whole, or system (e.g. an organisation), which can be manipulated or changed in a controlled way. The reified system can then be blamed for misfortune, or attempts are made to control or manipulate the system. Alternatively attention is paid to one individual "in control". This produces a conflict of causality whereby an individual has both free will and freedom to choose, and yet is expected to conform to organisational goals, as much management theory espouses (Senge, 1990). I notice how I was maintaining this split in the way I perceive Andrew as being in control and also talking about the Practice as if it had a mind of its own. However, there was no sense that I was able to change my values to fit the organisation's vision. My experience was of ongoing processes of relating between people at the Practice. There was no sense of being able to control the whole, or individuals for that matter. Instead my

experience was of blame, fantasy, rebellion and conformity as I struggled to maintain my position with an idealistic, and sometimes pessimistic view of the future.

I began to notice a theme about control emerging in my experiences more generally.

Who's controlling who?

The following month I attended an "Effecting Change" workshop – for our Primary Care Trust. The speaker talked about being in control of change. We broke into groups and I found myself in a group with two very vocal GPs who dominated the conversation. In our groups we were supposed to be thinking about how we could create change. However, in my group the topic of conversation revolved around the dissatisfaction with the control measures being passed down from the government and how they (the GPs) may leave general practice altogether. I was trying to conform to what was expected in our group, while there were other issues concerning the GPs. The assumption seemed to be that the government was in control.

During the break the general gossip amongst the GPs reflected negative thoughts about the government. The feeling appeared to be that the government, who demanded that targets be met and data collected, was controlling us.

Back in my group I asked what would happen if we refused to give the information or if we provided it in a different way. The PCT officer said someone would be sent in to take over control. I persisted by saying what if we could show that we were offering a good service? This didn't seem to be an option for the rest of the group, and they spoke of leaving the NHS. The speaker later said he didn't believe there was a grand plan from government but that they were protecting their own egos.

An issue which initially troubled me, was how far government policy "controls" what happens locally. How far is the government in control of the GPs, as the GPs appear to believe they are? How does the belief that they are controlled affect what they say and do? Certainly National policy has directed the formation of new health care organisations, with the formation of PCGs and PCTs. However, from a complex responsive processes perspective I understood that what is "dictated" nationally has resulted from a series of conversations between ministers and others. What this means is negotiated locally between people as we make sense of this in our own context. Different practices have interpreted the policy in different ways - indeed some have not attempted to change

their appointment systems. Therefore, the belief that the government is in control, is not as certain as may be believed.

This way of thinking was gradual for me, as I initially spoke about different "levels" i.e. government and local level. I have come to think in terms of human interaction at one level. Making sense of the government as being at a higher level or in control may lead to different ways of thinking and acting, and wanting to conform or rebel. This is evident at the practice where the reception staff "rebelled" against the idea of 360-degree feedback, even though it supposedly gave them limited capacity to voice their own views. Making sense of what is happening as human relating at one level, I am beginning to feel responsible for my own contribution in a way I may not have done previously.

I notice the theme of control when not only do I attribute individuals, such as the "speaker", or the "practice manager" as being "in control" but also abstract wholes such as "government", "PCT" and "practice". What is interesting is the response to the feeling of someone being in control. Here I am aware of how it is possible to blame an individual and/or the organisation when things go wrong or not as I would like, rather than feeling responsible myself as a participant in the continuous new and similar conversations which form themes organising experience.

Why change? The theme of risk and control

Turning to the literature, I wondered about the theme of control and how this has arisen in the wider NHS. It has been argued that in a litigious, risk society recent scandals such as the Bristol case, with high numbers of infant deaths after surgery, and the Shipman case, where a GP was murdering his elderly female patients, have resulted in government wanting to gain tighter controls to avoid this happening again (Ham and Alberti, 2002; Davies et al, 2000). Scandals such as these could be regarded as politically damaging for the government – or, in other words, for individual ministers. This has propelled quality issues to centre stage and made "quality improvement" a key policy area – arguably control in the guise of "customer care".

Ham and Alberti (2002), however, call for a mature debate which acknowledges that mistakes will occur however good the "systems" that are put in place. Indeed the government has been criticised for its command and control approach towards the NHS, with top down targets and accountability agreements (Hunter, 2001). Hunter (2001) argues that making things happen is down to local people and local relationships as opposed to government targets. The resulting preoccupation with

meeting these targets inevitably distracts from the aim of health care policy, which is to provide care for patients based on local needs. Shapiro (2000) suggests that an obsession with measurement inevitably stifles creativity. The NHS Service Delivery and Organisation (SDO) Research and Development Programme (2005) has recently called for research proposals to explore "the impact of governance and incentive arrangements on the performance of professionals, health care organisations and health systems". This cause and effect and systems view arguably pervades our thinking about the NHS.

The dominant view, also reflected in my experience at the practice, therefore, is that someone must be in control, held responsible (blamed – or named and shamed), and seen to be "doing something" about it, when things go wrong. If something goes wrong they can be removed, in the way the practice manager was made a scapegoat for the problems at the Practice. However, as my experience highlights, this doesn't necessarily mean the "problem" disappears with the removal of the apparent "cause".

Instead, the theories of complexity appear to explain how interacting agents produce unpredictable, novel behaviour without anyone controlling or designing the "system". Furthermore, small differences in interaction can be amplified to transform global situations, although it is impossible to predict how and when. This contrasts with the perhaps understandable and dominant way of speaking about trying to control or predict change, where this is the responsibility of the manager or those "at the top" of the organisation, and their survival depends on it.

I was also experiencing another aspect of change as changing organisational structures – such as the creation of Primary Care Trusts.

The theme of structural change

I was personally involved in the structural re-organisations of the NHS, which created Primary Care Groups (PCGs), and Primary Care Trusts (PCTs). My developing role as a PCG/PCT Board Nurse resulted in a steep learning curve, beginning to understand new terminology and getting to know GPs and other professional and lay members (Poole, 1999). During the change from PCG to PCT I remember feeling anxious about whether or not I would be successful in continuing my role as a PCG Board member in the new "structure". Relationships with a nurse colleague became strained as we competed for a position on the Executive committee. It felt as if we were "in limbo"

while waiting for the new "structure", or members of various committees to change, and new relationships had to be developed between people.

As PCG Board nurses we asked nurses' views about the change from PCG to PCT. The nurses seemed happy for us to provide them with information, and listen to their views – although they said they believed that this was futile, as they expected that the future of their service was pre-determined by those "in power". From my perspective, the future was by no means certain. This assumption seemed to become a self-fulfilling prophecy as decisions about a way forward occurred between managers in different PCTs. It appeared to me that no-one appeared to know what to do or how to do it. Initially as a PCG Board we complained about the lack of information and guidance from the government. More recently, we are complaining about the amount of control the government is demanding in the form of national targets. It appears that there is an expectation that someone is, or should be in control, but objection when there is too much apparent control from government. With a new Executive committee in place, I had to form new relationships with new members of the committee, and saw much less of the previous Executive Nurse colleague. Similarly, close working contact with the School Nurses diminished as they were "managed" by another PCT in the new structure.

I wondered what we mean by structure? Can the NHS be designed externally? Some writers think so. For example, Royston (2000) posits that the NHS needs to be designed as a network. Arguably, re-organisation and restructuring are attempts to gain control and produce change. As Ham (1992) observes "concern has focused on the apparent failure to carry out centrally determined policies at the local level" (p.160). However, he blames this on ambiguous policy statements leaving scope for deviance, rather than the unpredictability of human relating. He does, however, acknowledge that even with strong central control there may not be conformity locally and that "legislation is often little more than a record of the bargains struck in the health policy community" (ibid p.15), with policies as a way of maintaining political support. Despite recognising the messy, unpredictable nature of change in practice, which resonates with my own experience, the assumption appears to be that this needs better management and control.

I began to ask how the thinking about change has developed in this way and how the NHS has changed over time, in relation to changes in society. There are a number of ways of viewing the NHS reflected in the literature. Firstly, in organisational and structural terms the NHS has been described as a progression from a "bureaucracy"; to a "market"; and as the "third way" - seen as a

combination of the two (Ham, 1999). In terms of purpose or function there have been varying interpretations of how the NHS has served us as a society – such as the Marxist view that it supplied us with a healthy workforce, whilst individualising what were arguably problems with social causes (Klein, 1999; Loveridge, 1992). In terms of resources others have argued that the NHS Community Care Act (1989) introduced competition between carers to promote greater economy and increase efficiency (Loveridge, 1992). It was this act which allowed GPs to become Fundholders – to purchase care for their patients. Amidst concerns that this resulted in inequality for patients, in the late 1990's decision making powers were shifted to Primary Care Groups and latterly Trusts, with greater representation by other community and primary health care members, including lay members, as I described at the beginning of this chapter.

The approaches above assume there is an identifiable "problem" which can be "managed" or solved by policy change. However, as Ham (1992) debates, what we mean by the term policy is recognisable when you see it but less easily defined. Rather than fixed, policy can be viewed as a fluid process of decision making and action, between a complex mix of pressure groups, government, the media, managers, clinicians and patients. Ham and Alberti (2002; Ham, 1999a) argue that the rapidly changing world (since the inception of the NHS in 1948) is shifting the established ways of working, between the medical profession, the public and the government.

> "Health care systems throughout the world reflect the societies and values in which they are embedded, and the NHS is no exception" (Ham and Alberti, 2002, p.841)

Until the 1960's, they argue that the basis of the relationship between the medical profession and the government was of allowing one another autonomy – the medical profession having autonomy over their work, whilst allowing the government to determine the budget. Ham and Alberti (2002) cite three main reasons for change at around this time. Firstly, the increasing strength of organisations representing the public; secondly, emerging stories of low standards of care; and thirdly, the medical profession becoming increasingly demanding for increases in the NHS budget. Furthermore, in an increasingly consumerist society, with more access to information (e.g. in the media and with the internet) the public have become more challenging of professional decisions with higher expectations of services. Equally, whereas after the war people were used to "queuing" for rations, for example, increasingly people are unhappy to wait for anything (Klein, 1995). People are becoming more aware of their rights as consumers, and there is less tolerance for mistakes and poor service (Ham and Alberti, 2002). In other words there were changes in power relations between the medical profession, managers, the public and government.

These perspectives on the NHS describe with hindsight changes apparently due to policy change, or the intention of those more powerful, or changes in the balances of power between people. It could be assumed that this has happened in a pre-planned way by those in power, in attempts to gain control of an unwieldy organisation, or to control groups such as the medical profession, or to control resources. However, I later turned to the global, sociological perspective of Elias (1939), who argues that changes in social development can be viewed as largely unplanned and uncontrolled "civilising" processes, or developments which have emerged over time from the interdependencies between people (also see chapter 4). Increasing specialisation of functions such as health care has meant people have become increasingly dependent on others for their education or health, for example, and thereby more critical of services they receive. Those providing services are being held to account for what they do and blamed when things go wrong, with increasing fears of litigation.

Health care has thereby become dominated by political power with expectations of performance, delivery and accountability, heightening ontological insecurity and feelings of anxiety (Williams, 2005). People are then concerned with realising a future fantasy state, whilst surviving and saving one's reputation by appearing to be in control (ibid). Furthermore, this increasing specialisation has increased our sense of being different from one another, and a feeling of "me in here" and "society out there" – an inside or outside – dualities which pervade Western thought and provide a false sense of being able to control the whole (Elias, 1939). It is perhaps for these reasons that change has become a concern of many people in the NHS – either being responsible for effecting change, attempting to remove uncertainty and fears of mistakes, and experiencing a seemingly constant barrage of new structures, targets and directives.

Whilst this systems view has dominated Western thought for several centuries, I later discovered that as long ago as the 6th century BC, the Greek philosopher Heraclitus believed in a world of perpetual change, of eternal "Becoming", arising from the dynamic interplay of opposites as a unity he called "logos" (Graham, 2005; Capra, 1991). There are also similarities with the Taoist concept of a changing world, occurring naturally and spontaneously (Arthur, 1999; Capra, 1991). These ideas arguably resemble the idea of paradox and perpetual change suggested by the theory of complex responsive processes (see Chapter 4). However, Western thought continues to be dominated by dualities of mind and matter, separating reason from scientific truth.

This historical view is arguably important in understanding how the theme of change has emerged along with the wish to change the NHS as a "whole" in a controlled or desired way. It is easy to forget that we are talking about something complex, fluid and dynamic. Talking in an abstract way about the NHS allows us to discuss fairly consistent themes, such as "health care free at the point of delivery". I began to think that what we mean by the NHS – or the Practice – changes as we speak about issues which face us all such as quality, risk, fears of death and adequate resources for survival, rather than as "controlled" management of change.

My experience of structure change, therefore, reflects shifts in patterns of conversation, which inevitably result in some change but not necessarily in the desired way. Donaldson (2003) views organisations not as "things" but rather, "conversations as organising"– or inherently pattern forming. What becomes interesting is what we think we are doing when we talk about "changing the structure". I have come to understand talk about structural change as intention, which changes the nature of relationships between people. The following narrative, however, reflects the view of the organisation "as if" it is a "whole".

Measuring Fitness for Purpose

At a meeting of the Primary Care Trust Executive committee, an item on the agenda is entitled "Fitness for Purpose review". I am aware that a 150 page document has been issued for each Primary Care Trust (PCT) to work through, to assess the competency of "it" as an organisation. I have reluctantly filled in one small part. Many people have been working on the document to show whether we demonstrate "competence", for example by having a lead person for clinical governance. A PCT Director summarises the findings of the review, highlighting areas of concern (those scoring "amber" or "red"). He says we are on a par with other PCTs locally, as long as people have been truthful in filling out the forms. Areas where we are on target are scored "green". The Director asks if there were any areas that we are concerned about. One Executive member asks how the ambulance service has been given all "greens", when he feels there are problems getting patients to hospital. The Director replies that the document isn't measuring that sort of information. It only measures the organisation itself i.e. is there a structure present to deal with problems. The Chair thanks the Director and the management team for all their work, and for the excellent summary. He asks if there are any further comments.

There is no response.

Personally, I felt this process was far removed from patients' experiences and was more about "ticking the boxes". Viewing the organisation as a "thing" we were trying to measure formal structures or formal communication mechanisms as opposed to problems such as getting people to hospital. We could then question what indicators of quality we were in fact measuring, as formal structures are not capable in themselves of ensuring interaction. This distancing and reifying resulted in paying less attention to what is happening in our local interactions and what it was we were trying to do.

At the Practice, a new theme was emerging around the topic of Access. New targets were released in the NHS Plan (DOH, 2000), for patients to see their GP within 48 hours, by April 2002. It was decided to introduce the idea of Thinking Meetings to help to meet these targets. In these meetings, everyone was given the opportunity to speak by going around the table in turn. Although this ensured I had the opportunity to speak, I often felt pressured to say something when it came to my turn, and yet felt I wanted to respond to what the current speaker was saying in the moment. However, more people were formally involved in these discussions at meetings and working groups to improve Access for patients and accommodate a new way of booking appointments. Others voiced concerns that hearing everyone's view would take too long, and we needed to get on with making decisions.

I supposed that the more people involved may lead to creative new ideas. I was using ideas from complexity science which suggest that change arises spontaneously as diverse agents interact with one another. A complex responsive processes perspective relates this idea of diversity to the diversity of interacting experiences and interpretations, as people relate to one another, rather than repetitive patterns of agreement, when there is less likelihood of anything novel emerging. However, I wondered whether allowing other people's views may threaten the usual way decisions were made by the GPs – or shift the power relations between people.

There was a long history of disagreements between the nursing teams. I had tried previously to improve working relationships by having joint team meetings, but they dissolved after they became unproductive and we seemed to get stuck in repetitive conversations of criticism and blame. I was surprised when, after some time, I was asked if we could meet again. I arranged a meeting where we shared our news. The atmosphere was relaxed and although people had concerns they were also good humoured about them. I wondered about the different atmosphere. I was unable to explain

this spontaneous and unpredictable request for a meeting in terms of what I had done, or not done, as a leader, but rather as arising in the complex conversations we were having.

A meeting was held concerning the theme of "skillmix" – i.e. the make-up of the nursing team, in terms of grade of nurse to perform relevant roles / tasks. The imminent retirement of one of the practice nurses allowed a re-think about the make-up of the team and would allow us to employ a health care assistant to do a number of tasks. We talked about how long we needed to do tasks and whether to have 5 or 10 minute appointments. One GP, Ian, seemed irritated and talked about efficiency. I felt anxious when questioned about how long it takes to do aspects of our work, thinking that the GPs may have different views about what exactly nurses' work is. I was feeling threatened as my role or identity was being challenged.

After the meeting someone told me that the GPs had had a very heated meeting the night before about their income. They had decided to give the staff an increase in salary but would be unable to take one themselves. This put in perspective the behaviour of Ian, the GP concerned with efficiency. I was increasingly aware of emotions and personal concerns either known or unknown to me as being present in the conversations at the Practice. Whilst often the reasons given describe rationally how decisions are being made, my experiences were that rational and emotional aspects are present at the same time.

During a break for coffee, Andrew raised the subject of hourglass management at the practice and said that Beryl had to be allowed to manage. Andrew said people tended to go to him instead of the new practice manager. I suspected people saw him as getting things done. I then remembered my thoughts about 360-degree feedback and commented that people seemed more able to say what they thought to one another spontaneously. I gave an example of when Andrew had told me that he recognised a pattern of me doing things without consulting him. I had similarly felt able to tell him that I had felt as if I was being controlled. I also suggested that change happens spontaneously in unexpected ways.

I missed several Access meetings, however, things seemed to be going well, although there was a sense of anxiety, but also comradeship in our uncertainty. Andrew commented that people seemed to be involved and talking about it and felt included in what was happening. I agreed.
I wondered how the perspective of complexity was beginning to influence the way I was thinking and acting, or making sense of my experiences.

Making sense of my experiences at the Practice

Complexity ideas of self organisation and emergence, unpredictability (or surprise), and paradox (see also Appendix 1) are recognisable in ordinary everyday goings on in my working life. However, I am also aware of human aspects of experience such as power relating, as I tried to influence Andrew who I believed had the ability to make changes. The theory of complex responsive processes recognises human aspects of relating such as power relations, anxiety and fantasy in relation to change.

In particular I notice the way blame was attributed to one person (the previous practice manager), whilst similar patterns were emerging when Andrew was "managing" the practice, and when the new practice manager was appointed. It was easy to attribute authority and power to one individual. In doing so, there is also the feeling of "devolved responsibility" and attributing blame to someone with authority, e.g. Andrew, or to an organisation e.g. "the Practice". The way I am thinking and acting both enables me to think and act in a certain way, whilst also constraining that action. For example, if I believe that someone is in control, I may be less likely to take responsibility for my own actions.

Notable is the feeling of messiness and uncertainty as I am responding to changes in relationships with others, as well as responding to conversations about new policy and models of change. However, paradoxically (at the same time) I notice the feelings of sameness in the way things get done at the practice. I notice an expressed belief that the culture can be changed. However, I was experiencing "culture" as it was emerging in the conversations about blame, trust and the desire to make things better, which in some respects felt stable, whilst at the same time there was a sense of movement.

I wonder if the emerging ways of understanding what was happening have been a more helpful way of making sense. If, as complexity ideas suggest, change is largely unpredictable, what does this theory imply about how we think and act in organisational life? If change is emerging from our local interactions, what does this mean in practice? I have become conscious of thinking and acting in a number of new ways from this perspective. For example, I notice how I make particular effort to go and speak to people. Noticing the informal conversations, in corridors or in the coffee room, as well as in meetings, I am paying attention to the ordinary everyday way things get done. I attempt to speak, to express my point of view and take responsibility for speaking to people.

Paying attention to what is happening highlights how my own participation is important and I am aware of feeling responsible for my actions rather than using complexity theory as a way of explaining how I am *not* responsible. This theme continues through the following chapters.

I also have less expectation of myself as being a leader or change agent. The "failure" in this at the current practice set me thinking about why this was so. I now pay attention to the contribution I am making, but do not expect that I have the power to make things happen alone. History and context are influencing the emerging themes of conversation at this practice. Whilst earlier I had a rather idealised view of how working relationships should be, I now view the conflicts between the nursing teams to be inevitable – as way of preserving our own identities, in the way that Elias (1994) describes in his study of community groups. I recognise the fantasy, blame and gossip characterising some of the conversation at the practice where people's identity felt threatened. Noticing this happening in everyday conversation opens the possibility to speak in ways which may change this pattern of conversation – for example talking to Andrew about my concerns. The shift in patterns or themes, or change, is recognisable to me as feelings of surprise or "Aha" moments. I was not able to predict the request by some of the nurses to meet together again. This seemed to me to be positive, however, shifts in themes may equally be regarded as negative – such as scapegoating the former practice manager.

The accounts are also rational and emotional at the same time. I am aware of the ordinary everyday way of making sense of what is happening as highly emotional, with suspicions, mistrust, blame, anxiety, excitement, hopes, fears and kindness evident in the messiness of everyday working life. What is most significant for me is how I was caught up in the fantasy, blame and gossip in a rather fairy tale-like account (see also Appendix 2) of what was happening at the practice, which reflects the anxiety and uncertainty I, and perhaps other people, were having about their own identities or roles. This often gets lost from rational accounts of how to manage change, or post rationalised accounts of what has happened. If this is how things get done, then paying attention to these aspects of experience becomes important. A complex responsive processes perspective also adds the human dimension to complexity ideas of self organisation, emergence and paradox – such as control, power relating, inclusion and exclusion and the inevitable anxiety resulting from changes in identity, which I will expand on later in the thesis.

Summary

In this chapter I have explored some of my earlier narratives and shown how my sensemaking has developed as I grapple in a sometimes clunky way with complexity and complex responsive processes ideas. There are some rudimentary themes that will be developed further in the following chapters, such as power relating, emotion and feeling. There is also a feeling of the messiness of everyday working life and how "tools" perhaps attempt to provide a framework to "manage", "control" or produce more certainty and desired change. Whilst the tools enabled us to have conversations about change, they perhaps provided distance from the more emotional aspects of experience when focusing on the tool. The literature relating to change in the NHS, whilst recognising that change emerges spontaneously in this day to day interaction, tends to focus on approaches aiming to change the whole.

I will now turn to the literature on complexity theory to explore how these ideas have been used in thinking about and researching organisations and organisational change.

Chapter 3: How I am making sense of the theories of complexity or how I am thinking about change and methodology from this perspective

In this chapter I will explore how the ideas from the complexity sciences i.e. those arising from disciplines such as biology, mathematics and physics (Kauffman, 1995; Goodwin, 1994; Waldrop, 1992; Appendix 1) have been used by writers seeking to use insights for organisations and organisational change. I will be arguing that whilst ideas have been transferred metaphorically for use in organisations, they remain within a paradigm which seeks to understand and change the "whole" from the perspective of an objective observer. In the second part of the chapter I relate this way of thinking to my emerging perspective on my research methodology. I later began to move away from thinking about myself as an observer of others' views of change, to the position taken by the theory of complex responsive processes, which I will review in the following chapter.

The interest in the ideas suggested by the complexity sciences is evident. However, whilst using these ideas to explain how change happens spontaneously as we interact with one another, business writers seem to be transferring these insights metaphorically in order to find new ways of changing organisations. For example, Anderson and McDaniel (2000) suggest new levers for positive movement in organisations and other writers suggest using levers to shift the organisation to the edge of chaos – which is seen as the state where self organisation and emergence occur (van Eijnatten, 2002; Pascale, 2000). Others see complexity as a way of making organisations more caring by suggesting ways for leaders to foster such relationships (Lewin and Regine, 1999; Wheatley, 1992).

However, Peirce (2000), commenting on Arndt and Bigelow (2000) warns "A mere use of the theories to advance what organisations "should" look like and what leaders "should" do or market faddish solutions to old problems would fail to take advantage of the theory's power" (p.38). After initially thinking that complexity theory offered a different way of understanding how change happens, I realised that the majority of writers followed the dominant way of thinking about how to produce change in a "system" as designed by the manager or leader. One of the main insights from the complexity sciences, is that change happens spontaneously without any pre-designed plan for the whole or anyone outside of the "system" controlling it.

In my search of the literature in health care, I discovered that interest in the mathematics of non-linearity has begun to enter the domains of medicine and health over the past decade (Rambihar and Baum, 2000). These ideas have shifted the thinking about genes, the genome project and diseases. Genes interact with the environment and with each other in a complex, non-linear way, thus limiting the ability to predict outcomes e.g. whether a person with a particular gene will go on to develop a disease. Furthermore, researchers are studying the implications of complexity science and physical disease e.g. diabetes and cardiac disease, suggesting that equilibrium or stability is a precursor of death and that fluctuations are normal and healthy (Wilson et al, 2001; Goldberger, 1996).

I began to attend a group where health professionals and managers meet informally, converse via an e-group (www.complexityprimarycare.org) and have published on organisational and medical aspects of complexity theory (Kernick, 2004; Poole, 2004; Poole, 2003; Sweeney and Griffiths, 2002; Wilson et al, 2001; Griffiths and Byrne, 1998). It was interesting how this group "emerged" spontaneously without any prior plan or design.

Interest in complexity theory from an organisational perspective is evident with articles discussing implications of the theory by health writers (Greenhalgh, 2000). Royston and Dick (1998) call for an ecological approach to organising the NHS to improve performance. Indeed, I myself advocated thinking about the complexities of nursing practice in terms of complex living systems (Poole, 2002). Griffiths and Byrne (1998) suggest more variables need to be considered in qualitative research to reflect the contextual complexities of social research, whilst Hayles (1999) similarly offers new ways of researching complex questions and bridging the "what" and the "why" gap. Redfern and Christians (2002), studying 9 health care sites introducing evidence based practice, suggest that a linear model of change works best when conditions are less complex or more certain, and a complexity model of change works best when conditions are complex and uncertain. This supposes that complexity theory only operates in uncertain contexts and that certainty and uncertainty are recognisable "givens" and not dynamic processes.

Organisations such as the King's Fund (Pratt et al, 1999) and the NHS Learning Through Partnership in the UK use the theory in their work with organisations. The Plexus Institute (formally Voluntary Hospital Association in USA) provide a comprehensive website explaining the principles of complexity theory and how this can be applied to health care, using a variety of tools – to be applied as though they are under our control (Zimmerman et al, 1998). They also provide

numerous examples from practice in the form of stories and narratives from health workers applying complexity science ideas to their practice (Baskin et al, 2000; Lewin and Regine, 2000). Olner (1999) criticises these stories as anecdotal, whilst also suggesting that complexity science makes objective, linear thinking and empirical study antithetical to these ideas. He also fears that this approach will "go the way of TQM...applied incorrectly and eventually corrupted" and describes many of the ideas as "common sense" (ibid, p.1161). It is perhaps this notion of "common sense" in ordinary everyday experience which has not been given credence, and yet it is in these interactions that complexity theory suggests patterns or change is emerging.

A common idea adopted by many is that of "simple rules" (Plsek, 2000; Plsek, 2001; Plsek and Greenhalgh, 2001; Plsek and Wilson, 2001). This idea is based on computer simulations which produce emergent "flocking" behaviour in "boids" with three programmed simple rules. However, this cannot explain emergent behaviour, as all they are able to do is "flock". Plsek suggests that the manager provides "simple rules" for organisations to follow – which will allow for innovation and self organisation to occur. Their approach has been criticised for using mathematical metaphors loosely (Reid, 2001). The assumption is that people will indeed follow these rules in the way envisaged by the "instigator", or programmer and not as they each interpret them. Simple rules could be regarded as *emerging* accepted ways of behaving e.g. as culture, ideology or organising principles, as a result of people interacting, as opposed to being imposed externally with predictable results (Davies et al, 2000). Furthermore, they are not static, but continuously emerging in similar or different ways. Chaotic systems have a few simple rules which result in complex yet bounded behaviour e.g. the weather system. However, complex adaptive systems are based on very complex levels of interaction without any blueprint, so simple rules cannot be a helpful analogy with human beings relating to one another (Stacey, 2000).

Other interpretations of the theory have also been criticised. Martyn (2003) comments thus on Sweeney and Griffiths' (2002) book introducing complexity - "they are uncomfortably aware that skeptics may accuse them of putting a pretentious mathematical gloss on the commonplace observations that running a health service is complicated and that patients behave in unforeseeable ways" (p.228). In other words, is complexity theory telling us anything that we don't already intuitively know about life in organisations? I will be arguing that our ordinary everyday interactions, which includes conversations with ourselves, thinking and dreaming, are what we "do", and are the source of new patterns are emerging. This is where I am focusing my attention to make sense of change.

Research using complexity ideas in health care is limited. Kernick's (2004) book on complexity and healthcare organisation provides a variety of approaches, primarily from a complex adaptive systems perspective, such as systems modeling (Liddell and Powell, 2004); to retrospectively describing emergent practice (Durie et al, 2004); or by actively "applying" the theories in practice (Rambihar, 2004); or both of these at the same time (Fryer, 2004; Thomas, 2004). Durie et al (2004) describe, with hindsight, a "successful" community regeneration project in which representatives from the community, health, education, local government, police and social services spontaneously worked together to transform a local deprived community. Essentially people began to talk and listen to one another creating trusting relationships, with dramatic effects. They argue that this demonstrates how change emerges spontaneously without the need for "central control" or a pre-determined plan. In other words, they recognise the potential for spontaneous change without anyone controlling the process. Fryer (2004) describing his own experience of running an organisation also concludes that organisations can be run without a detailed grand plan, based on relationships which engender "trust, increasing connectivity and feedback between staff". The assumption is that organisations need to be "run" by someone in control. However, both of the above examples ignore the simultaneously potentially destructive aspects of change, and how different forms of organisation also emerge (such as hierarchies and bureaucracies) as people interact with one another.

Organisations which do plan and use tools to attempt to create change are also explained by complexity theory insights. What the above authors appear to be advocating is a way of creating the conditions for self organisation and emergence to occur – to effect change. For example, Douglas et al (2004) describe their experiences of whole systems working, stressing the importance of getting the "right" people together in the system with a shared purpose. This implies some sort of boundary to a system, and the ability of people to decide who is "right". Other writers advocate using the visual or performing arts to create the conditions to facilitate emergence (Burton, 2004; Naidoo and Naidoo, 2004). Rambihar (2004) claims his project was the first to use complexity and chaos in health. He applied complexity ideas to community healthcare projects, by creating non-hierarchical health promotion systems, with "self organisation, flexibility, a small number of simple rules and adaptation". The rules used were:-

- promote heart health using existing resources
- adapt to local needs

- use innovative and creative ideas
- create and use new resources where necessary

He also introduced complexity ideas of fractals (Appendix 1), chaos and complexity to the group which he says were useful – but doesn't elaborate how or why. The meetings focused on discussion and narratives, were agenda-less, and characterised by diversity of opinion, and "self organisation and emergence from few and simple rules" (p.343). I have discussed above the limitations of the use of "simple rules" for explaining behaviour in complexity terms. Rules are emerging and changing as we speak about them and as they conflict with other "rules".

More recently, Rowe and Hogarth (2005) used complex adaptive systems metaphors to inform a change initiative when working with health visitors in a primary heath care setting. Whilst assuming that "change was brought about using a Complex Adaptive Systems approach" (p. 396), rather than recognising the inherent and ongoing processes of change as we communicate with one another, they explore how an understanding of complexity ideas informed their approach to a more "inclusive, evolving and unpredictable process" (ibid). They take an observer position, assuming their ability "to prevent the system falling back into pre-established patterns" (p. 403). They conclude that this approach led to higher levels of uncertainty, responsibility and emotional impacts on practitioners, which they argue is underplayed by the literature on complex adaptive systems. This resonates with my own experiences of change, as already described. I will build on these themes throughout the thesis.

Two earlier studies use complexity theory to make sense of change – one retrospectively in several family practices, and one working with complexity ideas with a Social Services Board. Firstly, I will consider a study by Miller et al (1998). Data from participant observation field notes collected from 84 practices in one study and 27 practices from three similar studies in primary care in the USA was reviewed with literature from a wide range of social science fields, to provide a complexity model of primary care practice. The analysis that emerged was due to the exasperation of trying to produce an explanatory model from the results. They were unable to explain how many parts worked as a whole – greater than the sum of its parts. They also recognised an "organism-like quality" of each practice. Exploring the literature from the study of non-linear dynamical systems (complexity theory) they used their findings to apply a complexity model to the findings from each practice. Primarily they use a chaos theory concept of "attractors", or patterns of behaviour, to explain differences between practices.

Examining two case studies in more depth, they show how in one inner city practice the "attractors" are income generation and preventative services, whereas at a suburban practice serving a middle class population the attractors are efficiency and patient satisfaction. They highlight, therefore, the contextual nature of the results, albeit with hindsight, to explain or provide a better understanding of primary care practices as complex adaptive systems. Concepts from chaos theory can be useful to provide insights into human behaviour, but not as a direct analogy, as there are only a limited number of equations, and therefore a limited number of attractors to move towards. Chaos theory doesn't model intrinsic capabilities for creativity (Stacey et al, 2000). However, the theory of dissipative structures, based on experiments by Prigogine (1997) does give insight into how small fluctuations produce bifurcations, or self organising movements to a different form, unpredictably. In other words, change emerges through the amplification of slight variations of individual entities. It is this insight which Stacey (2000) argues provides an analogy with the intrinsic capacity for emergence and self organisation without anyone designing or controlling the process.

Miller et al (1998) suggest a model for change postulating ways of designing or controlling the process of change by "joining" – enhancing existing attractors; "transforming" - changing attractors with methods of "hammering, wedging or shocking"; and "learning" – teaching awareness of internal models (Miller et al, 1998). The assumption here is that it is possible to actively change attractors, as an observer outside the system, arguably returning to a linear model of change. In summary, the writers conclude that viewing practices as complex adaptive systems explains why guidelines and standardised interventions do not often work as planned, except when they serve the attractors – "One size will not fit all" (ibid p. 374). They conclude by suggesting that there are exciting possibilities offered by viewing practices as complex adaptive systems, but that data is limited. Furthermore, they suggest the need for more in-depth case studies of practices over time with the aid of computer simulations. This study offers insights into how complexity theory can inform our view of the difficulties of planned change and explain with hindsight why this might be so. Whilst recognising the contextual nature of change, they take an objective observer position, which fails to recognise the importance of continuous local interaction of which they are a part. Another study, however, takes this a stage further, by actively exploring complexity theory with those involved in the research (Zimmerman & Hayday, 1999).

Zimmerman and Hayday adopt an action research, or "action learning" approach to working with a Board of a Social Services organisation in the USA, in order to discover whether a complex adaptive system perspective can improve an organisation's effectiveness (effectiveness was defined as achieving outcomes supporting the mission or objectives of the organisation). This still assumes the ability to plan before acting, and the ability to "measure" effectiveness, where objectives are likely to change. Observation and tape recordings of board meetings and interviews with board members were carried out over a twelve month period. Transcribed data was themed and feedback given at the end of each board meeting, consistent with "feedback loops" employed in action learning. This followed previous exposure to principles of complexity theory. The president of the Board had asked for help "to make the Board more like a complex adaptive system". Zimmerman and Hayday (1999, p.282) changed the approach to study with them "what it meant for the board to be 'more like a complex adaptive system' ". Whilst the focus is on the present and local meaning, this statement assumes that it is possible to choose to become more like a complex adaptive system, or a state which needs to be actively attained.

Zimmerman and Hayday analysed the data from patterns which emerged from the research. One concern of the writers was the use of "fake" complexity – or the complexifying of simple issues and avoidance of complex issues. A model of relationships is also generated and a claim to have increased the "understanding of how complexity science can enhance the capacity to evolve in a rapidly changing environment", as if it were a system. Perhaps complexity science can challenge our current assumptions about how things happen or "evolve", thus change our behaviour, however, complexity science arguably gives an insight into what is already happening. They also describe reducing the number of "simple rules" in order to produce diversity and adaptation. They assume that rules or values can be externally provided or interpreted from observed patterns of interaction, as opposed to emerging patterns as ideology in interaction.

Board members do appear to have altered the way they view their organisation, based on the understanding of some complexity principles e.g. "it was uncomfortable to be uncertain and that we need to accept that it is healthy to be uncertain and to be uncomfortable" (p. 295). In meetings, words such as "discomfort" had changed to "terrified that we are kidding ourselves" (p.296). Zimmerman and Hayday argue that being able to acknowledge negative emotions in a safe situation, they didn't stay "stuck" in their fear, as they were able to name it. In conclusion, they state that methods drawn from Newtonian science are still useful in certain contexts within organisations. The power, they claim is in the skill in knowing when lessons from living systems

are needed as opposed to lessons from mechanical systems. Furthermore, in their analysis of the methodology used to study organisations as complex adaptive systems they suggest that an action research / "action learning" approach is well suited to the subject & development of complexity science in organisations – as research in this area is still in its infancy (Zimmerman and Hayday, 1999). Zimmerman and Hayday also call for honest reflections on our anxieties as social researchers in this new interdisciplinary field.

The two research papers therefore offer very different ways of applying complexity science to organisations. Zimmerman and Hayday had the advantage of concepts already having been known to the Board and organisation they researched and focuses on a structured approach of reflection in meetings to study how the organisation applies its principles. This approach has the advantage of using complexity principles in action as opposed to with hindsight. However, neither study explores what it is like to experience change as a participant. This is where my focus departs from and arguably enriches the perspective of what it is like to experience change as a participant in my own daily life in primary health care.

The above approaches advocating a complex adaptive systems perspective on organisations maintain a focus on control, simple rules, levels of organisation and creating the conditions for emergence to occur. In other words they take an observer position, sitting firmly within the tradition of attempting to produce desired change, which is in conflict with insights with the complexity sciences which suggest self organisation, emergence and paradox, happen spontaneously without any external design for a "whole". A complex responsive processes perspective, however, focuses on conversation as organising in a largely unpredictable way, at one level of interaction between human beings. An organisation is viewed as a pattern of talk, rather than a boundaried "system" which can be controlled in some way.

> "This perspective is subversive of mainstream notions of control, as well as prescriptions for designing whole organisations and instigating overall change initiatives such as culture change programmes, business process re-engineering and total quality management, which are meant to change the whole organisation. One comes to see that even though global interventions are thought to be directed to the whole, they are simply powerful generalised gestures to an imaginative construct which will call forth many responses and counter gestures, patterned in ways that are predictable and unpredictable at the same time. This resonates with repeated experience in which such global interventions do not achieve their promised outcome". (Stacey and Griffin, 2005, p.19)

A complex responsive processes perspective pays attention to the ongoing processes of interaction as a participant in those ongoing processes. As evident above, criticisms of approaches which apply complexity ideas to organisations argue that this is "common sense" or "intuitive" – or explaining what is known. It seems that ordinary, everyday human interaction is not considered worth focusing attention on as it is already "known". It is precisely this focus – i.e. the local interactions from where sameness and the new emerges which is the focus of a complex responsive processes approach. Furthermore, the literature on complexity theory does not provide any insights into my messy, fantasy laden experiences of was going on at the Practice, which the theory of complex responsive processes does draw attention to.

I recognise how the implications of these different stances have influenced my search for a methodology compatible with this way of thinking. I describe this initial feeling as "a foot in both camps", as I unconsciously maintained a position of a participant observer – seeking to find and prove something, in a similar way to approaches to change where the manager observes what needs changing in the whole organisation. In the next section I explore approaches to research which initially seemed similar to my own, and show how my thinking about research begins to change.

How I am thinking about methodology: A foot in both camps

Linked to the above perspectives on change, is the way research can be viewed. For example, positivist approaches to methodology view the world as observable by a researcher describing reality or observable truths, whereas a relativist perspective recognises multiple truths. Lincoln and Denzin (2000) describe a number of current crises in qualitative research. These crises also reflect my own questioning of what it was I was trying to do as a researcher. Qualitative research perspectives arguably grapple with, or retain the same split between the observing researcher and the researched, as the split between the manager and the organisation "out there" in models of organisational change. It appears that whilst advocating that truth is relative, they debate the issue of who or what they are representing, maintaining a fudge between the two stances.

In the same way, I struggled initially with what I now see as keeping a "foot in both camps". I was making sense of experience as a relativist but still hanging onto some aspects of positivism, as an observer or participant observer finding "truths" in a similar way to the way complex adaptive systems insights have been used in organisations. However, I have experienced a shift in my perspective on methodology which has been a messy, non-linear process as described by other researchers (Fraser, 2000; Seibold, 2000). Here I will return to focus further on how I approached

my research early on, and how this is changing as I make sense of experience as complex responsive processes, which I continue in the next chapter.

My first struggle was in thinking about who or what I was representing, as I describe in the previous chapter in relation to interviewing colleagues. Was it possible, for example, to represent others views and assumptions about change? As I struggled to make sense of how to use my interview "data", I felt dissatisfied with what I was trying to do. Lincoln and Denzin (2000) describe a crisis of representation, which asks who is the Other? How can we hope to speak about the experience of the Other? How can we develop a social science which includes the Other? There are various approaches to working with these problems.

I searched for a methodology which recognised the use of one's own experience as well as conveying the experience of others. I initially looked at the work of autoethnographers such as Ellis and Bochner (1996; Ellis and Flaherty, 1992) who explore alternative ways of writing using their own and others' texts, or "multiple voices" (Lincoln and Denzin, 2000). Other approaches focusing on the self as the subject of research come from a variety of disciplines e.g. social science, nursing, education and business (Conle, 2000; Seibold, 2000; Ellis and Bochner, 1996; Koch, 1996). Conle (2000) (from an education background) considers the merits of inquiry as personal narrative or experience, which reach out to social, historical and philosophical contexts, to gain a wider academic and personal significance. This resonates with what I was aiming to do in relation to my own experience in primary health care.

I found the style of writing in these approaches more evocative. For example, Tillmann-Healy (1996) gives a graphic personal account of her experiences as a bulimic, in "a culture of thinness" written to "pull you away from the abstractions and categories that fill traditional research on eating disorders and into the experience, to help you engage how bulimia feels" (p.104). Gergen (1999) argues that this form of writing allows us to critically review our taken for granted assumptions and to consider alternatives. Not only this, but evocative writing "touches us where we live, in our bodies" and allows self-reflexive processes of self-creation (Richardson, 1994, p.521).

Challenging the boundaries between literature and academic research, researchers use poetry, drama and interwoven narratives or voices in novel ways. Certainly I have personally found this form of research writing far more emotionally and intellectually stimulating than other more sterile,

forms of academic writing. Richardson (2000) challenges traditional academic forms of writing, as being "boring".

> "One reason then that our texts are boring is that our sense of self is diminished as we are homogenised through professional socialisation……through the suppression of individual voice…encouraged to take on the omniscient voice of science" (Richardson, 2000, p. 925)

These forms of writing resonate for me in the way they use stories and narratives of their own experiences. I recognise the bodily feelings and emotion inherent in my approach to my research, which the above approaches also recognise. However, they also attempt to speak for the "other" which I found increasingly problematic. I will say more about this in Chapter 4.

In terms of purpose, I recognise an emancipatory tone in what Richardson is saying, which I feel was present in my earlier writing. Reviewing approaches which fall into the family of action, participative or living inquiry, there is often an explicit political or emancipatory purpose. Reason and Bradbury (2001) define action research as:-

> "…a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes… It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities…..
> Action research is emancipatory; it leads not just to new practical knowledge, but also to new abilities to create knowledge"(Reason and Bradbury, 2001, pp. 1-2)

My earlier writing included a fairy story (Appendix 2) where I saw myself as the fairy godmother coming to rescue everyone! Similarly, my initial concern was how to enable the nursing team to work together better – expecting in a rather idealistic way that this was possible, and that I should be able to achieve it. However, I do not now see my purpose as giving voice to or emancipating others, in order to provide solutions or produce change. Whilst I consider that my research will have some effect on the ongoing conversations between people, albeit large or small, I cannot know that this will be positive or emancipatory.

Searching for a way of describing my approach in terms of methodology, at first glance, Marshall (2001), seemed to highlight some of the ongoing, emergent nature of inquiry, which I recognise in my own.

> "I pay attention for assumptions I use, repetitions, patterns, themes, dilemmas, key phrases which are charged with energy or that seem to hold multiple meanings to be puzzled about, and more. I work with a multi-dimensional frame of knowing; acknowledging and connecting between intellectual, emotional, practical, intuitive, sensory, imaginal and more knowings". (Marshall, 2001, p.433)

More recently she uses the term "living systemic thinking" to describe her experience of ongoing, emergent activity.

> "I have learnt that living systemic thinking is a long-term, emergent, never-ending activity, with any sense-making always open to re-vision as action, reflection and feedback unfold. Inquiry is key to living systemic thinking and takes many forms, being self reflective but also systemically engaged, and means taking strategic initiatives to learn more and track emerging data, knowing that I will never fully know. So, I need disciplines for interpreting and then acting/inquiring again. There is no "system" to know. Rather, my use of systemic thinking is fluid, blurred, emergent; a sense of 'organization' appearing in the moment only to dissolve or take on a similar pattern in a different form." (Marshall, 2004, p.324)

It is interesting to me that Marshall uses the term systemic, which sounds a rather static or spacial term for something she obviously experiences as emergent, in the way she talks of "organisation" as fleeting. The way in which she uses the word "system" seems similar to the way emerging patterns or themes are described by complex responsive processes. I have found it difficult to split action from interpretation or reflection in the way she seems to be suggesting, when I find myself reflecting, theorising, acting, and feeling at the same time. To me these are all aspects of living in an inquiring way, or being inquiring. Furthermore, dichotomies of experience are maintained (action and reflection; interpretation and reflection; self and other) which are dissonant with the notion of paradox, or simultaneously occurring aspects of experience.

I explored another body of work in research methodology which focuses on particular ways of reflecting on experience, by using reflexivity. Reflexivity can be understood as a "bending back on itself" (Steier, 1995, p.2) or, for example, thinking about why I am thinking about something. Traditional views of reflexivity also make a split between practice, reflexivity and action, and similarly the notion of reflective practice has also been viewed as a separate activity (see Chapter 5). Marcus (1994) asks "how much, where and why" while Steier (1995) asks, does research necessarily become autobiographical? Indeed, there are various interpretations of reflexivity. It can simply be viewed as an aspect of method, by being self-critical (Hollway and Jefferson, 2000; Denzin & Lincoln, 1994); or associated with a personal quest, playing on the subjective; and has been criticised and dismissed as self-indulgence and narcissism (Marcus, 1994, p.569). For

example, Denzin and Lincoln (1994) ask "Is reflexivity a self-indulgence or an aspect of method?" (p.568)

These perspectives concern me less as I agree with Steier's point that "by examining how we are part of our data, our research becomes not a self-centred product, but a reciprocal process. The "voices …are enhanced rather than lessened" (Steier, 1995). Steier goes on to suggest that "we understand and become aware of our own research activities as telling ourselves a story about ourselves" (p 3). He asserts that reflexivity is the methodology by which we can understand what we and others are doing. From a social constructionist standpoint, examining the self is socially constructed anyway, and research becomes a story about ourselves as researchers, as a social process. Whilst social constructionists give primacy to the social, Mead (1934) and Elias (1939) also point to the embodied process of the individual and the social forming and being formed by one another at the same time, becoming aware of ourselves through the eyes of the generalised "other".

Being reflective or using reflexivity as part of the method in order to minimise the researchers bias or influence, is therefore vastly different from reflexivity as methodology, where I am reflexively making sense of experience. For example, whereas I used to think of my reflection on a meeting as reflecting on something historically concrete, I now see this as a reconstruction of the past in the present. What becomes interesting is why particular historical aspects are important in my ongoing conversation with myself and others. As Reissman (1994, p.68) writes "the stories we tell ourselves about the past become the past, and through them we claim identities and compose lives". However, I would argue that this is always changing in the movement of the present. I am always acting in the present, in the context I find myself in, for example sitting at my desk, as I think in that moment. The reality I am exploring is not an interpretation of historical events as they appear to be real. Rather reality from this perspective is viewed as timeless human experience – in the sense that we can respond, empathise, relate events of our experience, past and present, which gives research a different, but valid purpose (Noble, 2002).

How does the thesis reflect this ongoing exploration? My experience of fleeting "Aha" moments, periods of confusion, feelings and conversation are messy processes, which seem the antithesis of a structured thesis which appears linear in format. It cannot show the proliferation of drafts and re-writes which went into forming it, or all the multifaceted aspects of life. However, in everyday

conversational life, we convey experience in a narrative like way, which contains story, and theory, or propositions, intertwined.

There are many definitions of narrative and story, encompassing definitions of how a story is constructed (Gabriel, 2000), to the observation that we think, dream and talk in narrative (Greenhalgh, 1999). Reissman (1994) argues that "the primary way we make sense of experience is by casting it in narrative form" (p.68). Stacey (2001) distinguishes between story and narrative, whereby story is a sequence of feeling states and events, whereas narrative contains a story linked by reflections and comments.

The dominant approach to research using narratives or stories is to treat them as an "it" or a "whole" in order to analyse them. Much has been written in nursing and other academic research about the use of narratives or stories in research (Frid et al, 2000). The approach has primarily been to categorise into themes (Mays and Pope, 2000). Field and Morse (1996) describe thematic analysis; semantic analysis and construct analysis. Passages or words are coded, however, they say that the analysis may be less reliable due to the subjective nature of the coding system. This assumes that it is possible to remove subjectivity. They do, however, recognise that numerical coding reduces "validity" as it denies the richness of the data and the research context. The complexity of deciding which categories to put phrases into and where they overlap risks losing any sense of meaning as it is continually emerging, as I found in my experiences of interviewing.

Savage (2000) posits that different ways of analysing data may produce different truths and that limiting to one method is problematic - "in a postmodern era analysing data to produce a definitive set of meanings is problematic and that multiple methods are preferable" (p.1419). The assumption here, I suggest, is that the underlying purpose is to provide meaning/s for research's sake or even implicitly to produce objective truths even if there is more than one. I am not looking to categorise "data" into themes or codes (Savage, 2000; Seibold, 2000; Field and Morse, 1996) which can lose the rich contextual nature of the research. Neither do I aim to minimise my own bias, or use triangulation to find a truth or increase understanding from a number of sources (Savage, 2000; Silverman, 1993). Instead, I would expect multiple and emergent "truths" to arise from interacting with people, including the reader, on different occasions.

I am aiming to capture the richness of my experience presented in narrative form. This differs from many traditional approaches above. I have increasingly come to think of these categories used to

describe continual interaction – whether it be "story"; "narrative"; "theoretical": "propositional"; or "abstract" in a more fluid and less distinguishable way. In my experience, it is difficult to find where one begins and another ends. For example, even when experimenting with writing a fairy story, I was at the same time experiencing emotion, whilst making links with theory. I would argue that once categories are used, there is a loss of the sense of a continual stream of experience which involves all of these aspects at the same time. Even when written down, narratives become real only when read by an embodied person. However, "narrative told" follows a linear structure and orders some of the messiness of experience (Stacey, 2001). In this way arguably narrative becomes a temporary expression of themes or patterns organising experience, which allows different meanings for different readers.

In this sense I write narratives of experiences which resonate, whereby I am aware of strong feelings or theoretical perspectives, at the same time. My narratives and stories are subjective, context related and temporary in nature but evoke multiple realities. My choice of narratives are also those that seem to say something about my research question "What is it like to experience change in primary care from a complex responsive processes perspective?" or best illustrate a point I am trying to make. However, I have often wondered why I notice what I notice and why I choose to write a particular narrative. I have often been aware of emotions or strong feelings which have compelled me to write, reflect, or have conversations with others. This question has led me to explore what I mean by experience and sensemaking.

I initially found Weick's (1995) work on sensemaking in organisations helpful in thinking about what we notice. Weick suggests that sensemaking happens retrospectively "he or she creates an object that was not "out there" to begin with but is now there for the noticing" (p.2). He suggests sensemaking involves identity, retrospect, enactment, social contact, ongoing events, cues and plausibility. He refers to Meryl Louis (1980) who views sensemaking as a thinking process which uses retrospective accounts to explain surprises. "Interpretation or meaning is attributed to surprises...It is crucial to note that meaning is assigned to surprise as an output of the sensemaking process, rather than arising concurrently with the perception or detection of differences" (Louis, 1980, p.241). This fits with my experience of noticing events which are surprising to me, however, the idea of this being retrospective is dissonant with my understanding of experience as a continual stream of narrative, conversation and feeling intertwined in the present. In other words, sensemaking is what we do, rather than something separate from experience.

Weick also recognises the emotional aspect of surprise - "a key event for emotion is the interruption of an expectation" (p.46). Emotion or feeling is present at the same time. Whilst recognising the emotional aspect of sensemaking, this is somewhat split from action of the body, whereas I am not aware of being able to split the two. Gergen (1999), however, from a social constructionist perspective argues that emotions are culturally constituted, and most social constructionists are ambivalent about the body, adhering to a discursive understanding of the construction of self and the body (Burkitt, 1999).

I later turned to sociologist Mead and neuroscientist Damasio who appear to explain what I am experiencing in terms of how human beings become conscious. Consciousness arises as "the apparent self emerges as the feeling of a feeling" (Damasio, 1999, p.30). He distinguishes between feelings which are inwardly directed and private, and emotions which are outwardly directed and public. He argues that there is no evidence to suggest that we are aware of all our feelings, which are unfolding as biological processes (ibid). Self consciousness arises where gestures become significant symbols, i.e. language, whereby the gesture (or significant symbol) means the same (or I would say similar) for the individual gesturing as the individual gestured to (Mead, 1934) - "to be self conscious is essentially to become an object to oneself in virtue of one's social relations to other individuals" (Mead, 1934, p.172). Speaking and gesturing are, therefore, always action of bodies, and never without feelings.

Reflecting on a "past" event is still action in the movement experienced as the present. My body is continually responding to the environment and feelings enable me to choose how to act in a situation, based on similar situations and feelings I have previously experienced. How I am feeling therefore becomes important in noticing how experience is both familiar and changing at the same time. This perspective differs from the expectation of a rational approach to research. It seems important to me to focus on how I am feeling *and* conversing with myself and others.

From this perspective, data analysis is *not* a separate activity, as I am continually thinking about, re-writing and having conversations with myself, others and the literature. Working with narratives and stories, the analysis is in the interaction – me with my narrative and the sense the reader makes. This is necessarily incomplete, as it will mean different things to different readers. In this sense stories, narratives and theoretical perspectives transcend "data" in that they allow a rich picture through suggestion, ways of using language etc, which can extend its potential for resonating with readers. Its openness allows multiple meanings to be drawn (Noble, 2002).

A central concern for researchers has been the question of validity – or is the research valid? I wondered what this might mean from the perspective I am taking. Denzin and Lincoln (1994) map the criteria used for judging research into four main paradigms, ranging from the scientifically credible and generalisable, of the positivist paradigms; to action, praxis and historical situatedness of the critical theorists and feminists; to authenticity and trustworthiness of the constructivists; and emotionality, feeling and subjectivity of the post structuralists. What is present in some of these criteria is the assumption that the practice under scrutiny is the research "itself" and they fail to acknowledge the felt experience that is in the researcher's trigger to do the research. Many disregard the embodied, emotional and socially constructed nature of research.

As previously mentioned, researchers have been criticised for approaches which can be viewed as self indulgent or introspective (Hertz, 1997; Mykhalovskiy, 1997). The tone of some writing may suggest this (Donaldson, 2003). However, this view of the self continues to maintain a dichotomy between the self and the Other. The paradoxical notion of the individual and social forming and being formed by each other at the same time (Elias, 1939; Mead, 1934) in my view counters any claim of self indulgence.

Criteria enable research to be considered acceptable by a research community (Denzin and Lincoln, 2000; Mays and Pope, 2000; Koch, 1996), and arguably provide a "security blanket" which helps contain anxieties surrounding uncertainty and ambiguity. And yet, the nature of human experience is paradoxical, therefore by meeting either / or criteria we inevitably exclude other considerations (Griffin, 2002). Criteria also have to be negotiated in the contexts emerging in everyday life. My own experiences of having to write something which is acceptable to two different disciplines (Business School and Nursing) highlight the different expectations and constraints which emerge and are continually negotiated. I cannot write anything I choose and still survive, however, I can choose to push the boundaries or take risks. The challenges of being between two academic disciplines has been recognised by Shotter (1993).

> "at the boundaries, as those on the margins of disciplines know to their cost, there are a whole range of exclusionary practices working to sustain the limited and orderly nature of its subject matter" (Shotter, 1993, p.5).

Furthermore, Gergen (1999) comments on the way different traditions e.g. biology, psychology or mathematics will expect a different array of words to reflect that tradition. He gives a personal

account of his own experience of writing in the particular style and format of his own area of scientific psychology as a student. However, research approaches are always evolving. At the same time, constraints, such as accepted word counts, formats and the sort of literature one can refer to, are also enabling me to complete a "thesis".

For other writers, the extent to which the research writings resonate with the experience of the reader is considered to be criteria for judgement (Stacey et al 2000; Mykhalovskiy, 1997). Stacey et al's point is "whether they (narratives and stories) resonate with the experience of others and assist them to make sense of that experience" (p.203). The idea of resonance originates with Foulkes' (1948) notion of the group taking on or feeling the emotions of others.

> "The idea behind the concept of resonance is that an individual exposed to another individual and his communications in behaviour and words seems instinctively and unconsciously to respond to them in the same coin as it were" (Foulkes, 1948, p.290)

In other words, "a body vibrating in sympathy" (referring to sound, Collins English Dictionary, 1979). Resonance may have a negative sense – such as clashing (Foulkes, 1948). However, it is not possible to know in advance whether narratives will resonate for others. For example, abstract mathematical or scientific writing is unlikely to evoke resonance if I am unfamiliar with that language or terminology. Furthermore, I cannot know whether my writing resonates with whoever reads it.

However, in the ongoing writing and talking with others during the process of writing this thesis, I have had discussions with colleagues, supervisors and peers in a PhD group, who meet regularly to review each others work. This process in itself highlights the value of my contribution when my work is challenged; more questions are raised; or where my stories resonate for others, who tell stories of similar experiences. Similarly in my work situation I am aware of how I am speaking and acting with others, which may help others make sense of their experiences differently.

My own "criteria", could be said to be firstly valuing my own experience. Secondly, the feeling of resonance – i.e. paying attention to experiences which resonate for me and potentially for others. Thirdly, my contribution to ongoing conversation – by developing the theory through my own experiences and narratives which allow multiple perspectives and possibilities for ongoing conversation. Lastly, by making connections with my selection of relevant literature, the context of

primary health care, and my sphere of social contacts. In the following narrative chapters I hope to convey examples of the above.

My developing understanding of concepts emerging from the theory of complex responsive processes resonates with the emerging stance I am taking on methodology. Here I have explored how my thinking about research methodology has evolved with issues arising about representation, purpose and validity as I have increasingly worked with the ideas of complexity and complex responsive processes. The theory of complex responsive processes moves away from thinking about organisations, or research, as "systems" or "things" outside of what it is we are already doing in ongoing processes of relating to one another. Similarly, I was able to move away from a feeling of having a foot in both camps, which has been a gradual and difficult process when continually bumping up against dominant ways of thinking and speaking about research. I will now explore what has become the foundational theory for my sensemaking, and what this implies for research methodology, in the following chapter on the theory of complex responsive processes.

Chapter 4: How the theory of complex responsive processes provides a different view of change and how my methodological stance develops from this perspective

The theory of complex responsive processes was only just beginning to emerge when I initially began to take an interest in complexity and change. However, the concepts resonated with my experiences of change - embracing the complexity ideas of self organisation, emergence and paradox, whilst also including the messy human side of relating I was experiencing, which involves power relating, anxiety and fantasy, evident in my experience at the Practice (Chapter 2). These aspects of experience are often ignored in models of change – or seen as problems to be removed. Furthermore, the theory of complex responsive processes focuses on one's own experience as processes of relating, rather than maintaining an observer perspective on "wholes" or systems outside of everyday experience. Here I will review the theory of complex responsive processes, which has become the foundational theory for my sensemaking and my methodological stance.

This particular branch of complexity thinking arose from Stacey's earlier work where he initially claimed organisations were chaotic systems, and later complex adaptive systems (Stacey, 2000; Stacey, 1996). However, he describes a growing dissatisfaction with the way his ideas were interpreted in systemic terms. Later he turned to group analytic theory and social constructionism, and along with Griffin and Shaw, working in a doctoral group, began to see the complexity sciences as a source of analogy (i.e. similarity of relationship, or the similarity between human interaction in the form of symbols and the interaction of computer symbols) with processes of human relating.

Whilst drawing on the theories of complexity, Stacey et al (2000) define "complex responsive processes" as a development of complexity theories for human processes of relating, located within social and psychological theory, as opposed to thinking derived from engineering. They argue that care needs to be taken when drawing conclusions from other domains, such as the complexity sciences to the domain of human relating, as the sciences maintain the position of an observer of system, such as the computer programmer observing the models they are studying. When transferring ideas to human relating, it is not possible to assume the position of the programmer, when we are always part of the processes of relating. Rather than viewing the agent as each individual in a system interacting, they argue that it is *relating* itself which has an inherent capacity

to self organise and emerge as themes organising our conversations (ibid). A way I have come to think of this difference is that rather than sitting observing the clouds moving about overhead, I am moving *as* cloud. Griffin (2002) gives a similar example of the difference between sitting on a river bank, observing, or in a boat on the river – to actually *being* the river.

Stacey et al (2000) draw on the work of social psychologist Mead (1934) and sociologist Elias (1939), who also describe an emergent, process theory of human relating. As suggested above, Stacey et al (2000) argue that insights from the complexity sciences can be used by way of analogy (i.e. similarity of *relationship*, as opposed to metaphor which describes similar *attributes*) to explain human relating. Stacey (2003b) succinctly summarises key aspects of complex responsive processes thus

> "The processes being referred to are those of communicative action and power relating between human bodies, where those processes of interaction have the intrinsic capacity for coherently patterning themselves. Communicative interaction between human bodies patterns itself as coherent narrative-like themes fundamentally to do with being, doing and becoming together. From this perspective, the patterning of communicative action patterns further communicative interaction. Interacting humans are not thought of as producing anything outside of this direct interaction, such as a social or cultural system, a group mind, a matrix or a common pool of meaning. Direct interaction leads to more direct action and nothing else. We produce artifacts and tools in that interaction to use in further interaction but we do not produce mysterious wholes outside our direct experience" (Stacey, 2003b, p.119)

This clearly differs from the approach taken by writers on complexity in organisations who maintain the position of an observer of a system.

I wondered how the theory of complex responsive processes might sit in relation to other theories. For example, there are recognisable links with postpositivism, poststructuralism and social constructionism which have developed over the past century, arguably as a reaction to rational, scientific and positivist ways of thinking. However, the theory of complex responsive processes differs in the ontological and epistemological (nature of reality and knowledge) perspectives of the above approaches, which maintain or struggle with dualities or dichotomies of individual and social, self and other, known and unknown, thus ignoring the notion of paradox. Paradox, from a complex responsive processes perspective, is not something resolvable - rather the individual and social, the known and unknown, change and stability are *simultaneously* present in our experience as we continually relate to one another. Furthermore, significant differences in this approach to understanding human interaction and change are in key philosophical concepts about causality, or

purpose, and how time is viewed. I hope these differences will become clearer below and throughout the thesis.

Whilst social constructionists see reality as arising from interactions between people, many are ambivalent about the body. Rather the suggestion is that we can only know reality through language. Mead (1934), however, takes account of the body in a theory of human relating as symbols, or bodily gestures and feelings, which are inherently pattern forming. He also embraces the notions of emergence and paradox, resonant with the complexity sciences, whereby the individual/ social are continually being formed by processes of interaction.

The emergence of meaning – gesture and response

The importance of Mead's (1934) work from this perspective, is his symbolic theory of communication. Mead describes the gesture as a symbol which points to or stands for a meaning. Meanings are thereby social and context dependent. He distinguishes between protosymbols which are located in the body and are experienced as feelings and emotions, and significant symbols which are gestures, including language. Protosymbols are changes in the rhythm of the body, i.e. feelings. For example, when someone frowns at another person and the other person responds by feeling anxious. Other environmental factors such as the sound of the sea (a gesture or stimulus) may evoke peaceful bodily feelings. Human beings have developed the capacity for language (significant symbols) which is the

> "mechanism by which mind is socially constituted and through which the self that is conscious of itself as an object appears" (Mead, 1934, p.xiv)

Significant symbols evoke a similar response in the one gesturing and in the one gestured to and are predominantly vocal (language). This enables humans to be aware of, or mindful of the gestures we are making. A significant symbol could equally be a gesture (e.g. pointing at something) which may have similar meaning for both. Protosymbols are not at a more basic or more primitive level. Rather, protosymbols and significant symbols are happening simultaneously and cannot be separated from one another. Human communication is, therefore, a continuous bodily process of gesture and response which takes on a circular, or iterative, rather than linear structure. In other words, this is a self organising process where meanings emerge spontaneously.

Stacey (2001) adds another type of symbol which he calls reified symbols, which stand for abstract frameworks of understanding, for example medicine or mathematics, or an "organisation". He also

suggests that these symbols of communication (protosymbols, significant symbols and reified symbols) of human beings are analogous with the computer symbols used in the complexity sciences, which have been shown to be inherently pattern forming.

Mead's work differs from behaviourism, where individuals are thought to act in response to a stimulus in a cause and effect way, or knowledge transferred from one person to another in a sender receiver model of communication. The dominant way of speaking about meanings as objects being transferred from one person to another, rather than in the circular, iterative way Mead suggests, is illuminated by Lakoff and Johnson (1980) who demonstrate the way we use conduit metaphors e.g. "he gave her an idea"; "she grasped the idea". Rather, Mead suggests that meaning emerges in the response to a gesture, depending on how the gesture is received. In other words this is contextual and potentially transformative. For example, when someone smiles to another, this may be interpreted as a friendly gesture, or as a patronising look, thus allowing the possibility for different meanings from the first gesture (e.g. a friendly conversation, or a submissive response etc). Thus the individual and the social are forming and being formed by one another at the same time.

> "The social act is not explained by building it up out of stimulus plus response; it must be taken as a dynamic whole - as something going on - a complex whole" (Mead, 1934, p.7)

The continual process of gesture and response suggested by Mead points to a circular time structure. This differs from the traditional view of time as having a linear structure of past, present and future, with the present being a point dividing past from future e.g. on a time line. For example, we refer to historical events as absolute facts when we speak of them in the present. The perspective on time taken by a complex responsive processes perspective reflects Mead's view

> "The theory of complex responsive processes takes a particular perspective on time, thought of as the living present. The time structure of the living present is paradoxical in that the interaction takes place in a present which reproduces the past in expectation of the future, and that expectation changes the reproduction of the past. In other words, this is a perspective of continuous iteration in the present in which the past is reproduced, always with the potential for transformation" (Stacey, 2003b, pp.119,120)

For example, I might tell the story of how I achieve success at one practice as I am anticipating a new role in the future. This way of thinking has significantly changed the way I make sense of notions such as reflective practice, which I will discuss in the next chapter.

Mead thereby sees the individual as emerging in the social and differs from post-structuralists (Foucault, 1970; Derrida, 1976) who tend to reduce subjectivity and meaning to discourse. Similarly discourse analysts (Schlegloff, 1988; Sacks, 1992) focus on language rather than situating language and meaning in processes and emerging contexts of social interaction. However, arguably Mead does not elaborate on the notion of power or constraint, or explain how emotions and structures emerge (Plummer, 1998).

I will now turn to the work of sociologist Elias, whose process sociology adopts this view of time and the idea of emergence, resonant with the complexity sciences (Stacey et al, 2000). He also suggests how power relating emerges from interdependencies of people relating to one another with associated emotions of fantasy, shame and gossip, inherent in my experiences of change at the Practice.

Elias's process sociology

Elias (1939) recognises how human societies have changed over time in unpredictable ways, without any overall plan, as essentially self organising and emergent processes. I also suggest that his work provides the human dimension to ideas suggested by the complexity sciences, relating to issues such as interdependencies or power relating, and fantasy, gossip and shame.

Elias's work stretching over decades differs with mainstream sociological approaches in a number of important ways. In particular, he combines micro and macro sociology, the theoretical and the empirical – with subjects such as crime, sexuality, sport, shame, emotion, identity, and violence among others – and remains fairly consistent in standpoint over the length of his career. He also recogises paradox, whereby the individual and the social are simultaneously forming and being formed by one another at the same time. However, his work was not widely recognised until the 1980's, due to the delay in translation from German to English (Hughes, 1998; Mennell, 1992). Perhaps for this reason he has been criticised for the difficulty in making sense of his work in its entirety – as issues are often scattered in different places (Mennell, 1992). His idea of "civilising processes" has also been criticised as it is claimed that human processes have taken a backwards turn with the holocaust and greater permissiveness. However, this misinterprets Elias's use of the term "civilised" – which refers to spurts and changes in direction rather than the common use of the word civilised (Hughes, 1998; Elias, 1987). Whilst his use of the word "civilising" implies an evolution in human behaviour, he never asserts that this process is for the "good".

Mennell (1992), reviewing his work suggests "the central concepts here and throughout Elias's work are "process' and 'interdependence'". The importance of Elias's "process sociology", is in several interconnected principles in his work. What he calls "civilising processes" have emerged over time without any planned or external design. Rather, humans are social, interdependent beings, developing socially constructed "habitus" or accepted ways of behaving such as manners or meeting etiquette. He gives the example of how children learn "in accordance with the standards reached in their society" (Elias, 1987, p.56). These interdependencies can be understood in terms of changing power relations. He therefore sees human societies as processes of development and change rather than timeless states.

Sociologists traditionally study groups or individuals in the present, as outsiders or observers of societies, paying less attention to the wider context and processes of change. They are also influenced by competing paradigms concerning structure and agency. From a structuralist paradigm the focus is on social structures which drive individuals as if by an "external force", whilst from an ethnomethodological paradigm the focus is on the active and productive capabilities of individuals (Hughes, 1998). However, Elias explains how academic splits between the individual and the social, ontology and epistemology, have occurred as reifications emerging in a stage of social development, or civilising processes (Elias, 1939). An "invisible wall" has developed whereby human beings are viewed as Homo clausus (or closed man) due to an increasing awareness of bodily functions and shame associated with a feeling of "me in here" and "society out there".

> "The changed social modes of life imposed a growing restraint on feelings, a greater need to observe and think before one acted, with regard to both physical objects and human beings. This gave greater value and emphasis to consciousness of oneself as an individual detached from all other people and things" (Elias, 1991, p.105)

Viewing ourselves as Homines aperti (open, bonded pluralities of *interdependent* human beings) would, he argues help to move away from debates and dichotomies which undermine our understanding (ibid). Furthermore, arising from this perspective is an understanding of power as fundamentally relational and processual and relating to the interdependence of human beings as they constrain what is possible to say and do as they interact with one another.

This way of thinking removes the need to think in terms of different levels e.g. individual and organisational (Elias, 1991). The understanding of process thereby contrasts from perceiving process as forming a whole or system. Rather, processes of interaction are endless. As Elias argues

(1991) the words we use tend to reduce process to states. Using words such as "identifying" and "distancing" suggest their temporal nature, whereas "structure" and "outcome" suggest fixed states. In the same way he proposes that talking and thinking are also processes of bodily action. Elias (1991) imparts the example of walking as action of the body, suggesting that it makes no sense to talk of walking having a boundary or being inside or outside of walking.

Elias (1991) provides a further perspective on how the state of affairs, whereby humans have an ability to detach themselves (a shift in the I-We balance) has emerged. He argues that the increasing ability of humans to gain control of nature e.g. by harnessing wind or water for energy goes hand in hand with increasing social and self control.

> "Control of nature, social control and self-control form a kind of chain ring; they form a triangle of interconnected functions which can serve as a basic pattern for the observation of human affairs. One side cannot develop without the others; the extent and form of one depend on those of the others; and if one of them collapses, sooner or later the others follow" (Elias, 1991, p.138).

This perhaps helps to understand how assumptions about *control* of change – for example in the NHS – have arisen.

Elias recognises the inevitability of being part of the process one is studying, yet also notices the ability of humans to become detached and observe themselves. I find his explanation of the dynamic of involvement and detachment helps to make sense of this. As human beings we do have an ability to observe ourselves, or take a detached perspective from the view of the "other", from the position of the evolving social expectations and meanings of a group. This ability has enabled humans to observe with detachment, forming a symbolic representation, theory or model and by means of actions based on that representation, attempt to change the situation. Elias stresses, however, that this may not work out as intended. His ideas about how the process of change happens are perhaps illustrated thus

> "basic tissue resulting from many single plans and actions of men (which) can give rise to changes and patterns that no individual person has planned or created. From this interdependence of people arises an order *sui generis*, an order more compelling and stronger than the will of the individual people composing it. It is this order of interweaving human impulses and strivings, this social order, which determines the course of historical change; it underlies the civilising process" (Elias, 1939 p.444)

Elias does not refer to an *external* controlling force or system. Rather, change emerges from the interaction between people, which is always enabled and constrained by the expected ways of behaving.

I will now explore the perspective on change implied by the theory of complex responsive processes.

A complex responsive processes perspective on change; identity, ideology and anxiety

In terms of human relating, a complex responsive processes perspective refers to change as the transformation of thematic patterning of communicative interaction, or in other words changes in micro interactions. Furthermore, change is seen as change in the patterns or themes organising conversation. What this means for human experience is changing and stable identities, ideologies and the associated dynamics of anxiety.

Stacey et al (2000) argue that the overall purpose, or answer to the "why?" question, from this perspective, is the continual iteration of, and expression of, *identity*. A sense of identity is felt in the body as changes in rhythms or feeling states, as we respond to one another and our environment.

> "These unique bodily time contours constitute a person's feelings as unique experiences of self, or identity" (Stacey 2001 p.103)

It is through interaction that continuity and transformation of individual and collective identity is expressed. This view of causality differs from the dominant way of speaking and acting which uses two conflicting teleological frameworks to make sense of our experience, namely rationalist and formative causality. In other words, we commonly think about individuals as having a choice in determining autonomously chosen goals (rationalist). However, we also adopt the belief that, as in nature, there is movement towards a mature state (formative causality) e.g. an acorn becomes an oak tree, or an organisation reaches a strategic goal. This dualistic thinking originated with Kant, who argued that formative causality could not be applied to human beings who are autonomous. This would explain the split in the experience of being both part of a system and being an individual with free will, seen in the previous chapters on traditional systems models of change and also a complex adaptive systems perspective.

Stacey et al (2000) aim to resolve this by offering "transformative causality", whereby there is movement toward a future that is perpetually produced by the movement itself, by paradoxically expressing identity and difference, continuity and transformation, the known and unknown, at the same time. The "purpose" is for the expression of collective and individual identity and difference, paradoxically at the same time. Again, the important point is that paradox, in this sense, is not something which can be resolved.

Stacey (2001) argues that when insights from the complexity sciences are understood from this perspective, there is the potential for novel ways of making sense of organisational change.

> "The kind of self organisation implied is diverse micro interaction of a paradoxical kind that sustains identity and potentially transforms it. Changes in identity depend upon spontaneity and diversity of variations in micro interactions" (Stacey, 2001, p.60)

Diversity, misunderstanding and trust, as Fonseca (2002) maintains, enable the sort of free flowing conversational life whereby new themes are more likely to emerge. However, he stresses none of these are quantifiable or measurable things "out there" which can be manipulated to provide the "right" formula to produce change (ibid), such as those recommended by writers in the previous chapter who advocate creating the conditions to facilitate emergence. I will explore how my identity is changing in relation to my experiences as a Nurse Practitioner in the following chapter.

Patterns or themes, or ideology, organising our experience emerge spontaneously from interaction itself, preserving power differences in self organising and often unconscious ways. Ideology is simultaneously enabling and constraining. Stacey (2001) describes the process of interaction between people as informal and legitimate (unofficial and official), conscious and unconscious themes which interact and compete in ways which may shift power relations. He warns however, that themes are not stored anywhere, but are continually reproduced and potentially transformed in ongoing relating between people.

> "Ideology is not stored anywhere, transmitted and then shared. Rather it is a patterning process, that is narrative themes of inclusion and exclusion organising themselves in perpetual reproduction and potential transformation. Ideology exists only in the speaking of it.....A key aspect of ideology is the binary oppositions that characterise it and the most basic of these is the distinction between "them" and "us". Ideology is thus a form of communication that preserves the current order by making that current order seem natural" (Stacey 2001 p.153)

Griffin (2002) describes Mead's theory of how idealised values emerge in interaction e.g. "patients must receive the best possible care". However, what Griffin (2002) describes as an idealised value has to be negotiated or functionalised in daily interaction, for example whether treatment is affordable. This is where conflict arises and is negotiated as people interact with one another as a process of continual interaction. I explore how ideological themes are played out in my experiences relating to Patient and Public Involvement in Chapter 6.

Furthermore, from a complex responsive processes perspective changes in identity and ideological themes are also inherently anxiety provoking when ones' survival depends on feelings of belonging. Stacey argues

> "If communicative action is essential, not only for the survival of every individual, but also for the continued reproduction and transformation of their selves or identities, then exclusion must be felt as very threatening.....the deepest existential anxiety must be aroused by any threat of separation or exclusion since it means the potential loss or fragmentation of identity, even death" (Stacey 2001 p.149)

Responses to anxiety in turn trigger more themes to do with coping with feelings of anxiety. Therefore, particularly in the context of primary health care, and health care more generally, where life and death situations are paramount, the way anxiety is coped with becomes a key area of focus.

> "Themes to do with inclusion and exclusion, or power...arouse feelings of existential anxiety, which trigger themes to deal with that anxiety in some way...there is a link between anxiety and the use of fantasy to cope with it.....These interrelated matters of power and anxiety, fantasy, imagination and misunderstanding, therefore, are central to an understanding of the communicative action that is human relating" (ibid, p.149)

The themes of anxiety, feelings and fantasy are evident throughout the thesis. The narratives I will be using in the following chapters illustrate how anxiety emerges and responses to it. In Chapter 7, I focus particularly on the themes of anxiety and risk by using narratives of my experiences of what it is like to live with anxiety.

Implications of the theory of complex responsive processes

Instead of focusing on change as something to be planned, controlled and predicted, a complex responsive processes perspective turns to the iterative processes of interaction between people. Change is the paradoxical processes of changing and yet recognisable identities; themes organising interaction (or ideology); and patterns of inclusion and exclusion (or power relating), and the associated anxiety which surrounds this. Taking the themes of identity; ideology and anxiety as a

complex responsive processes perspective on what change means, these are areas I will be exploring through narratives of my own experience and exploration of the literature.

> "the conversational life of an organisation is a potentially transformative, knowledge creating process, when through the diversity of participation it has the dynamics of fluid spontaneity, liveliness and excitement, inevitably accompanied by misunderstanding, anxiety-provoking threats to identity and threats to official ideology and current power relations. If one is to make sense of the process as one participates in it, then all of these aspects require some attention" (Stacey 2001, p.183)

Furthermore, what is lacking in the approaches to change in the previous chapter, is the perspective of what it is like to experience change *as it is happening*. Approaching change from a different philosophical stance as suggested by the theory of complex responsive processes therefore addresses this gap.

Despite rejecting the idealistic undertones of some social constructionist writing, Stacey is critical of current ways of thinking and acting in organisations, for example with quality inspections and targets - "quality assurance systems....are a massive waste of resource and even more a damaging source of frustration and anxiety" reflecting an "ideology of control"(Stacey, 2001 p.226). At the same time, however, whilst giving an in depth theoretical perspective to understand organisations as complex responsive processes, he highlights that if one accepts the theory, it is impossible to provide prescriptions for managers within organisations (Stacey, 2000). Rather, the theory enables us to understand what is *already* happening. The tendency is to look for answers, or prescriptions about what to "do" differently, which misses the point that talking, thinking and doing are aspects of the same processes, and ignores the impossibility of standing outside the processes of interaction to determine future patterns. As mentioned in the previous chapter, there have been criticisms of what is regarded as anecdotal evidence or "common sense" (Olner, 1999). This assumes that knowledge is only valid if it can be scientifically tested or proven and disregards the validity of narrative knowledge – arising as complex processes of human relating. If this is the source of change, narrative knowledge is arguably a valid focus of attention.

Whilst Stacey warns against giving prescriptions, he does suggest that implications of the theory lead to *paying attention* differently (Stacey, 2003a). I will discuss this further in the next section on methodology. Subsequent work from complex responsive processes perspectives focuses on *conversation* as the way we make sense of experience (Shaw, 2002). What seems lacking for me in some of the writing is the embodied nature of this experience. And yet, in theoretical terms, Stacey

stresses that "feelings and communicative actions in the medium of feelings are always part of any human interaction" (Stacey, 2001, p.118). Stacey et al (2000) however, admit that their writing is largely propositional or theoretical. The emotional aspect therefore appears sparse in this style of writing. This is an area I will be focusing on in my narratives. Stacey (2000) makes the point that a theory needs to stand up to what he calls the "reality test" – i.e. whether the concepts resonate, or help to make sense of experience. This is where I contribute to the theory by exploring whether the concepts resonate with my experiences in following chapters.

A complex responsive processes perspective has shifted my attention to my experiences in my day to day life, working in primary health care. Furthermore, the theory of complex responsive processes of relating points to an ontology, epistemology and methodology where reality is understood as arising in our participation in processes of relating. What emerges is a participatory, narrative methodology as opposed to an observer- observed, reporting relationship. As Stacey, Griffin and Shaw suggest, a move away from thinking in systems terms about organisations has implications for methodology. "It means trying to understand human action in organisations from within that action, as a participant in it" (Stacey et al, 2000). More recently, management researchers have taken this position in their research (Stacey and Griffin, 2005; Christensen, 2005; Parsley, 2005; Fonseca, 2002; Shaw, 2002; Streatfield, 2001; Bentley, 2000; Fraser, 2000; Aram and Noble, 1998; Fonseca, 1998; Shaw, 1998; Streatfield, 1998). Stacey and Griffin (2005) argue that research is also complex responsive processes and the research method takes experience seriously and involves reflexively exploring ordinary everyday experience. I will expand on this in the next section where I talk about my methodological stance from this perspective.

My Research Methodology: shifting realities

Philosophical questions of purpose or ideology, ethics and validity arise when thinking about methodology, which I will address here. My thinking about these questions has developed at the same time as my developing understanding of the theory. In terms of philosophical or ideological stance, as described in the previous chapter, for some time I struggled with what I call a "foot in both camps". Moving away from a pluralist or relativist stance which struggles with what Lincoln and Denzin (2000) call the crises of the seventh moment in qualitative research, I have come to view reality *as* experience. Indeed, as I argue in the previous chapter most postmodern approaches struggle with a dichotomy or "fudge" between two paradigms. This turn around in my thinking about what research means from this perspective can be explained in terms of ontology, or the nature of reality. Rather than a positivist view, whereby reality is seen as something external to

experience which can be discovered, captured and passed on to others in the form of knowledge, a complex responsive processes perspective sees reality *as* experience. Experience, or what is known, emerges from complex responsive processes of relating, as continuous processes of gesture and response (Stacey et al, 2000).

For me, the separate notions of ontology, epistemology and methodology become meaningless as separate entities, from this perspective. Reality and knowledge are collapsed as reality *is* experience, *is* knowledge, *is* the way we come to know the world.

A complex responsive processes perspective thereby suggests a move away from either extreme positivist or extreme relativist positions, or a fudge between the two, to a paradoxical view of reality and knowledge. As suggested by Mead, reality, or ontology, arises in temporal processes of gesture and response (Mead, 1934), rather than being something "out there" to be captured and passed on to others, in a sender-receiver model of communication. Epistemology, or the theory of knowledge, similarly arises as experience, as interactive processes, including feelings, gestures and language. Methodology, or how we come to know the world, is therefore essentially a participatory, narrative process where research and practice become intertwined in a process of seeking to make sense of this context and surviving in it (Noble, 2002).

Issues concerning representation are therefore paradoxical (see Chapter 3). I can only know and therefore "represent" my subjective experience. However, from this perspective I am emerging through processes of interaction in the same way that the social also emerges. What I hear affects what I say and what I say affects what I hear, thus participating in what can be called emergent inquiry (Stacey, 2003a). What is known is continually emerging in these relationships with others and my experience therefore reflects the social at the same time as my individual experience (Stacey and Griffin, 2005). I therefore do not see research as a separate activity from complex responsive processes as that is what experience is. Neither am I able to split theory from practice, or action from reflection.

This reflects Mead's (1934) view of the self as forming and being formed at the same time as the social. Indeed, I see myself through the eyes of "the other", or as Mead (1934) says, the "generalised other".

> "Selves must be accounted for in terms of the social process, and in terms of communication; and individuals must be brought into essential relation within that process before communication, or the contact between minds of different individuals, becomes possible. Mind arises through communication by a conversation of gestures in a social process or context of experience – not communication through mind" (Mead, 1934, p.50)

Establishing my position whereby reality and knowledge are known by a continual embodied process of gesture and response, the notion of purpose also shifts. As stated above, Stacey (2003b) argues that in terms of thinking about how identities arise and change the key questions are: "Who am I and how have I come to be who I am? Who are we and how have we come to be who we are? How are we all changing, evolving, or to put it another way learning?" (p.1). Rather than having any endpoint or permanent discovery, the purpose is to make sense of experience, from where new patterns are continuously emerging.

> "The purpose is not to solve a problem or make an improvement to the organisation but to develop the practitioner's skill in paying attention to the complexity of the local, micro interactions he or she is engaged in because it is in these that wider organisational patterns emerge" (Stacey and Griffin, 2005, p.24)

Furthermore, rather than being emancipatory research, often explicitly stated by action research methodologies (Reason and Bradbury, 2003), Stacey and Griffin (2005) suggest

> "it is not possible for committed groups of people to intentionally change the widespread patterning of interaction. All they can change is their own interactions and from this the widespread patterning will emerge in ways that they cannot intend nor fully understand.....the aim of the method is, therefore, not one of changing social "wholes" but of making sense of the "live" experience of interaction.....As people make sense differently they act differently and it is in this action, in continuing interaction with others, that macro patterns change in ways that cannot be predicted or controlled" (Stacey and Griffin, 2005, p.33)

Furthermore, a complex responsive processes perspective draws attention to the creative and destructive aspects of experience which are necessary for the novel to occur – and which may not be seen as positive. My purpose therefore differs in some ways from postmodern research which aims to give voice to others or shift the balance of power. Whilst power relating is evident in my writing, my purpose is to make sense of experience, paying attention to patterns and themes as they emerge rather than trying to produce desired change, which paradoxically also becomes liberating. My purpose is to explore what it is like to focus attention on, and make sense of, everyday experience from this perspective and in this context of primary health care.

My research does follow a growing body of research as researcher /practitioner, as previously mentioned. Shaw (2002), Streatfield, (2001), and Donaldson, (2003) describe their methodology as belonging to the participative inquiry or action inquiry family of research, as researcher-practitioner participating as consultant, or manager in their own field of work. Latterly methodology from a complex responsive processes perspective has been described as *emergent exploration of experience* (Parsley, 2005; Stacey and Griffin, 2005).

There are some similarities with other approaches to research. For example, Reason and Bradbury (2001) also recognise the ongoing nature of research as experience - "In action research knowledge is a living, evolving process of coming to know rooted in everyday experience; it is a verb rather than a noun". And Torbert (1991) describes my experience of research and action as analytically distinguishable, and yet inextricably intertwined in practice. The notion of praxis, described by Freire (1972) – or action that is informed - reflects this simultaneous reflection and action, which cannot be reduced to "verbalism or activism".

> "For apart from inquiry, apart from the praxis, men cannot be truly human. Knowledge emerges only through invention and re-invention, through the restless, impatient, continuing, hopeful inquiry men pursue in the world, with the world and with each other" (Freire, 1972, p.66)

However, as suggested above, there are important differences concerning purpose between an explicit emancipatory, political purpose of an action research approach (which I discussed in Chapter 3) and a complex responsive processes approach, which focuses on the value of taking my own experience seriously (Stacey and Griffin, 2005).

Shaw (1998) describes her research as a search for the words that simultaneously describe and reflect on her actions – and concludes that the key words are participation, conversation and narration. Narrative knowledge is propositional (abstract theoretical) as well as embedded in anecdotes and stories. However, stories and anecdotes are often dismissed as mere story or fabrication. The importance of narrative knowledge and anecdote is recognised by McNaughton (1998), who from a medical perspective points out "the centrality of the anecdote as a means to what physicians know should be recognised as a reality". An example highlights this for me, where a radiologist is examining two chest x-rays. Both have a shadow on the lung and both patients were coughing up blood. One was from a 19 year old, who had returned from world travel, and the other was from a 50 year old smoker. These stories enabled the radiologist to diagnose TB in one and lung cancer in the other (Greenhalgh, 1998). Narrative knowledge is the way we make sense of

experience, which involves story, theory and analysis intertwined. Rather than narrative being split off from ordinary everyday experience, from a complex responsive processes perspective, narrative is the way we are continually making sense of experience.

What does it mean to make sense of experience from this perspective? Stacey (2003), stressing that there are no prescriptions arising from this theory, suggests a refocusing of attention on:-

- the quality of participation
- the quality of conversational life
- the quality of anxiety and how it is lived with
- the quality of diversity
- uncertainty and paradox.

Despite having written many narratives before Stacey's (1993a) book, where he suggests a refocusing of attention, the temptation was to use these categories subsequently as a "tool" to frame my reflections on experience. However, I chose to write and reflect on themes which arose for me rather than trying to fit them into "categories". The notion of themes as defined by Stacey (2001), refers to individual and group themes organising experience, which arise between people, experienced as fluctuations in the feeling rhythms of bodies. Each individual responds differently to emerging themes, however. In refocusing my attention as implied by the theory, I became aware of the qualities Stacey suggests above, as well as other themes which emerged for me, which I will discuss in further chapters.

In refocusing attention I mean a process of noticing themes and feelings as they arise. Sometimes I may jot down a note during a meeting, when something strikes me as interesting. At other times I write rough notes furiously at home either on paper or directly onto the computer when something is puzzling, or feels like an Aha moment when a pattern seems to emerge. I may talk about my experiences with a colleague or my partner or at the PhD group. My narratives record this process as I am articulating emerging themes in a critical and reflexive way. I find myself continuously editing, deleting and reinstating parts into and out of my thesis as they strike me as having something important to say in relation to "what is it like to experience change in primary health care from a complex responsive processes perspective?" As I have come to view my research *as* experience – I am noticing feelings, paying attention to what is going on, asking questions and making connections, as conversations with myself, with the literature and with others, as a

continuous process. I am not trying to capture anything static, but rather living in an inquiring and reflexive way, as complex responsive processes, in my everyday life.

Ethical considerations have arisen throughout my work, as described in Chapter 2. At times I was initially concerned about how I was "representing" others in my narratives. However, I realise that I can only ever write about and know my own experience. What is real is always moving and I continually think, write and talk with others. Furthermore, it is not possible to know or reflect the direct experience of others, or speak on their behalf. However, in the way I respond to what Mead calls the "generalised other" – or what I imagine people are thinking are forming and being formed by interactions I have with other people – I also reflect the social.

From a complex responsive processes perspective, therefore, ethics are not something "out there", to be satisfied and then ignored. In my daily life I am continually making judgements about how to act and respond, and what to include in stories or narratives. Ethical principles arise continually as I take responsibility for my actions, and yet paradoxically I cannot know how another will respond. However, this does not absolve me from the responsibility for my actions. Ethics can be considered as idealised, or "cult values", which are functionalised in day to day interaction (Griffin, 2002). For example, when writing a book chapter I paid attention to how it may be read by someone familiar with the context I was writing about. I made changes accordingly where I thought it may cause offense. My approach therefore differs from a traditional view of ethics as something outside of everyday experience.

My concerns, therefore, in writing about my own practice are very real in the sense of my own survival, where I have to continue to work in that environment and continue to relate to colleagues and family. I live with the responsibility of writing sensitively, whilst also risking personal disclosure, and yet not editing out so much that I lose the essence of what I want to say. The balance, therefore, is between not intentionally upsetting anyone, and yet saying something meaningful.

In terms of validity, I increasingly make sense of this from a complex responsive processes perspective. As my research reflects my own experience, there can be no objective validity (Stacey and Griffin, 2005). The value is in the way it may resonate for others and help them to make sense of their own experience. The notion of time as continuous iterative processes which do not form any sort of system outside of experience make the notion of "transferability", for example, from

one practice to another with a set of rules, template or recipe for success, meaningless. Similarly, the notion of paradox where the individual and social are aspects of the same process, have corresponding implications for what research means. These concepts validate focusing attention on aspects of our own experience, which also reflects the social. It becomes a legitimate activity to focus attention on our own local interaction from where both the similar and the new are emerging– i.e. change. Furthermore, the value is in the way it reflects experience of what it is like to experience organisational life, which is messy, uncertain and emotional, rather than a post rationalisation of events from a highly rational perspective (ibid).

In summary, my methodological approach is an emergent exploration of experience, *as* complex responsive processes of relating. Consistent with complex responsive processes concepts of time, causality and paradox, this approach validates paying attention to my emerging experiences. As such, it speaks not only about me, but reflects a wider social perspective, in particular in my area of work in primary health care, my exploration of relevant literature and of the numerous conversations with supervisors, study group, colleagues, friends and family. In the process of experience and writing I have come to understand my own area of study and work differently, and inevitably I think and act differently. This will undoubtedly have some effect on the social i.e. people I am interacting with. Similarly anyone reading the thesis may find new ways of making sense of their own experiences. Taking this stance, the contribution lies less in propositions and more in the cumulative meaning I try to convey by paying attention to ordinary, everyday experience.

Having shown how my thinking has moved on as I have increasingly worked with these ideas, I now return to how I am paying attention to my thinking and practice as complex responsive processes. As discussed above, change from a complex responsive processes perspective is simultaneously continuing and changing identities and ideologies, and associated anxiety, emerging in local interaction. The following three chapters focus on the way I am increasingly making sense of experience in a narrative like way *as* complex responsive processes, with story and analysis intertwined, as I begin to notice the implications implicit in this way of thinking and acting in my day to day working life. In the next chapter I think about the notion of how my identity is changing in relation to my experiences as a nurse practitioner, working with patients in primary health care.

Chapter 5: How my perspective on consulting in practice is changing and how I am thinking about identity and time

I now turn to my experiences in my work as a nurse practitioner working in a general practice (primary health care). Initially puzzled by my experiences of trying to "manage change", my focus had been on organisational aspects of my experiences with the practice team members I was working with (see Chapter 2). I ignored the aspects of my work which involved seeing patients as a nurse practitioner. My partner highlighted this to me when I was describing an experience with a patient, which I will describe below. However, I initially resisted reflecting on my practice with patients, as I hadn't felt this area of my work was relevant to the "sort of" change I was exploring. I felt that focusing on this new area of my work would slow me down in already frantic 3 hour sessions of 10 minute appointments. I was just learning new skills in diagnosing and treating patients with acute illness. However, I have gradually begun to question what it is I am doing in my consultations with patients. I began to pay attention to consultations as complex responsive processes where "consultations" are relational processes which may follow stable patterns, but always with the potential for change.

In this chapter, I briefly touch on complex responsive processes perspectives on changing identity, in the context of health care. I then explore what this means as I make sense of my experiences with a patient. I became aware of identity in relation to the way time is viewed from this perspective and offer a different way of thinking about "reflective practice". I then consider traditional views of consultations with patients compared with how I am beginning to make sense of consultations as emerging relational processes. Finally, I explore the idea of changing identity in the context of the dominant duality of minds and bodies in health care. Whilst the focus is on how I am making sense of change in terms of my identity in consultations with patients, there are also a number of recurring themes evident throughout the thesis, such as anxiety and power relating.

The theory of complex responsive processes views change as "gradual or abrupt changes in identity, depending on the spontaneity or diversity of variations of micro interactions" (Stacey et al, 2000) – see Chapter 4. This view of identity is relational, emerging as individual and social are forming and being formed by one another paradoxically at the same time (Elias, 1939). This contrasts with ethnomethodological views of identity where the individual is primary and separate from the social, or a social constructionist paradigm where the social is primary to the individual

(Gergen, 1999). Giddens' (1984) theory of structuration aims to synthesise these extremes, yet arguably retains a dualistic approach, stressing either "agency" at the expense of "structure" or vice versa (Hughes, 1998). From a complex responsive processes perspective I began to recognise that changes in primary health care could be seen as arising from variations in micro interactions, such as me with a colleague or a patient. Rather than me as an expert (sender) giving information to the patient (receiver), who we are would be emerging as we relate to one another. Emerging themes would then affect the sort of interactions we are having – for example the expectations we have of one another as "patient" and "nurse".

As mentioned in the previous chapter, threats to one's identity evoke responses which involve a range of feelings including anxiety, and attempts to maintain established power relations, which are evident in my narratives. This is particularly interesting from a "health" perspective where there is a tendency for doctors, nurses and patients to split the psychological, social and physical (Wilson, 2001; Dowrick, 1997; Damasio, 1994; Heath, 1994). What also becomes interesting is how feelings such as anxiety are lived with, and how this may enable or limit the potential for change to occur. I continue this theme in Chapter 7.

Historical themes and expectations concerning "roles" (identities) of doctors, nurses and patients are evident in my narratives. Roles are shifting in a number of ways, such as nurses taking on aspects of what was traditionally considered the realm of the doctor alone, whilst nurses "delegate" traditional nursing responsibilities to health care assistants or "carers" (Horrocks et al, 2002; Scotland, 2002). Changes in the way patients are viewed are evident – a theme I will turn to in the following chapter. Reasons for this shift have been described in various ways such as political, to reduce the power of the medical profession, or due to a lack of resources. With increasing costs of healthcare, and lack of trained doctors and nurses, "skill-mix", or delegating to someone less qualified, arguably becomes a way of obtaining "cheap doctors". The new role of nurse practitioners differs from the traditional practice nurse's role of completing tasks ordered by the doctor e.g. blood tests or dressings (Poole, 2000). Providing "certainty" with defined tasks, roles and guidelines to follow may be reassuring but may also reduce the necessity to question what it is we are doing. I began to think how in Eliasian terms these changes are emerging as power relations which simultaneously enable and constrain what we do, rather than being planned or intended by anyone "outside" of or "in control" of everyday interaction. In other words, my own "role" or identity is emerging as I am consulting with patients, which I consider in the following narratives.

Consulting in Practice: shifting identities

It's early morning and my partner hands me a copy of an article for me to read about consultations with patients. I glance at it briefly, trying to make sense of where it has come from and what relevance it may have to what I am currently thinking about. I settle down on the bar stool with a cup of tea to read it.

I find myself becoming irritated as the paper talks about the patient as a system, which needs to be explored in terms of its own rhythms, in order to assess the health of a person. The paper is a transcript of a "Plexus call" where people interested in health and complexity discuss areas of interest via a telephone link (www.plexusinstitute.org, 2002). The two people being interviewed are family practitioners, I gather. I am thinking about how they are using metaphors from complexity science to explain why they consult in a particular way. They use one paper by Goldberger (1996), suggesting that heart rate variability is an indicator of health, and stable rhythms a precursor to ill health and death, to suggest that body rhythms must also be variable. I am noticing how their view of complexity alters the way they practice, and in particular how they ask different questions about sleeping and eating patterns, thinking about the whole body as a system, and also record heart rates to assess for variability. I am thinking that they have distanced themselves by talking about the patient as a system, disregarding their own presence in the consultations – i.e. they take the position of objective observer and the patient is seen as an autonomous individual – like an operating mechanism. I mention my irritation to my partner who suggests it may be useful to compare my way of seeing things from a complex responsive processes perspective, with their approach.

I get up to put the kettle on. I am thinking about my own consultations with patients, and what expectations I have. I remember a recent consultation with a female patient, where I felt the communication "broke down" (a mechanical metaphor – I felt there was dissonance between us). I felt the patient interrupted my normal flow of "doing things" in a consultation i.e. taking a history, examining the patient and then agreeing on diagnosis or treatment or giving health advice. This also reflects a sender-receiver model of communication and a medical model of the consultation (Neighbour, 1987; Balint, 1957).

I turn to my partner to tell him the story of this particular consultation. I find myself qualifying this by reminding him that in its telling it can be viewed as a whole, a story complete in itself. I am recognising a pattern whereby he may say to me "why didn't you do this or that" or "what have

you learned from it", or "what would you do differently next time". I feel anxious that it might be easy to see with hindsight where I might have said this or that differently, which may have changed the conversation, but in the continuous flow of the conversation I could not know what patterns would emerge. I didn't have the benefit of hindsight in knowing how the patient would respond to me and I acted with good intention during the process. This is an important difference in how I would previously have reflected on experience, based on a linear view of time, and I was recognising my partner would still be looking for what I could have done differently.

I begin, describing a woman in her 30's who comes to see me with her young son and daughter, perhaps about aged 5 and 4. I recognise her face and smile. She sits down and tells me she has been unwell for 4 days and must get better, because she has the children to look after. I ask her how she is feeling. She hurriedly tells me she has had a sore throat and cold and is dizzy and tired. Again she asks me to hurry up, as she has the children with her, and asks if I am going to check her blood pressure. I jar at this point, this isn't the first thing on my mind and I feel my normal flow of eliciting the problem has been disturbed. I agree, also saying that I need to find out what the problem is so I can try to help. She stares at me and there is an uncomfortable silence. I summarise, "so you've been feeling unwell for 4 days?" We are interrupted by her children moving my trolley around the room behind her– she turns to shout "behave!" at them and I say "don't worry, I'll keep an eye on them". Again she stresses the need to get better to look after them. I ask if there is anyone who can help her to look after them. She snaps back saying she doesn't need anyone to help look after her children. She says she just needs some antibiotics to get her better "but you aren't going to give me any!" Feeling rebuffed, I get up to examine her, checking her blood pressure and listening to her chest. I tell her I can't hear any infection on her chest and her blood pressure is fine. I explain it is likely to be a virus. Despite trying to keep the conversation open the woman gets up quickly to leave. I feel frustrated and dissatisfied.

My partner suggests she is in denial about her children and projecting her frustration onto me. Acting as an expert, he gives advice in a way which fits with particular abstract frameworks, for example psychological approaches and terms e.g. denial. I feel slightly irritated as my partner suggests what I could have done differently. In the flow of conversation I was doing the best I could in a situation which felt "on the edge". I was struggling to make sense of what happened from a complex responsive processes perspective whilst also surviving in a context of a traditional understanding of learning and doing things differently next time. Initially, I felt the consultation "broke down" early on and whatever I did I could not resolve or "fix" it. I recognise this way of

thinking is based on a model of trying to fix a problem, rather than making sense of what is going on as an ongoing process. This traditional perspective didn't fit with my experience in the moment of doing one's best, without the benefit of hindsight. Models of reflective practice seem to adopt this approach to reflecting on past experience with a view to learning from past mistakes, or thinking about what one could have done differently, as a separate activity (Palmer et al, 1994) (I will expand on this below). This approach differs in a subtle way from my emerging sensemaking from a complex responsive processes perspective.

This way of thinking seemed to have implications for thinking about identity and time. Traditionally, we live our lives in a linear way, as a story we tell ourselves about ourselves, or as life as a journey (Lakoff and Johnson, 1980, p.174). This differs from the complex responsive processes idea of time as iterative rather than linear, and experience as transformative (stable and changing at the same time), and therefore not repeatable. I wondered about this way of thinking about changing identities in terms of educational methods and reflective practice. When viewing time in the traditional linear way, with past, present and future as particular points in time, it makes sense to talk about historical events as if they are fixed in time, with the present as a point separating past and future. However, this view of time is not shared by all cultures (Abram, 1996). Shotter (1993) describes Whorf's work with the Hopi (Native Americans) who view time as carrying the past and future in the present in a temporal rather than spacial way

> "While currently we spacialise time and talk of it as a dimension of measurement, and think of ourselves as living somewhere upon that dimension "in" an historically changing world, the Hopi...dynamise space and talk of it as space in which their thinkings and feelings are in responsive contact with the influences at work in their surroundings" (Shotter, 1993, p.155)

As Shotter (1993) remarks, it is in bumping up against different ways of speaking and viewing the world which "saves us from being wholly entrapped within intra-linguistic realities of our own making" (p.116). Similarly, a complex responsive processes perspective sees time as a temporal process, continually forming the past and intention about the future in the experience of the present.

Referring firstly to Hegel, and secondly to Mead, Stacey et al (2000) suggest that

> "the source of change lies in the detail of interactive movement in the living present, movement of a circular kind that is reflected in the macro-sweep of time, past and future. In complexity terms this is a fractal process" (p.36)
>
> "the here and now is not simply a point in time but also has a temporal structure...The here and now then has a circular temporal structure because the gesture takes its meaning from

> the response (micro future) which only has meaning in relation to the gesture (the micro past), and the response in turn acts back to potentially change the gesture (micro past)...What is happening here is truly paradoxical for the future is changing the past just as the past is changing the future" (p.35)

From this perspective the past cannot be viewed as a discrete whole, but is rather being continually reproduced in the "living" present. Indeed, those writing about complex responsive processes use the term "living present" to describe this important point. This rather alien term requires the above explanation in theoretical terms, however, as dominant ways of speaking implicitly view time in a linear way. As Abram (1996) argues, in the West we are so focused on either the past, by obsessively videoing or photographing events, or concerned about the future with insurance policies for our cars or ourselves, rather than being aware of the living present. Abram (1996) vividly describes how he imagines time as a point separating the past and future like the centre of an hourglass, with balloons of past and future time separated from one another. As he increasingly focuses on the living present, he imagines the other dimensions shrinking and dissolving into the immediacy of the present.

In my narrative above, my conversation with my partner suggested a fixed past which I was reflecting on and which I needed to learn from. However, our conversation was changing aspects of the past in the present as I retold the story with intention about the future and how I wanted to appear to my partner and he to me, for example. From a complex responsive processes perspective what is considered important is paying attention to what is happening in the conversations I am having now, which includes aspects of the past as they are reconstructed in the present, as well as intention about the future. As I am participating in this continual interaction I am responsible for my actions and yet cannot know in advance how another will respond. Furthermore, my history and the context I find myself in limit the sort of response I am able to make. "Your gesture calls forth a response in me but only a response I am capable of making and that depends on my history" (Stacey, 2001, p.91). What becomes important is why I am having this conversation with myself and my partner about this consultation and what is emerging as we speak about it. I suggest that this was because of a difference in the micro interactions of my experience with the patient which threatened my "normal", habitual way of doing things and therefore my identity. How I see myself, (my identity) was emerging as a relational process in the consultation with the patient. Although consultations often seem similar, I realise that they are never repeatable and have the potential to change.

Building on this notion of how time is viewed, and therefore an emerging sense of identity, I continued to think about the idea of reflective practice as mentioned above.

Reflecting; or reflective practice

I was in a group of about 10 people at a complexity conference, who were asking "Is there a way of *applying* complex responsive processes or not?" I listened to contributions from people telling their experiences of how they made sense of their work. Someone was concerned that a new boss was directive and hierarchical and not informed by complexity ideas. There was discussion about hierarchies not necessarily being "bad" and that hierarchies and directive leaders emerge in some situations. Someone then said we didn't need complex responsive processes to understand what was happening. It was about being self aware and *reflective* in one's own practice. As the time allocated for the discussion was coming to the end, someone said they had been noticing their feelings during the discussion and were aware of feeling stupid. There was silence for a minute or two before someone thanked her and said they found it difficult to speak about feelings. Someone else said they felt the conversation had been competitive. Another said they felt a bit hurt as they were feeling confident and wanted to contribute to the conversation. I said I noticed how everyone was now leaning forward, engaged in the conversation and that I felt energised. After the group dispersed, there were further conversations between people and in the main group about the conversation that had taken place.

I thought about the comments that one doesn't need the theory of complex responsive processes to make sense of experience. Rather, self-awareness and *reflection* were important. In my example above, I sensed we were reflecting *as* we were thinking and speaking in the moment. However, I think there is something missing if the theoretical basis for "reflection" is based on a way of thinking of reflection as an "it" outside of ordinary everyday experience. The focus on learning from mistakes and reflecting on past experience is based on the traditional way of viewing time (as above). A process view, combined with insights from the complexity sciences about local interaction producing unpredictable and unrepeatable global patterns without any external plan, provide a different focus for reflection and self-awareness. However, at first glance the complex responsive processes approach to paying attention or refocusing attention may seem the same as a traditional view of reflective practice.

The literature, particularly in nursing, cites Schon as the originator of the thinking behind reflective practice. Turning to Schon (1983), the background to his work was in the loss of confidence in the

professions and the primacy of academia and research. Schon seeks to explore what it is professionals do in practice when research does not meet the day to day experiences of practice. For example, he says 85% of the problems a doctor sees are not in the book. Similarly, Goodman (1998) highlights the inability of nurses to describe what they do – which is often regarded as everyday, or mundane. Schon (1983) describes very clearly the messiness of practice as the "swampy lowland" of "experience, trial and error, intuition and muddling through" (p.43) which certainly resonates with my experience. He uses words such as "feel for", "improvise", "jazz" and "surprise" (p.55).

Traditionally, for the doctor who is expected to have the answers, to admit uncertainty would be a sign of weakness (ibid). However, Schon espouses a new reflective practice whereby the practitioner "gives up" his unquestioned authority and becomes more aware of frames which organise his practice. He advocates "reflective practitioners" and a "reflective contract" with clients, which acknowledges the exploration of meaning through reflective conversation with the client. However, rather than simply choosing, as a practitioner, to "give up" expert status Schon fails to recognise how this emerges in relation with the client. For example, often a patient wants me to tell them what to do, saying "you're the nurse". On other occasions I have felt like the guardian of resources when patients say "I need some antibiotics". Themes to do with roles and expectations emerge in the ongoing conversation and within the constraints of the context e.g. appointment time, interruptions from others etc.

Schon also describes how "in actual practice practitioners do, without paralysis, reflect-in-action" (p.281). He suggests "the fear of a paralysis...comes not from the experience of practice, but from a lingering model of practical rationality, which is in much need of reflection" (p.281). Perhaps there is a need to appear to be rational, and look professional. I think Schon is saying that we have lost the ability to focus on what it is we are doing in practice, instead thinking we need to learn technical rationality i.e. theory, before being able to *apply* this in practice. This also resonates with my own initial struggle to make sense of experience "from a complex responsive processes perspective", as if applying "something" outside of experience.

It is precisely this which I argue has happened, in the way these ideas have been used in advocating reflective practice in nursing. Reflective practice in nursing literature has been defined as a way to:-

> "Empower nurses to become fully cognisant of their own knowledge and actions, the personal and professional histories which have shaped them, the symbols and images inherent in the language they use, the myths and the metaphors which sustain them in practice, their nursing experiences, and the potentialities and constraints of their work setting" Street (1991, p.1)

However, what has emerged from education in nursing is the notion of reflective practice, which is often reified (or made concrete) as a separate activity from direct experience, often with an ideological tone, such as nursing as a "vocation". Palmer et al (1994) suggest a need for reflection to address the rapid pace of change in nursing and the demands of "high speed" care and at the same time individualised care required of them. Reflective practice is also a prevalent requirement for many professions, for many postured reasons such as the governmental (in many senses) lifelong learning agenda or professional or peer pressure. Betts (2004) suggests three main types of reflective practice, "theology, therapy and picket line", relating to the requirements of reflective practice.

She describes "theology" as reflective practice approaches in management education which seem to "embrace the notion of reflective practice as conformity to a kind of theological dogma, a notion of obedient development of a currently accepted competence about management which allies and aligns itself to organizational practice and aims" (Betts, 2004, p.242). This is similar to the notion of imposed cult values in organisations which must be conformed to, such as nursing as a "vocation", referred to above (Mead, 1934; Griffin, 2002). Betts (2004) continues "In this sense the mirror already has a reflection in it. In the mirror is a model, which needs to be matched. If the reflection is not in line with the model, then practices must be adopted which allow (or ensure) closer resemblance to the desired figure" (p.242). Reflective practice as "therapy", on the other hand demands scrutiny of the self, a "confessional" and self improvement, such as greater self confidence, empathy, assertiveness or "goodness" (ibid).

A third type of reflection

> "lurking between the two, rarely explicitly encouraged but sometimes simply, blindingly there, is..... a radical shift in perspective, a root-and-branch change in how the world is viewed, may take place and a new story is seen as an explanation for what is going on. Things can be different. The focus for this new view is about asking what it means that something is being done in a particular way. What set of assumptions allow for it to happen like that and how does the reflective practitioner react to those assumptions? Do they want to be aligned in that way and what are the consequences of a refusal to engage?" (Betts, 2004, p.244)

This idea resonates with the way I feel when making links and connections or when something strikes me as unusual, interesting or surprising, or provokes an emotional response, although not necessarily in the way "picket line" infers a protest. However, generally this happens in an unpredictable way in the constant stream of experience which includes ideological themes (theology above), self-reflection (therapy above) and feelings of resonance or dissonance (picket line). Models of reflection often provide a framework of questions for exploring experiences, however may be limited, as concerns are often more about completing the paper exercise and fitting responses to the questions asked. I suggest that all of the above are aspects of reflection, which are complex responsive processes of relating.

Another recommendation for a particular way of learning from one's experience, with the help of reflective educators, is proposed by Mezirow's (2000) theory of transformational learning. Mezirow's (2000) theory involves reflectively transforming the beliefs, attitudes, opinions, and emotional reactions that constitute meaning schemes, by a process of critical reflection. Catalysts for transformation are what he calls "disorienting dilemmas" – or situations which do not fit one's preconceived notions. Mezirow was influcenced by the constructivist thought of Freire (1972) who describes the process of conscientization, or "the deepening of the attitude of awareness" as "it is only as they rethink their assumptions in action that they can change" (pp. 80, 81). Constructivism assumes that meaning exists within ourselves rather than in external forms. According to Mezirow (2000), transformational learning involves becoming more critical and reflective, becoming aware of one's assumptions and testing them through a process of reflective dialogue. Reflective educators help with this process. Whilst these ideas suggest we learn by challenging assumptions when faced with a situation which doesn't fit with our current way of making sense, the suggestion is of a separate activity with an expert educator. Mezirow describes this type of learning as transformational, suggesting a particular form of reflection, which differs from that suggested by the theory of complex responsive processes where transformation arises spontaneously as individuals interact with one another.

However, it could be questioned whether there are situations which enable "good" quality conversations which allow for greater reflection. Betts (2004) remarks that not all students are capable of reflection – instead blaming others for difficult experiences. They are unable to examine themselves with any level of detachment. This typical way of viewing oneself (the individual) as split from the "other" (the social) shifts the focus of attention or blame onto something or someone outside of one's own everyday experience. Perhaps a lack of self awareness arises from this way of

thinking, or where there is a fragile sense of identity. The quality of interaction, where there is a feeling of trust, for example where I was able to share my experience with my partner, despite some differences in perspective allowed me to challenge established ways of thinking.

My attention is focused on my participation and a continuous process of making sense of my experience in a reflexive way. I am arguing therefore that reflecting (and reflexivity) is an aspect of complex responsive processes of relating and not a separate activity from ordinary experience.

I also thought more about this view of time and the non-repeatability of experience when I experienced a training session with a GP and trainee nurse practitioner.

The other side of the camera

I felt a similar sense of being expected to learn from past mistakes when watching a video of one of my patient consultations, used as an educational tool. Videos of consultations are commonly used for training GPs. I showed a consultation of a "routine" problem with a patient, which I felt had gone well, during a tutorial with a trainee nurse practitioner and GP trainer. I was keen to impress the GP and my nurse colleague. I chose a consultation which I thought would be a model of good clinical practice, although at the time both the patient and I had privately expressed our anxieties about the video tape recording us. We both admitted to one another that we felt we were performing for the video. It was like having a silent observer in the room and I behaved in a way which I thought was expected of me, for the "observer".

On close scrutiny of the tape, the GP noticed that the patient had mentioned her brother who had a catheter and I hadn't asked her about it (he suggested that without asking, I could not know if this was a relevant concern – for example, did the brother have bladder cancer?). I felt really bad about it and angry and confused as I felt they had spotted something which I, at the time, had not been aware of. Surely the patient would have asked outright, or on leaving, if she were concerned? Would I not have sensed her anxiety, as I was in the room sitting next to her, whereas we were watching on a video?

In the tutorial we were reconstructing a story with each other, whereas this consultation had happened several weeks before. The GP was giving his opinion as the "expert" i.e. more expert than me. Is this then a helpful tool to use for training purposes? Certainly I became anxious and felt I had shown myself to be insensitive to the patient on that occasion. Maybe I was so concerned to

produce a "model" consultation, based on showing my clinical knowledge and skills that I failed to "connect" with the patient. Perhaps the most important outcome from a traditional learning perspective would be if I had changed my practice as a result. No doubt the experience becomes part of my own, and others' history which may be recreated in similar situations. However, I did the best I could at the time. Situations may be similar but never the same, never the same patient in the same context, and with the same audience and therefore I am not sure how helpful it was. In this situation the camera had become the "objective observer" – or outside the continual process as it was emerging. Learning happens during experience itself. Many times I have reflected on my practice and felt uncomfortable about it and presume that this will affect me spontaneously in the moment rather than as something learned which will be stored spacially for future reference.

Turning to the literature I made sense of this "container" or "storage" way of thinking about learning as based on a systems approach and cognitive psychological assumptions - knowledge stored in individual heads. Freire (1972) describes this way of thinking about education as the teacher "banking" a "deposit" for the student to learn – or knowledge as stored or "contained" in an individuals head. From a complex responsive processes perspective, learning is a responsive relational process of communicative interaction (Stacey, 2001) - participative action rather than mimicry. Knowledge arises as themes patterning interactions which are constantly reproduced always with the potential for transformation of identity of individual / social at the same time. The conversations I am having with myself now as I make sense of my experience is also "learning". Knowledge, then, is seen as meaning making which is continually reproduced and potentially transformed in the action of communicative relating – it can't be shared or spread around, other than in the way themes resonate in ongoing interactions.

Thinking about the way identity and roles are emerging, I wondered how other complexity writers were viewing consultations with patients.

The Plexus call: patient as system or processes of relating

I finished reading the Plexus paper on returning home from a PCT meeting. I began formulating how I would respond to what the Plexus people were saying in their call to one another, where two doctors (Lindberg and Rush) are discussing how a complex adaptive systems view influences their ways of consulting with patients (www.plexusinstitute.org).

Rush is saying she thinks of the patient as a whole system and tries to help them to understand themselves that way. Lindberg responds saying

> "the perspective of complexity science helps me to cut to the quick faster. Complexity science helps me to help them understand why things happen as they do in a complex biological system. You have to give some suggestions and feedback. In complexity everything is connected to everything else....you are embedded in your family in your world and these things are influencing your particular situation, disease, whatever" (Lindberg www.plexusinstitute.org)

I find myself agreeing that a person's history and complex network of relationships and the environment in which they live or work affect the way a person makes sense of their experiences. However, I am beginning to think about the consultation as a mutual exploration or conversation between the patient and myself about what is going on.

Lindberg is saying he tries to move away from focusing on "fixing the broken parts" to assessing the system overall. He gives the example of measuring heart rate variability - referring to Goldberger (1996) as he says this oscillates over time and "is a very powerful prognostic tool". I am thinking that this sounds like focusing on the parts of a system. However, I have read about Goldberger's study which highlights that variability is a sign of health, whilst a state of equilibrium a sign of death, which is contrary to historical views of health as stability being the "norm". Rush says she also measures heart rate variability and also focuses a lot on sleep – "I believe it is key to the maintenance of interconnectivity of the whole system". She says she asks the patient "Hey hey what is going on in your life?" as she thinks there is usually some "emotional crisis". Emotion here is described as a crisis rather than emerging as a dynamic process of experience.

Lindberg then reflects my increasing feeling about the way my consultations follow a particular pattern of a medical examination.

> "the problem I've found with the traditional medical exam is that it is a formal protocol that you follow intended to make sure you are covering all the bases. But it comes across as not a conversation but an interrogation and you cut off the patient when they go off into tangents. What I try to do (is to)..... solve a mystery. This is a non linear conversation. There is no agenda. We just say whatever comes to our mind or at least I start doing that e.g. "you look worried". It is a very natural thing" (Lindberg, www.plexusinstitute.org)

Rush says she asks "well what do you think is going on?" so then "we can proceed in partnership and so the sooner it is a kind of co-exploration". I often say "What are your thoughts?" to patients,

which I noticed one of the GPs at the practice saying. Some of the ideas I learned during a counselling course also help with reflecting what the patient has said by summarising, and allowing patients time to think and speak. There is then the idea of a co-exploration. However, rather than solving a mystery, which also reflects the detective way I often try to discover what the "problem" *is*, I am beginning to think that this is emerging as we relate to one another in the moment. Perhaps the feeling of Aha moments, which may seem as if the mystery has been discovered, is more a feeling of resonance between us, or a feeling of being understood.

Lindberg then makes the point that some areas of health care need a "fix the parts person" – such as orthopaedic surgeons. I also recognise there are practical physical things I do e.g. listen to a chest or dress a wound, but at the same time I an interacting with the other person all the time, negotiating what I can and can't do. I am thinking about how bodies relate to and resonate with one another, and the environment – relational rather than closed systems. The body can be regarded as having a boundary like the skin, but on closer examination from a biological perspective we can be viewed as processes which are inseparable from our environment (Goodwin, 1994; Maturana & Varela, 1987). For example, the physical response of a mother to her crying baby, or intense feelings during a thunderstorm. Biological and social processes in this sense can't be separated from each other.

So is my emerging sensemaking from a complex responsive processes perspective saying anything very different from the complex adaptive systems approach taken above by Rush and Lindberg? The general stance taken is one of being outside the system, observing, facilitating and fixing where possible - focusing on an individual body as a whole biological system, rather than meaning emerging as we are relating together in the moment. Rush and Lindberg recognise that an individual is embedded in a family network and context. However, this is not a static given, but is continuously created. Lindberg advocates facilitation of spontaneous conversation and creativity and allowing a rhythm or wave to happen, which suggests the ability to control and expresses his intention. However, his own presence in the process of interacting with a patient in the moment seems to be lost from the discussion about what they are doing, taking the position of expert, and outsider.

Wilson et al (2001) also use the complexity sciences to argue against the way of thinking which treats the body as a machine.

> "neither illness nor human behaviour is predictable and neither can safely be "modeled" in a simple cause and effect system. The human body is not a machine and its malfunctioning cannot be adequately analysed by breaking the system down into its component parts and considering each in isolation. Despite this fact cause and effect modeling underpins much of the problem solving we attempt in clinical encounters; this perhaps explains why we so often fail" (Wilson et al 2001, p.685)

In relation to diabetes, they suggest that this cannot be managed according to a linear cause and effect model, and the patient must also use their intuition. However they suggest multiple variables may ultimately be analysed with a neural network software system. They also advocate exploring the patient's shadow system and working alongside it, when trying to move the patient to a state far from equilibrium, whereby they are more likely to change. Whilst using complexity metaphors, they maintain an objective observer position and disregard relational aspects such as power relating and anxiety. They also disregard the inevitable unpredictability of "a state far from equilibrium" – or the edge of chaos metaphor.

Wilson et al (2001) also make recommendations for consultations with patients, based on a complex adaptive systems approach, when in the "complex zone" (i.e. in uncertain conditions), which they have adapted from Zimmerman (1998). They suggest:-

> *Use intuition and muddle through*—Doctors frequently make what would be the best but not definitively the"right" decision on the basis of experience, evidence, and knowledge of the patient's story
> *Experiment*—Try different management options with patients, using an empirical trial of treatment
> *Minimum specification*—Offer patients general goals,suggestions, and examples but do not attempt to work everything out for them—your tidy solution is unlikely to be compatible with all aspects of their lifestyle and values
> *Chunking*—Instead of trying to sort out every problem, try solving one or two (using problem solving techniques); other solutions may follow naturally once a new pattern has emerged
> *Use metaphors*—Communication can be difficult when issues are complex. Using metaphors can often create a shared understanding—for example, "you seem like a tree bowed over by the wind" or "what does that last hypo remind you of?"
> *Provocative questions*—Ask questions that might throw light on basic assumptions, especially when the patient is "stuck"—for example, "if you got better, might this

cause some problems for you?" (Adapted from Wilson et al 2001, p.686)

The authors do not suggest how patients may respond to the above. Perhaps what they are advocating here are observations about what GPs *do*. The problem is then how to *apply* the tools. Whilst I recognise the above as arising in many consultations with patients, I find this is a more fluid response in the moment, to what the patient is saying. Focusing on tools, or "performing for the camera", may distract from how I am also intuitively responding to feelings, or "gut feel" and the patient's response, in the moment. I have found that when paying attention to a tool or technique I am less able to respond to what the patient is saying, and more likely to irritate the patient. Perhaps the above also allow practitioners to retain their sense of identity as an "expert" and "in control".

I turned to the literature to try to understand how the doctor – patient relationship has emerged.

Changing identities: a historical perspective

The literature surrounding the development of health care and the roles of patients, doctors and nurses reflects changes in identity and therefore power relations between individuals and society. This can be understood from an Eliasian perspective emerging as unplanned processes from the interdependencies between people. It has been suggested that prior to the 18th century, doctors gained the custom of their patients by being well mannered, sociable and by listening to them, with minimum physical examination (Hogarth and Marks, 1998). With the development of hospitals in the late 18th century the balance of power shifted as doctors became skilled in classifying disease in large numbers of people, and physical examination of the body could be measured precisely with new instruments such as thermometers, auroscopes etc. They became less reliant on the patient's story and unique histories – looking instead for common characteristics of disease in different people. Furthermore, prior to the 19th century, disease was seen as a holistic deviance from a natural state – later becoming an accident where disease had seized upon the object of man (ibid). Donald (1998) describes the meta-narratives of disease as "punishment; as a sign of holiness; virtue; idleness or poverty; as the result of imbalances in the body; or of invading organisms" (p.22) – or several of these simultaneously. Patients then put their faith in an expert whom they did not question (Kennedy, 2003).

The concept of an "expert" has more recently been challenged. "Both are experts in their own fields—the doctor in clinical matters, and the patient in his or her experience, feelings, fears, hopes, and desires" (Kennedy, 2003, p.1276). Arguably, Balint's (1957) work in the 1950's, had begun to change this view. Studying complex cases with other GPs, he recognised the doctor's part in the outcome for the patient. He suggested that

> "it was not only the bottle of medicine or the box of pills that mattered, but the way the doctor gave them to his patient – in fact, the whole atmosphere in which the drug was given and taken" (Balint, 1957, p.1)

He goes on to argue that the doctor can actually do harm to the patient, for example, by ordering unnecessary tests, causing unnecessary suffering. Balint's work helped GPs to appreciate the way "two narratives intersect in complicated ways within medical consultations, the patient's and the doctors" (Hogarth and Marks, 1998, p.144). Although his work shifted the attention onto the patient's narrative, it has been argued that there has not been a significant difference to the training and accreditation of medicine (Greenhalgh, 1998).

Indeed, much of the current literature and research on consultations with patients examines behaviour change, educating patients and ensuring they follow agreed treatments, previously termed "compliance". Donald (1998), however, argues that evidence based practice has shifted attention and power from the doctor as "expert" to the relative truth of statistical odds – by studying what treatments work, although arguably for the "average" person who often does not exist (Bradshaw, 2000). More recently, research has explored how "compliant" doctors are with following evidence based guidelines and suggests this is difficult to achieve (Ferlie et al, 2000). The new concept of "concordance", also arguably reflects the changing themes of patients as receivers of health care, to patients as customers, and now as partners in the way health care is provided. "The concept of concordance suggests frank exchange of information, negotiation, and a spirit of cooperation" (Mullen, 1997, p.691). However, some still implicitly assume that concordance will ultimately result in patient compliance (Mukherjee, 2003). Despite today's espoused model of "patient centred care", some patients are still blamed for "non compliance" if they do not follow advice given. Although the term "concordance" can be viewed as arising as "official" terminology e.g. from people in government, this may reflect a shift in patterns of power relating in society more widely. What it means to be a doctor, patient or nurse, arises in my micro interactions with the patient, and this is also reflected socially, at the same time. In other words there are shifting balances of power between doctor, patient and what is regarded as "truth".

Arguably, if the doctor is viewed or views herself as an expert, with hidden knowledge or truth, power relations are preserved, thereby constraining the conversation and limiting the possibility for a negotiated "truth" for the doctor or nurse and the patient. Benner's (1984) work in nursing suggests how novice nurses gradually become "experts" when they rely on intuition – or "gut feeling", or a "sense of uneasiness" which embrace all aspects of experience in order to make sense of a situation. I remember as a "novice" nurse practitioner a GP asking me – "what barks, wears a collar and has three legs?" I looked puzzled – and he replied "a dog". He was able to convey the idea that no two "text book" cases are ever exactly the same, and the idea that experience in recognising and noticing similar patterns in what I saw and what the patient was telling me were what was important.

From a complex responsive processes perspective I make sense of expert knowledge emerging in relation to others rather than being stored or held in an individual. Becoming an expert in diagnosing "acute illness" only makes sense in the context of a medical model in primary health care. Meaning may therefore be limited to those who share common understandings. For example, abstract- systematic frameworks (Stacey, 2001) such as medicine, may provide meaning from within that framework e.g. what raised blood pressure means, and yet may have a different meaning for a patient who feels well. In each consultation with a patient there is a negotiation of meaning emerging in the relationship, rather than being stored in my own head as an expert. The reifying of "expert" and "knowledge" as belonging to someone changes as I make sense of knowledge and expertise as processes emerging and potentially changing in interaction between people. However, a systemic approach dominates consultations with patients where the main task is to identify a "problem" and provide a "solution".

Research has suggested that patients seeing their GP often leave feeling their problem has been inadequately addressed (Williams et al, 1995). It has been argued that patients often have an idea or story of their "problem" or "solution", although they may not tell the doctor in the consultation (Heath, 1998). The idea of eliciting a problem and trying to fix it, perhaps reflects historical perspectives of positivism and systems thinking – where the "problem", or the "test results" become an "it", detached from the ongoing processes of relating to one another. Indeed, Marinker (1998) argues "the notion of disease is essentially abstract – an ideal model, a template against which the more untidy experiences of individual doctors and their patients can be tested and observed" (p.105). The role of the doctor is viewed as the interpreter of the patient's complex

narrative, to assess what is *really* going on (Greenhalgh, 1998). The patient's messy story is sorted into one or two clear physical or emotional "problems" which are dealt with one at a time, to find the "solution". This assumes there is an external reality to be discovered and the ability of the doctor to determine "it". It is interesting that where clinician agreement on diagnosis has been compared, there is "a singularly unimpressive level of agreement beyond chance" (Greenhalgh, 1998, p.249). Attempting to reduce the problem to one clinically recognisable, may miss the many interrelated concerns a patient brings and may leave the patient feeling dissatisfied that they have not felt listened to.

There has been a growing recognition of the importance of narratives, or the patient's story, in general practice in particular. Launer (1998) taking a social constructionist perspective suggests a search for an appropriate new story for each patient. Indeed, it has been argued that professional expertise takes an exclusively narrative form, made up of "illness scripts" – of all the patients seen with similar and contrasting stories (Hogarth, 1998). Whilst some approaches recognise the importance of listening to the patient's narrative, and the doctor's, or nurse's, part in determining the "outcome", the traditional view of a consultation follows a linear medical model.

Rather than assuming there is a "problem" and a "solution", Arthur (1999) suggests we face continually unfolding stories or situations. I recognised this when seeing a patient who was a frequent attender. I had often felt frustrated and anxious to "sort out" his problems. However, on one recent occasion I felt uncomfortable as I was trying to draw the consultation to a close. As I recognised my feelings and stopped talking, the patient then revealed personal concerns he said he had not felt able to disclose previously. Although on this occasion this took longer, there seemed to be a shift in the pattern of the conversations we had been having. This calls into question the constraint and the myth of the ten minute consultation (Heath, 1998). Increasing demands on health care necessitates shorter consulting times to enable more patients to be seen. Whilst this arguably contains the anxiety associated with attempting to meet the needs of so many people, the potential for trust to emerge and emotion to be expressed and thus the potential for spontaneity and change may be limited (see also Chapter 7).

The anxiety of being in a new role may lead to attempts to stick to habits and norms and familiar patterns of doing things. I have recognised the formal ways and habits I use, involving recognisable stages of taking a history, a physical examination, making a diagnosis, and negotiating a treatment plan with the patient. This feels safer, particularly in a context where there are fears and threats of

litigation. Routine practices are "safe" for me, the patients and the "organisation", producing stable patterns, routine and security. This helps to remove some of the anxieties surrounding uncertainty. However, as my narratives highlight, there is always the potential for change in the "normal" patterns of relating in a consultation.

However, roles of doctors, nurses and patients were previously more clearly defined. As roles become blurred, with nurses taking on doctors' work, and patients becoming more like customers or clients, boundaries soften. Elias (1939) suggests a dynamic whereby as groups become more homogenous e.g. patients, nurses and doctors, differentiation from others becomes more important to maintain, in order to impose renewed heterogeneity on oneself and others. I have found Elias and Scotson's (1994) study of community groups at Winston Parva helpful in making sense of what Elias calls "interdependencies", or power relations between interdependent people. A new group of people moving to an estate were described as having lower status and morals by the established group, despite no other racial or class differences between them. Elias and Scotson observe the way the established group describe the newcomers as "lazy" and "delinquent" and how the established groups' "stricter morals....enhance the chances of a superior group to assert and to maintain their power and superiority" (p.153). Furthermore

> "adherence to the common code serves their members as a social badge. It strengthens the feeling of belonging together in relation to "inferiors", who tend to show less restraint in situations in which the "superiors" demand it" (Elias and Scotson, 1994, p.153)

I understand this as themes emerging, which help to sustain the identity of individuals and groups, such as medical terminology which includes some and excludes others. However, more informed patients with access to the internet, for example, may threaten the expert status of clinicians. As I take on the role previously undertaken by a doctor, I recognise I enjoy a feeling of status, working in some ways like a doctor, yet still a nurse, and feel uncomfortable when this is challenged by a patient who comes to see me and states what she wants from me – which resonates with feelings of being a "servant" nurse!

My own experiences of being a patient highlight for me some subtle assumed norms of practice, and different expectations in different situations. I notice how ways of doing things which seem "normal", as well as bumping up against those which jar, stand out for me more than in situations where I am so engrossed in what I am doing in a habitual way.

On the Couch I

I attended the local hospital for an ultrasound scan. I had been instructed to drink two pints of water an hour prior to the test. As I waited for my appointment, I watched the cleaner walking slowly up and down with a large mop, in the corridor where I sat checking my watch and feeling increasingly uncomfortable. Another lady sat down next to me, saying she was nervous and had been unable to drink that much water. A nursing assistant popped her head around a door saying sorry for the delay, but that they were just waiting for the doctor to arrive.

A little while later the lady sitting next to me was called though to a room out of sight, appearing again half an hour later, by which time I was very uncomfortable. It was now my turn (half an hour late) and as I entered a darkened room a nursing assistant asked my date of birth. The Sister, in a navy blue uniform, asked me to climb onto the couch. From behind a screen emerged a bearded man who was introduced to me by the Sister as Dr X. He didn't speak other than to ask me what side the pain was on. He sat down on a chair by the couch and proceeded to stare at a screen while he scanned my body. I felt rather vulnerable lying there, as if my body didn't belong to me as a person any more. I felt anonymous as they all three gazed at the monitor, and the doctor commanded "Deep breath....hold it" to me every now and then, or asked me to change position. On one occasion after being instructed to take a deep breath I wasn't instructed to let it go again. Eventually I had to continue breathing! The nursing assistant asked if I was alright and I said "yes, but I'm afraid I had to start breathing again!" I relaxed a little as they all started to laugh, the doctor apologising, saying "we get so engrossed in the screen that the patient ends up going blue on the couch". The doctor then started to ask the nurses what they thought various parts of the screen showed of my "insides". I still didn't feel part of this conversation.

As I got up to leave, I hesitated, wondering if I dare ask what, if anything, they had seen which may indicate a problem. I didn't think it was the norm to ask for the "results", as I knew they would be sent to my GP. I tentatively asked "Nothing obvious then?" The doctor replied, "No, I'm afraid not".

On the Couch II

The following week, I was on holiday in a hotel in the West Country. The weather wasn't wonderful – April showers, so we had booked into a hotel with leisure facilities. A leaflet in the room listed various treatments available and their prices.

As my partner wanted to watch the Grand Prix on the television, and feeling rather stiff after the journey, I decided to treat myself to a massage. This was an adventure for me. I had had one once before and was surprised that I actually quite enjoyed it, despite having been anxious about what it may entail, especially the thought of someone touching my body.

I nervously attended at the allocated time for my session. The therapist, a complete stranger, smiled and led me into the darkened room where music was playing softly, candles were lit and there was a pleasant, relaxing aroma. Once settled on the couch, we chatted as she massaged my neck and back. I wasn't expecting to chat, as I had assumed after my previous experience of a massage that you were supposed to be quiet and relax. However, our conversation continued around the themes of holidays, families and our experiences of work. Time seemed to disappear and after the session had ended I had no idea of how long I had been lying there and was feeling quite relaxed.

Afterwards, I reflected on how very different these two experiences were, despite the similar theme of being "on the couch". I reflected on the habitual themes that have emerged over time to make these rituals or practices seem "normal" and yet there were opportunities for variation in what was emerging, in each context. These rituals also enabled us to feel "safe", to have some sense of what to expect. There were constraints to the possibilities of what might happen and yet these enabled us to proceed with what we were expecting to some extent.

The main theme for me was the theme of power and how this emerged in each context. For example, I was aware of the roles of doctor, nurse and patient, and how my expectations of each constrained what I did and said but also allowed the procedure to take place without questioning every detail of who does what. I relate this to Griffin's notion of power as enabling constraints (Griffin, 2002). I immediately noticed the nurse in uniform. This conjured up aspects of my historical experiences of nurses, which included being a nurse myself, and other aspects such as "caring" or "subservience" which arose for me in the context of the experience of the present. Our restrained communication didn't allow for any variation in my impressions of the Sister or junior nurse. Similarly, I reflected on my communication with the doctor, where in the moment I chose to ask, albeit in a tentative way, if he had seen a "problem". In that moment I felt he held the crucial information I was looking for and in that way I was dependent on him. Power in this sense was related to my dependence on him for information. However, he also depended on me to allow his work to continue. I recognise the way I sometimes try to avoid showing any reaction which a patient may pick up on, when I refer them to a doctor to obtain "results" of tests.

Griffin argues that ideological themes organise our experience of being together as power relating, or enabling constraints (Griffin, 2002; see also Chapter 6). Our categorising confirms who we are and excludes others, at the same time. In order to belong to a group we are both enabled and constrained by the ideology, or expected ways of behaving, of the group. Power in this sense is not something we can do without. Elias and Scotson's (1994) idea of power as interdependencies which limit the scope of our response, also seems to express what was going on in my experience above, rather than being due to someone having power over another as external to experience.

> "There is a certain abhorrence against the idea that "societies" or to put it less equivocally the configurations which individuals form with each other exercise some power over the individuals which form them and limit their freedom. ....configurations limit the scope of the individual's decisions and in many ways have a compelling force even though this power does not reside as it is often made to appear outside individuals, but merely results from the interdependence between individuals" (Elias and Scotson, 1994, p.172)

The process of categorising e.g. "nurse", "doctor", "patient" also sustains differences – those who are "in" and those who are "out". In making sense of what is happening I am inevitably categorising and simplifying when I use words such as doctor or nurse, reflecting conscious or unconscious ideological themes. I made assumptions about the meaning of the nurses' uniforms, for example. I also noticed how my body being "examined" seemed separate from me as a person, and reflected on the dominant view of the body as machine, or parts which need fixing if they go wrong and the health / medical model. However, there were many other interacting themes going on for me and presumably others present not limited just to assumptions about roles.

In the second experience of being "on the couch", I experienced this treatment on a different basis. Interestingly, I hadn't noticed whether the therapist was in uniform. I reflected on the relationship I was developing with this stranger, which included other aspects of ourselves including our families, work and holidays. This resonates with the view of power as not something static - or as not being something one holds (e.g. in one's pocket) but rather emerges in a co-dependant relationship (Elias, 1939). This always happens in the continual flow of conversation which contains reconstruction of some aspects of historical past, although different for different people. However, the way we perceive power affects the responses we are likely to make. For example, my perception of a doctor being more powerful, may limit the choices I have in the way I respond. A complex responsive processes perspective is challenging the way I think about power, and my ability or choice to respond in a different way.

I reflected on how it feels to be the "patient" of an "expert" and how my choice of response seemed to be between complying, or rebelling. I am wondering how I can respond in a different way which will allow the potential for a different type of conversation. I am also reflecting on my own habitual patterns of behaviour when I am the "expert". I have questioned my role as a "nurse practitioner" working with "patients". What is it I am doing when I examine patients on "my couch"? How is this stable and changing at the same time? I am aware of "speaking out loud" as I make sense with the patient of what is going on, rather than necessarily coming up with a definite diagnosis or "solution" to a "problem". Paying attention to these themes as they are emerging inevitably allows the possibility for something new to emerge, which may be "good" or "bad", or both, and never knowable in advance.

I also recognise how established ways of behaving may reproduce established patterns of power relating with me as the "expert". I recognise how power relations are maintained in a number of ways. The way I position my desk, the height of my chair, and whether the patient can see my computer screen, are sometimes unconscious ways of preserving power relations (Mizan, 2004). Changes in identity also feel threatening and anxiety provoking and there may be attempts to maintain the current power relations. My own response to the difficult consultation I described earlier was to question what was happening, and blame myself, as perhaps my own sense of identity was more fragile in this new role. Where one's identity is threatened in this way, the response may be defensive and blaming, or fantasising about the other person or group (see Chapter 4).

> "Such shifts generate intense anxiety and communicative action is recruited in some way to deal with this existential anxiety. These ways may be highly destructive of effective joint action and may even completely disrupt the reproduction and creative transformation of coherent communication" (Stacey, 2001, p.156)

When I later heard that the female patient I describe at the beginning of the chapter, had been asked to find another GP surgery, due to "communication difficulties", I related this to feelings of anxiety, suggested above. It was suggested that the patient might have a "personality disorder". Labeling or categorising in this way arguably allows or enables a particular way of speaking and acting – in this case exclusion from further communication and potential change. Similarly the way people are categorised at "patient" or "nurse" or "doctor" makes assumptions about identity which may be perceived as threatening – or potentially excluding. I am finding that by understanding that changing patterns of relating are anxiety provoking, I am more able to live with that anxiety.

In my consultations I also notice how dichotomies are evident in the way I am thinking about health and illness, mind and body.

Making sense; a relational perspective

A female patient is telling me about a severe headache she has had for a week. I ask her what has been happening? She mentions some "bad news" a few days ago. I get up to take her blood pressure trying to make sense of what she is telling me. I am aware of her telling me about the "bad news" and wonder what this might mean but am concerned not to seem to be prying. I repeat what she has said to me "You said you had some bad news on Sunday". She tells me her ex-husband has just been released from prison. She says she is anxious, as there is a court order saying her ex-husband isn't allowed anywhere near her and her daughter. I begin to feel an "Aha!" moment as this begins to make sense for me. I ask if I can feel her neck, wondering if her body is as tense as the situation she is describing. She jumps as I press on the tense muscles of her neck. We agree that her headaches are probably made worse by this situation. I am feeling that together we have made sense of what is happening for her. She has been able to speak about it and a way forward which seems to makes sense to her too.

As discussed above, patients usually present a physical "problem" to be fixed, although there may be a complex mix of what they think the problem is and what is expected of them as a patient – sometimes detaching their bodies from their mind. The patient then allows intimate examination of their body, which has gone wrong. Indeed, feelings and emotion have become a fragment of specialist medicine dealt with by a psychiatrist (Marinker, 1998). Specialisation reduces the person to different parts of body and mind (ibid) and denies their inseparability, and of health and ill-health being in a continual dynamic. The concept of experience and the mind in Western culture relies on a metaphor of a container e.g. "my inner feelings and thoughts" (Lakoff and Johnson, 1980), or "in our minds", or "the forefront or the back of our minds" (Shotter, 1993, p.108). However, the neuroscientist Damasio's (1999; Damasio, 1994) work on the brain, consciousness and emotion suggests mind and body are inseparable (see Chapter 8).

I am aware of how my own bodily reaction often resonates with a patient's anxiety or anger and how I constrain myself from showing this as far as possible, trying to remain calm and controlled, in my "role" as nurse practitioner. Emotional labour, where emotional self-constraint becomes important in particular role e.g. air hostesses, and nursing (Bunting, 2004; McQueen, 2004;

Hoschild, 1983) is well recognised. I will take up these themes further in Chapter 8. However, my emotional response to the "difficult" consultation produced dissonance with a pattern which is habitually reproduced in consultations with patients. I felt as if the patient's emotions became my own as I experienced feelings of helplessness. Dowrick and Shildrick (1997) highlight how emotions of both the clinician and the patient emerge in consultations thus

> "the dichotomy between well and sick, doctor and patient, is replaced by a more subtle and honest interchange of needs. For example, during a recent consultation I was feeling extremely stressed and anxious. Three patients noticed my distress and offered me sympathy and encouragement. All three have very severe mental health problems but were able and willing to give support as well as receive it." (Dowrick and Shildrick, 1997, p.1243)

Indeed, Damasio (1994; Damasio, 1999) recognises the possibility for resonance or similar feelings between two interacting individuals. More recently I am conscious of how I am *feeling* in the consultation and wonder whether expressing this may provide the opportunity for new meaning to emerge. Interestingly, where I felt an emotional response and dissonance in my experience in my first example this enabled further conversation and reflection.

Although my perception of what is going on is changing, the implications for this way of thinking initially seemed constrained in the context of the patient's expectations of me and other constraints such as time. However, I am beginning to notice my own feelings, such as a tightening of my stomach or a sense of unease and how I may respond by asking a question, for example. I am noticing how the questions I ask may contribute to the emerging story as we are making sense of what is going on. Rather than trying to find the "complaint", I am making sense of why the patient is "complaining". Rather than focusing on "what is wrong?" or "what has to be done?", which splits thought and action, problem and outcome, I am beginning to focus on ongoing processes by asking - "what is happening?" or "what sense are we making of this together?" In other words, I am beginning to think about my own consultations as an *emerging relational process*, where meaning is emerging in the interaction. I hope to show how my experiences with patients reflect this way of thinking in further chapters.

I conclude with a short example which expresses a shift in my practice.

Meaning in the moment

A patient is telling me about a recent illness. I ask several questions and the patient thoughtfully responds. I am puzzled by the history and ask a colleague to join us. I give a brief summary to my colleague concerning what we have discussed so far and the patient chips in. I find that my colleague is asking similar questions but the patient responds differently, sometimes giving different answers to the questions I have already asked. Gradually a pattern emerges about the patient's illness which seems meaningful.

Previously I would have felt that I had not elicited the patient's problem accurately. Now I see this as emerging in the relationship between people.

Summary

My experiences above explore aspects of what it is like to work in my role as a Nurse Practitioner seeing patients in a general practice from a complex responsive processes perspective. The fundamental differences emerging for me, in this way of thinking about consultations, are firstly, in the way identities are continually emerging from micro interactions, as what it means to be a nurse, doctor or patient is continually being negotiated. I notice some of the ways I maintain my position (or identity) such as following habitual procedures and using labels which keep the established balances of power. Paying attention to what is happening in those micro interactions there is always the potential for habitual patterns to change. This has heightened my sense of responsibility in the moment for noticing and responding to my own and others conversation, body language and feelings in the moment, as I am viewing consultations as *emerging relational processes*. This way of thinking about consultations with patients allows me to consider whether my sometimes "stock phrases" are less likely to produce change. I am also thinking about the potential for my own responses to make a difference, by asking different questions and recognising and acting on my own emotional responses in the moment.

Secondly, viewing time as continuous iterative processes has significant implications for what reflective practice and education mean from this perspective. Similarly, process thinking has implications for notions of "problem", "expert" and "knowledge" as ongoing processes of power relating rather than fixed states. Rather than focusing on something outside of direct experience the focus is on what I am thinking and doing in the moment, which includes aspect of the past and intention for the future.

In this chapter I have explored the themes of identity and how this is changing in the context of my work as a nurse practitioner consulting with patients. From a complex responsive processes perspective, change is also seen as changing ideological themes (see Chapter 4). My next chapter moves on to explore the theme of Patient and Public Involvement and how I am living with "imposed" ideology from a complex responsive processes perspective. Themes emerging above, such as power relating and anxiety are also evident as a continuing thread throughout these narratives.

Chapter 6: How I am living with the ideology of Patient and Public Involvement, or living with changing ideologies and power relations

In Chapter 5 I make sense of my experiences of change in the context of my work as a Nurse Practitioner. Implicit in the narratives are expected ways of behaving as a doctor, nurse or patient as they arise in everyday conversation, which reflect changing identities and ideological themes. I now want to explore the notion of ideology further, through my own experiences of living with ideological and cultural themes as they emerge in the context of my work as Nurse Executive/ Board member of a Primary Care Trust. Change, from a complex responsive processes perspective, is seen as changes in ideological themes organising our interactions. Using narratives of my experience I will explore how ideology as policy change, culture and values, surrounding the theme of Patient and Public Involvement, arises in everyday interactions.

A number of themes emerge here, which mirror those in the previous chapter on identity. In exploring the theme of Patient and Public Involvement (PPI), I show how ideological themes, traditionally seen as "out there" or "imposed" arise and are continuously negotiated in my daily working life. Whilst enabling us to talk about something (e.g. Patient and Public Involvement), I argue that when reifying in this way, the original intention (for example, improving patient care) may be lost as we focus on a task, such as "patient surveys". I also argue that "imposed ideology" exists only in the way we perceive it as such. Perceiving an external "controller" such as the government or PCT affects *how* we speak and act in everyday processes. I highlight how ideological themes allow a feeling of devolved responsibility or a reason for *not* doing something, as well as a feeling of enabling one to do something.

I explore how habits and norms (ideology) emerge in enabling and constraining ways which either sustain or change current power relations. I focus on a meeting with the theme of the Expert Patient, exploring how ideological themes express who is "in" and who is "out" and thus feelings of inclusion or exclusion. Evident here are also feelings of shame for not complying, and feelings of anxiety in challenging the accepted ways of speaking and acting. Conforming to expected ways of speaking then becomes "safer". However, I propose that paying attention to what I am doing in this way makes me aware of the potential and risks associated with speaking or acting in a way which may shift the conversation, or ideological themes, as they are emerging.

Where then, does the idea of Patient and Public Involvement (PPI) come from? Does PPI label or reify an emerging ideological theme? How does this "ideal" influence how we think and act or the conversations we are having? Taking a macro perspective these changes are emerging in the language of new policies, and changes in how patients are described over time as passive recipients, or customers, or partners in receiving health care. These themes, or ideology, from a complex responsive processes perspective, are organising everyday conversations as they are changing and stable at the same time. I will briefly discuss the background to the theme of Patient and Public Involvement, before exploring what this means in day to day working life.

Background: The theme of culture change: putting the patient at the centre

The explicit aim of The New NHS is to provide "modernised" services based on the needs of the patient, whilst involving them as partners in the provision of care

> "where the voices of patients, their carers and the public are heard through every level of the service, acting as a powerful lever for change and improvement" (DOH, 2001a, p. 2).

Furthermore, the NHS Plan (2000) talks of the need for culture change, to put patients and the public at the centre of the NHS. The aim is to "strengthen accountability to local communities, speed up change and create patient responsive services" (DOH, 2002). NHS organisations are seen to be responsible for involving patients in the planning and delivery of services, with targets for involving the public featuring highly in Trust Accountability frameworks.

In primary health care, Primary Care Trusts are responsible for making decisions about the health of local people and commissioning (purchasing) health care from providers such as NHS hospital Trusts. The aim is to rid primary care of inequalities and promote closer working with the public on local health issues (DOH, 2004a; DOH, 2003; DOH, 1999) For the first time, lay people hold positions on PCT Boards. South's (2004) study reflects a reified view of PPI by reporting that PCTs can "make progress in implementing patient and public involvement as a legitimate and significant activity for primary health care organisations" (p.132). From this perspective Patient and Public Involvement then becomes a "thing" which can be "implemented".

Whilst the intention arguably reflects a shift in power relations, these aims could be regarded as having an element of fantasy about them, suggesting the public can be *put* "at the centre" of the NHS. Where anxieties are high, with life and death situations and scandals, such as those described earlier, conversational life is characterised by a high degree of fantasy (Elias, 1939) and other

emotions. I was struck by the following quote by the GP Chair of the NHS Alliance[6], reminding me of my own fairy story, with fantasies about magicians, heroes and villains (see Appendix 2).

> "It was time to 'get rid of the mad magician of Whitehall' which treated frontline primary care managers and clinicians as 'rats that run around the magician's maze, jumping to his commands' and whose views were ignored" (Harding, 2004, p.5)

This perhaps reflects the anxieties felt by GPs of being "controlled" by government policy and ideals. However, in Mead's (1934) terms new policies can be regarded as "gestures" from those in authority (such as the government), which demand a response from those involved in health care. Ideological themes emerge from local interaction (e.g. ideals, values, policies, visions, mission statements), which in turn influence the sort of conversations we are having, which in turn affect emerging themes. However, they are often viewed as something separate from, and outside of, continual interaction which determines our action as individuals, on the one hand, and as a personified organisation, on the other.

> "Idealised values emerge in the historical evolution of any institution and these are ascribed to the institution itself" (Griffin, 2002, p.198).

Griffin uses Mead's (1934) term "cult values", which are "collective idealisations that divert attention from the detail of interaction in the living present" (Griffin, 2002, p.116). Cult values are those which are thought of "as if" they are an object (e.g. PPI in the example above, or "a national commitment to democracy" (Griffin and Stacey, 2005, p.141)). Indeed, Griffin argues that this way of thinking, which leads to thinking we are victims of a system, may actually be damaging, in the way that responsibility is attributed to an abstract "whole", or alternatively to one person, for example the Chief Executive of an organisation.

Furthermore, Stacey and Griffin (2005) stress that, rather than an external whole determining our behaviour, ideology can only be found in the human experience of interaction, where it is particularised and functionalised, and is always evolving. In other words, ideological themes only exist in the way they are continually negotiated as we interact with one another to progress specific events (particularised), such as involving a patient in their own healthcare by discussing treatment options (functionalised), with competing ideals such as cost effectiveness, or equality. My interest, therefore, is in exploring what it means to pay attention to my own experiences of living with policy change, or gestures suggesting a need for "culture change", in my daily working life. The

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[6] see Appendix 1

following series of narratives show how the ideological theme of Patient and Public Involvement arises, as I am also relating my experience to the theory of complex responsive processes, in a similar style to Chapter 2. The narratives illustrate the messiness of everyday life, working with and forming ideological themes in the ongoing flow of conversation.

Living with Patient and Public Involvement: Who's Involving Who?

As an Executive Nurse of the PCT, I chose to lead on the area of Patient and Public Involvement. I am aware that my interest stems from a desire to be responsive to patients needs rather than those determined by professionals or managers. I recognise that my own life history and experiences as a nurse and a woman affect these views and may reflect my desire to help those I *perceive* to be in less powerful positions or "outsiders".

As part of my work on the Patient and Public Involvement sub-group, I was given the role of leading on patient surveys. This involved co-ordinating each service (for example foot health, community physiotherapy and health visiting) to produce a patient satisfaction survey to show how we were performing as a PCT. Initially this didn't fill me with enthusiasm. However, I began to feel this was an opportunity to speak about responding to patients' needs. This, and my other lead area, the Expert Patient (see later), seemed to allow "permission" or a way to speak in a different way in response to government initiatives.

In March 2003 I attended an evening meeting to which we (Primary Care Trust representatives) had invited members of the public who had shown an interest in being involved in the PCT. Five representatives from the PCT were there, including myself. Only 7 members of the public attended out of 20 original expressions of interest and 50,000 leaflets being sent out to homes. We sat around a very large wooden table in a Council meeting room. I was feeling uncomfortable by the formal nature of the room layout and the necessity to talk loudly in order to be heard by people across the room. We introduced ourselves and expressed our interest in being there. The members of the public gave their personal stories of dissatisfaction about the care that they, or a relative, had received, such as ward cleanliness, unavailability of information, or fighting bureaucracy.

Following one example of poor ward cleanliness, the communications representative from the PCT, Tina, explained how managers responsible for ensuring ward cleanliness had been removed in re-organisations, but that Modern Matrons were being put back. She was hopeful that this would help, as someone would be accountable. One man said surely it doesn't need a manager to notice

what needs doing on the ward and putting it right. I suddenly felt a sense of agreement and thought about how our practice nurses noticed uncleanliness and reported it straight away to the Practice Manager, who changed the cleaner we use. We now have a cleaner who is a relative of one of our receptionists and it feels more of a family affair. My opportunity to state this was lost as the conversation continued, however. Someone else said "surely people just need to take responsibility". Tina said it may be due to the poor sense of ownership by many agency and bank staff used. (I have later reflected that even at the practice we are shifting responsibility for cleanliness onto the cleaner – who when defective gets changed – rather a mechanistic response!)

I wondered about the lack of response from members of the public, despite the number of leaflets sent out, and that those that did attend had an "agenda" or felt concerns which brought them to the meeting. My supervisor pointed out that NHS waiting lists have thousands of people queuing up to "be involved" in the NHS! I also wondered about the layout and atmosphere in the room which felt formal – and the way as a PCT member I felt defensive or on the firing line of the members of public present. I was thinking that the PCT is not directly responsible for ward cleanliness as we only "commission" hospital services. Patients do not make a distinction about services they see as all part of the NHS, however. Viewing the PCT or the hospital as an "it" – or someone else's responsibility made it easier to blame someone else, or in this case the "hospital" or "agency staff".

Who's surveying who?

At a nursing clinical supervision group which I was facilitating, I asked what they thought about patient surveys. I hoped a representative from the Practice Nurses group would attend a meeting on this subject that I was due to chair. I felt it would look bad on me if I couldn't influence people to attend. However, I realised it wasn't just about me, but possibly more about the topic, lots of other work to do, and various other reasons, at the same time. I began thinking differently about the quality of my contribution or my interactions with others that might influence them to attend.

The nurses then talked about what they thought patients wanted - to be able to make appointments, to speak to a person on the phone, and to see the same doctor they usually see. I agreed but said some people don't mind who they see, and how we need to be flexible, as everyone isn't the same. I described my experience with an automated telephone system, making selections from choices four times before speaking to a real person. I asked the telephonist if other people complained about this and was told "the majority of people are happy with the service". I felt like I was being

sidelined to "not the majority" or "difficult people" and my wishes to be treated personally were not considered important.

I wonder whether the Practice Nurses felt they should attend to please me, perceiving I was more powerful than they were. I felt powerless in trying to persuade a Practice Manager to attend. I was also feeling this might be a waste of time, merely ticking off a target as being met. Perhaps others feel as unmotivated as I did. On the other hand we could make it something worthwhile and do what we want to do rather than what we see as being told we have to do.

I realise I am having a conversation with myself, or different aspects of myself as others see me, as I write and as I think. Themes emerge in our conversations (above) and my internal conversation. Again this is bodily action, where feelings and concerns about my own identity and credibility emerge as I have to survive in that situation. Whatever my intentions for change, I am continuously negotiating with others, who equally have their own intentions. What emerges are themes or patterns which none of us can predict or plan in advance.

The Patient Survey Meeting

I felt quite passionate and excited as the first meeting loomed, as I realised I would have the opportunity to say what I felt about how we respond to patients, and my scepticism about using surveys. I internally rehearsed what I was going to say as I chaired the meeting. I suggested we all say who we were, what our interest was and what experience we had, if any, of patient surveys. I began, saying I felt ambivalent about patient surveys as being the best way of obtaining information about patients' views. My experience of surveys is irritation at irrelevant questions or not asking those I would like to have answered. I also have the feeling that my comments will be ignored if they are outside the "tick box", or at least appear to disappear into some black hole. I was more interested in other ways of listening to patients as, after all, in our day to day work patients often tell us of their positive or negative experiences of health care they have received. I noticed the other health professionals around the table nodding and smiling at this point. (I have recently thought about this more and noticed how I respond to what patients have told me – whether I have discussed it further with anyone. Patients surveys seem like an external way of trying to obtain something measurable when we are always in a process of responding to others gestures).

The aim was to obtain feedback from patients. The use of the word feedback suggests a feedback loop, as in mechanical or heating systems, completing a cycle, or a whole, whereas the gesture-response of complex responsive processes is of continuous iteration. Reifying something as a system or a thing ignores the temporal nature of experience as movement. Drawing a boundary around "patients" delineates "them" from others – but Stacey asks, on what basis? He argues that organisations are biological individuals relating to each other in the medium of symbols, forming and being formed by figurations of power relations between them, their organisation and others in a community. The processes of relating have a history, of the individual, the group, organisation, community and wider society, all of which are processes of relating. The process of relating also encompasses a physical space, available resources and tools and technologies. People are also members of more than one group, organisation and community and membership of one affects how they function in another. With this interconnection between people, drawing boundaries, whilst allowing us to talk about something, tends to close down further thought. I grapple with the idea of organisational boundaries below.

The PCT officer present at the patient survey meeting said we needed a way to assess how we were doing across the whole organisation, in order to report to the Board, meet our star rating targets and improve our services to patients. This seemed like a large agenda for something seen as a discrete whole, in order to account for ourselves as a PCT. The PCT Officer said surveys were one way to do this but perhaps the group could look at other ways of obtaining feedback e.g. via focus groups, suggestion boxes etc. later. I said we needed to be clear why we were doing it and what we would do with the results. I later reflected that the conversation had changed direction and focused on patient surveys – after all that was what people attending were expecting of the meeting – so that's what we did. It felt like something more concrete or "safer" to do rather than discussing how patients respond in everyday conversation in a variety of ways. However, talking about "results" of the surveys assumes they are fixed, rather than one aspect of ongoing conversation. At another meeting I had attended, results of an audit were assumed to be facts describing the current state of affairs, yet it later became obvious that things had changed since the audit was undertaken.

I notice I am constrained in my responses to others, not in a fixed way, but through a complex interplay of choices I have open to me in the emerging context, as well as aspects of my own history, and with others and their own histories, which arise in the moment. However, these constraints are also enabling at the same time, as this complex interplay with difference involves a negotiation of meaning and a potential for new themes to emerge. In the example above, the

anxiety of doing something other than our emerging view of what was expected of us, closed down the conversation to a more conforming theme, thereby reducing anxiety.

Measuring Patient and Public Involvement

A few days later I received an email from an auditing body asking the PCT to evaluate a tool to measure "its" performance in relation to Patient and Public Involvement. If we commented on the assessment tool, we would receive £10k to use on work in the PCT in relation to PPI. Feeling overwhelmed by pressure of work I decided to look at it after my progression viva the following week.

Two weeks later I met with one of the PCT managers, and we discussed the assessment tool. He had done the required work to evaluate the tool and justify how we would spend the £10k. He suggested using the money to fund a researcher to produce a measurement tool, which would highlight how we were doing with red, green and amber lights. I said I thought we could use the money to fund events/meetings where we had patient and public groups present. He agreed that we could do this as well. As someone entered the room distracting us, I was aware of my internal disquiet at the idea of using the money for yet another measurement tool. After the person left the room, I expressed my lack of conviction about trying to measure qualitative performance and devising a tool to do so. The manager agreed but said that the researcher could also talk to people and ask how they thought we were doing as a PCT.

I reflected on the powerful feelings of constraint and conformity resulting from fears around performance and star ratings, and personal accountability resulting from targets and measures. My job is relatively secure. However, PCT managers are under constant pressure to achieve targets with the real threat of losing their jobs if they don't deliver what is required. Rather than rebelling, my colleague wanted to devise yet another way of assessing our work, conforming to what he believed was expected of him. I felt a clearer sense of this need when I recently started to hold meetings with the practice nurses at the surgery. Initially I found myself keeping written notes to record what we had discussed. I reasoned that I was doing this to justify the time taken for the meeting and my position of "manager" and "chair". This puzzled and troubled me, as I had been concerned to keep the meetings as informal as possible, to allow the group (which included two new nurses) to get to know one another and feel free to discuss any issues which spontaneously arose. I later abandoned my notes, trusting my sense of the value of the meetings as people appeared to speak freely about any topic as it arose, whilst also feeling sure of the support of the

(new) Practice Manager. The realisation of a perceived need to account for what I am doing, particularly for an imagined or real "other" became clearer, as well as the feeling of trusting oneself, when in a trusting environment.

Themes of "compliance" can be seen as relating to managers and clinicians as well as patient "compliance". The detachment of patients' experience seen as something "out there" to be measured and quantified distracts from the everyday experience of relating and responding to one another. Our conversation then became focused on our accounting to one another and bore little relation to the intended idea of "involving the public".

The Patient and Public Involvement Meeting

At a subsequent meeting of the PPI group, I reported on the group's progress on patient surveys, or ways of obtaining "feedback" from patients. I also mentioned my dislike of surveys for this purpose and others present responded with their own experiences – suggesting patients often fear giving the wrong answer in case their care is compromised, or that patients conform with answers they think are expected of them. A lay member said they only measure what is asked and that patients don't always feel as if they are "patients". Another clinician reflected on workshops held recently where people with long-term health problems spoke to a room full of clinicians. She said the room was silent as everyone listened to the very real experiences of someone who lived with chronic illness, and it set the tone for the rest of the workshop. We then talked about the Expert Patient programme, where people with chronic illness attend a training course designed to help them live with and manage their condition more effectively. A researcher present said that training patients was one thing but they then face barriers when speaking with clinicians and dealing with long held professional attitudes. Empowered, non- compliant patients may threaten the "expert" status of clinicians and therefore their identity.

I felt energised by the conversation at the above meeting, which was free flowing and resonated with my own experiences. I wondered why this was, and noticed the less formal nature of the meeting and the more diverse views expressed by a mixture of clinicians, managers and, in particular, the lay person.

I made sense of this in terms of the diversity of the sort of conversations which were emerging in this group. It is these variations, or differences in views emerging between people, which, from a complex responsive processes perspective have the potential for new meaning or themes to emerge.

I also felt that this lively feeling felt like being on the edge of something. I wondered about the analogy with the complexity sciences dynamic of chaos, stability, and "edge of chaos" when agents interact (see Appendix 1). In complex responsive processes terms, where themes organising our conversation become repetitive and habitual, conversational dynamics may become neurotic, lifeless and depressing and "stuck". Where conversational life is unstable, there may be confusion and distress and fragmentation of identity. Other conversational processes display a dynamic analogous to the "edge of chaos" where conversations of this type are fluid, lively and energetic whilst grasping at meaning. There is excitement and yet anxiety at the same time. These conversational processes have the potential for transformation and tend to be characterised by diversity of ideas and themes, where differences are amplified and constantly negotiated as they "rub up" against one another. However, the idea of getting the "right level" of diversity into the system e.g. by adding a lay member, externalises what is essentially a self organising process and does not guarantee "success". The lay member may not feel able to contribute where the language of "management" or clinical terminology may exclude him/her from the conversation, for example. It also implies that the agent is the individual, rather than conversational processes among, within and between individuals. The importance, therefore, is in the diversity in the ideas, feelings and gestures and responses between people.

The Management Meeting

I had to report to a management meeting about work on patient surveys. I found myself speaking about progress on the surveys themselves, not mentioning my feelings about their value. I was asked who would analyse the data and who was represented at the survey meeting. The focus of the conversation turned to obtaining funding for someone to analyse the data. I later reflected on how the conversation had developed at the last two meetings, and how at this meeting patient experience was lost in "data" and "analysis". I also notice how talking about patients' "feedback" becomes an "it", made concrete by survey results.

I noticed how the language used leads to conversations of a particular kind. Using temporal words such as "responding" suggest an ongoing flow, as in gesture and response, of complex responsive processes.

The Newspaper Report

The local newspaper is full of reports about the on-going saga of local health services, since the closure of the baby unit at the local hospital and the transfer of maternity services to another

hospital. Mothers have written to the newspaper and letters have been published either complaining about the poor standards of care at the other hospital or giving praise for the care received. Patients are responding in a very powerful way. Midwives have spoken out, again in the newspaper, expressing concerns about moving the service and the effect on women's care.

I wonder how health professionals and managers are responding to this and imagine them feeling defensive about it. A defensive response then becomes a gesture to a continuing gesture / response. Our responses to others are then determining the patterns and themes emerging in our conversation as continuous processes. Paying attention to our responses in this way may facilitate new ways of making sense of what is happening.

Responding to a Patient

An elderly gentleman attends my clinic to have his dressing changed. He has been seeing my colleague for some time with a leg ulcer. He is telling me that a friend has recommended a special sort of honey which has good healing properties and wonders what I think about it. I tell him that although I have heard of it I know very little, but will make some inquiries. I also suggest he mention it to the nurse who regularly changes his dressings at the surgery.

Later in the day I talk about this with my colleague. We discuss whether any research has been done on this honey and what would be the implications of using it. Would we need his doctor's approval to use it? Who would buy the honey and who would be responsible if anything went wrong, such as his ulcer getting worse? I think nothing more about it until my I see my colleague the following week. She has asked a nurse at another surgery who is using the honey and has had "good" results. Another nurse has told her research is still ongoing so we don't have any evidence yet. She has asked the patient's GP who has agreed to try it, as long as the patient buys the honey and accepts responsibility for using it. Litigation, licensing and cost issues have been discussed at a surgery meeting.

A few weeks later the gentleman comes to see me again for his dressing. He is feeling very pleased. Although his leg has been painful, the ulcer is nearly healed. I am amazed at the improvement in his leg. I am wondering how much this is due to the honey, or that he has felt listened to and involved in his own treatment, or both, and whether that matters.

I make sense of this as themes organising experience being played out in everyday conversation. Constraints on the patient and colleagues and myself are continually being negotiated. I was constrained by what I perceived were my professional boundaries of time, what was "legal", doing no harm etc. Griffin calls these constraints enabling constraints (Griffin, 2002). They enable us to take action and there is always the potential for change to occur, however small. However, constraints can also serve as a way of *not* doing something we don't want to do. For example, although I continued the professional discussion, I chose not to take responsibility for making a decision whether or not to use the honey for a number of competing reasons, such as "litigation" or "professional accountability" and perhaps my rather transient relationship with this patient whom I viewed as "belonging" to my colleague. In these details of day to day interaction between "patients" and "professionals" it is possible for small or large shifts or movement in what is considered normal practice. In this example the patient has taken a risk in asking about the honey treatment which demanded a response from nurses and doctors which enabled a novel form of practice in this context.

Patient Survey Meeting 2

At our second meeting we spent a considerable amount of time trying to agree common questions to ask patients. This proved almost impossible, as each service was doing very different things. The idea of having core questions was so that we could combine results for overall PCT organisational performance. Viewing the PCT as a system did not recognise the diversity of services provided. The more we tried to fit the questions around the organisation as a whole, the less meaning the questions had to the people providing the services. It seemed we were trying to fit things into boxes for the sake of ticking the boxes to show we were improving. However, the theme of complying with what we believed was required of us dominated our conversation. I began to feel like "getting it done quickly" to tick the box myself. I was having trouble talking about the PCT as an organisation when I was talking with this diverse group of people doing different work. There seemed so little in common and such a range of information that we were unable to form an agreement.

In complex responsive processes terms I made sense of this as too many interactions or information overload, leading to feelings of disorder or "chaos". Furthermore, faced with what was seen as an unavoidable task i.e. carrying out patient surveys, which would be assessed in the CHI (Commission for Health Improvement) visit, the options were to comply with the requirement, or

to rebel and risk being penalised in our star ratings. The focus on involving the public seemed lost in the desire to conform to meeting targets and expectations.

Patient Survey Meeting 3

At the third meeting, which I was chairing, I felt really tired. I was concerned that no-one would have done anything since the last meeting and we would still be struggling along. However, when I got there two people quickly arrived and said they had done their draft surveys for their service. Another three people arrived and they had done the same. I was amazed. We looked at each other's surveys and raised a few points where they differed. It was agreed that I would take the surveys to the Director of Services meeting and see if we could pilot them. Someone asked what would we do with the results. One person felt there wouldn't be much we could do. The physiotherapist said she could talk with her team if the patients said they didn't feel listened to. I felt energised and agreed that this would give us the opportunity to talk about how we relate to patients. I felt the meeting was more energetic and lively and there was some relaxed humour. It seemed that the surveys were easier to devise in smaller teams. I felt we were perhaps becoming more trusting as we got to know one another. I wondered how we could take this further with ideas about responding to patients.

There is something satisfying and seductive about meeting expectations, and working together in a trusting environment. I remembered reading Fonseca's (2002) work on innovation, where he suggests that this happens when there is sufficient trust between people. We were doing what was expected of us and yet we also found a purpose that went beyond compliance. I had begun to ignore my earlier misgivings about what it was we were actually achieving. I began to make sense of this as the way patterns of expected behaviour – or habits and norms are formed. There was sufficient trust and also enough energy between us to allow us to make sense of what we were doing together in a more positive way. However, I also recognise that expected ways of behaving in a group may become constraining and lessen the potential for change – although habits are not repeated in exactly the same way. If someone challenged the accepted way of doing things, or a new member joined the group, there is the possibility for a new pattern to emerge. Furthermore, targets, star ratings and job security both enable and constrain the sort of conversations and feelings we are having.

The ongoing reflections above show the messy contextual nature of responding to an "imposed" ideological theme and how it is continually negotiated or functionalised in day to day life (Griffin, 2002). What strikes me is the compulsion to conform in order to meet targets and survive. One

strong ideological theme, then, is arguably the extent of the belief in an external "other", or system with power or control. It is then possible to attribute blame on an externalised "whole". Whether or not people actually believe that something exists external to what they are doing, this way of thinking and acting may serve as a defense against the anxiety of uncertainty. Those "in power" serve a purpose for us in enabling us to take or absolve responsibility. However, this distracts us from paying attention to what it is we are doing and how this is forming the sort of conversations we continue to have as we are also formed by them. Thinking in this way, I have become more aware of questioning the established way of doing things, whilst also recognising the risk involved in choosing to challenge them. How, then, does a complex responsive processes perspective differ from more dominant ways of viewing ideology and culture?

Perspectives on ideology

The dominant view defines ideology as a set of beliefs *held* by a group of people or whole systems (Leung, 2000; van Dijk, 1998; Lye, 1997; Morgan, 1997; Derrida, 1994), or alternatively as something imposed by, or benefiting, some more powerful than others (Shotter, 1993; Ham, 1992). Ideology is seen as something which exists outside of ordinary everyday interaction between people. The implied assumption is that this happens in a pre- determined or planned way by someone outside of the system (e.g. organisation). Undoubtedly those in powerful positions are able to propose policy or directives on others, however, they cannot predict how others will respond.

What then is the difference between ideology and culture? Schein (1985) describes culture as taken for granted assumptions which result from enough shared experiences to have a shared view – "a learned product of group experience" (p.7). Furthermore he states that culture is learned "and can be changed if one understands the dynamics of the learning process" by learning and unlearning complex beliefs and assumptions (p.8). Referring to Argyris and Schon, he suggests they can be changed by double loop learning, although Schein says this is "intrinsically difficult because assumptions are, by definition, not confrontable or debatable" (p.18). Van Dijk (1998) also distinguishes between beliefs of a whole society or culture, and ideologies which he says are more specific beliefs of various social groups within an overall culture. He goes on to say that culture also includes common knowledge, which he distinguishes from ideology thus

> "cultural knowledge...may be defined as the (fuzzy) set of those beliefs that are shared by (virtually) all competent members of a culture, and that are held to be true by those members by similarly shared criteria of truth" (van Dijk, 1998 p.37).

This seems a very fixed way of describing culture and ideology, rather than the ongoing messy way I have experienced ideology as emerging in everyday life. What Griffin (2002) describes as *imposed* ideology is, I would argue, imposed only in the way we perceive it as such. This doesn't lessen the strong feelings of needing to conform, however, as unless complied with, one becomes excluded from the dominant way of speaking (compliance conversations), for example with reference to star rating targets, in my narrative above.

Cult values: rules and "no rules"

I also experienced indirectly what the notion of "imposed" ideology might mean when I invited a speaker to a "complexity in primary care group" meeting to talk about an organisation which claimed, with hindsight, to demonstrate complexity theory principles in the way the organisation ran. The speaker described how people were treated as "adults", job descriptions were abolished, people determined their own hours and leave, and rules were abolished. She described how people were more connected with one another and communication improved, thus increasing efficiency. Someone asked what happened if people didn't like this way of working. The speaker acknowledged that some people left after two weeks or were asked to leave if they didn't fit in. She described how many experienced such changes in their own lives that marriages began to suffer, and how she planned to include spouses in the organisations "away days" to help them too. I began to sense that having "no rules" was a cult value, or rule in itself, which required conformity in its members.

The dominant way of thinking attributes characteristics of an organisation as an "it" or a personified whole e.g. the NHS. However, as values are continually negotiated and bump up against one another in daily life we are alerted to "the dangers of thinking that cult values are the values of the personalised institution or system that are directly applied to us as overriding universal norms, conformity to which constitutes the requirement of continuing membership of the institution" (Griffin, 2002, p.117). Whilst values can be seen as 'good" e.g. family values, morals, democracy, justice, they can become tyrannical where non-adherence deems others selfish when they don't conform.

> "The direct application of cult values...ascribed to collectives as if they were individuals and to be applied in all circumstances silences people into conformity" (Griffin , 2002, p.117).

As the following experience highlights, formal values may be ascribed to an organisation whilst everyday experience is always a functionalisation of these values in everyday conversation.

Formal and informal: trust or blame

At a Professional Executive Committee meeting of the PCT, a facilitator encouraged us to express the challenges of working as a member of the committee. Several GP members had resigned and were due to leave the following month. As I was continuing as a member of the committee, I carefully voiced my frustrations of having to focus on providing information to "tick the boxes" rather than making what I thought would be improvements in health care. I noticed that the GPs explained their motives for leaving the committee as primarily to do with pressure of work or ill health. I was just recovering myself from a period of ill health and I was aware of a manager on long-term sick leave and others who were leaving the organisation. When everyone had had their say, the GP who had been first to speak (one of those leaving the organisation) said he had forgotten to say that he felt that the culture of the organisation was to "blame" others and not to value people for the skills they had. This resonated with my own feelings, and yet I stayed with the uncomfortable silence before the facilitator then continued with another theme, ignoring what had been said.

I reflected on this unofficial theme expressed as a "blame culture", where the formally expressed values were of a "trusting" organisation with a culture of "openness" and one which "values its staff". Although the GP had risked speaking about this in the formal meeting, I noticed how I felt silenced at that moment and more conforming to the official ways of speaking. I feared saying something which would threaten my position as part of the group – I would be seen as an outsider and perceived I would have to leave too. Speaking about this in a formal meeting was risky, however, may have enabled a shift in ways of speaking. On this occasion the anxiety proved too great and the conversation closed down.

I make sense of this now as official ideologies e.g. a "culture of openness" and "valuing people", at the same time as unofficial experiences of blame and lack of trust. However, these official and unofficial ideologies are never separate things, as they always intermingle and depend on one another (Burkitt, 1999).

Cult values, culture and ideologies, then, are themes emerging in local interactions (including gesture and body language) between people, whether in government offices where politicians talk

to one another, or between doctors, nurses, and patients in whatever role. Policy statements reach out to a wide number of people but the response depends on the local capacity to respond. How people respond then affects those in powerful positions, and their next response – forming and being formed by one another. As my narratives show, responses to communications from people in positions of power cannot be guaranteed or predicted. Indeed, managers and clinicians have been known to be highly creative in their accounting for how targets are met (Dobson, 2004; Ferriman, 2004). An ethic of conformity, however, displaces attention from the ongoing responsibility and accountability we have to each other in our daily lives, onto an autonomous whole e.g. the government or Department of Health.

Ideology: as power relating

Whereas the above narratives focus on an "imposed" ideology, i.e. PPI, it became apparent to me that a complex mix of often unconscious ideologies are competing at the same time, in situations often taken for granted, for example in my consultations with patients (see Chapter 5). Ideologies also help to maintain the current power relations (Stacey, 2001). By paying attention to my experiences I have become more aware of how I am helping to perpetuate or change these themes.

This last narrative explores my sensemaking in a meeting to discuss the Expert Patient programme, which highlights feelings of inclusion and exclusion as they emerge in this context.

The Expert Patient: Are you one of us?

I traveled some distance for a meeting of PCT representatives responsible for leading on the Expert Patient Programme (EPP). The Expert Patient Programme is a government directed programme to run courses for people with long term conditions, to help them better manage their illness (DOH, 2001). This idea originates in the USA, where it was deemed to be successful in improving peoples' ability to cope with chronic illness, helping them return to work in some cases, and reducing the need for patients to consult health professionals. The courses teach people how to cope with living with their condition, for example relating to medical people; healthy diet; relaxation techniques; and managing depression.

I was leading on the Expert Patient Programme for our PCT and I was aware that we were behind other local PCTs in running courses. However, I had recently discovered that we were funding another organisation, "Arthritis Care", to run courses on our behalf. I guess I was feeling as if we were "cheating" a bit and that I was feeling guilty for not having organised our own courses

sooner. I eventually found my way to the meeting place –a church hall, hidden by vegetation and high hedges, with bars at the door and a buzzer entry system. It took a few minutes for someone to answer and release the door to let me in. It felt like an "under cover" operation as I entered the cold austere building and an echoey room where two people were already sitting drinking tea and talking. I found a tea urn, which was filled with cold water, eventually discovering a flask of hot water to make tea, and sat down at the same table as the two other people. I sensed my developing irritation with a woman who I felt was "droning on". Eventually other people started to arrive and I recognised the feeling of being an outsider, as I knew only one other person.

We moved into another, altogether more friendly room with sun streaming though the windows. I soon realised that the person "droning on" was actually a "patient" who had been on one of the courses and I sensed was a "star pupil" – one of the "converted" who had also trained as a tutor to run future courses. She had set up a group for people to attend when the course had ended and seemed almost evangelistic about the courses and ready to change the world. She had already featured on local radio and television. Meanwhile, the rest of the group were managers, (only two of us were nurses) at varying stages of rolling out the EPP programme.

In turn people fed back on their stories of rolling out the programme – mainly success stories. A nurse (in uniform, who arrived late) appeared angry, looking down and fidgeting. When it was her turn to speak, she asked the group whether they were all managers. I said I was a nurse too (I wasn't wearing a uniform). She told us that she had been given the lead role with the promise of promotion, but had no support and no allocated time to work on the programme. I began to feel uncomfortable with the changing atmosphere in the room and I noticed how the Chair suggested they discuss this outside the meeting. I hadn't realised at that stage that one of the EPP Trainers was present at the meeting, and also someone who assesses PCTs on performance and quality. It appeared that the nurse was in danger of changing the tone of the meeting, which until now seemed very positive. I noticed the emerging theme of how the meeting was run, despite this being a new meeting with no pre-defined rules, apart from the physical setting and the agenda. Whilst some people knew one another or who was going to be present at the meeting, no-one could have predicted in advance what this nurse or another person might say, which of course is always true in any setting.

I told the group that we were using Arthritis Care to run our courses for us. I was questioned whether we would be able to use their evaluation of the programmes for the PCTs purposes (who

owned that "data"?). I hoped so. This would enable us to conform, or tick the box, and relieve us of a lot of hard work, which felt good to me in that sense. However, I was aware of this emerging theme of being an outsider and of feelings of guilt and shame about not conforming to the norm, and yet also wanting to be part of the positive nature of the meeting.

After we had given our stories of where we were so far, the Chair handed over to an EPP Trainer who had apparently been running courses for years. He suffered from a long-term condition himself and talked enthusiastically about the "cause" (EPP) and the benefits for himself and others, although he said people who weren't ready to change were not suited. Again I reflected on the theme of being an insider or outsider. He said anyone could attend who felt they had a condition which affects their life. Nurse tutors who had a condition could run courses, however, he said they had to learn to be vulnerable – to shed the shell they develop as nurses. This resonated with me, as I remember as a student nurse desperately trying to hide feelings of repulsion, or of sadness at sights of disfigured patients as a result of surgery or skin problems; or knowing someone was dying, and not wanting it to show on my face. This sometimes arises now when I try to hide my own anxiety with patients and in other relationships.

The trainer said EPP had grown organically until it had now been imposed on PCTs. Government policy has reified "it" to be rolled out and applied nationally – producing conformity or rebellion. I wondered about the PCT not represented at the meeting – were they rebelling? The trainer went on to say the EPP was about power – a social model in a medical setting. In other words a social model was challenging power seen as "held" by the medical profession. I was aware of power relating emerging as ideological themes as we were relating to one another.

The PCT auditor said the problems were in measuring the EPP. Someone said "what gets measured gets done". I later thought that like a "simple rule" it may focus attention but not necessarily produce the desired effect. What worked for me were the stories which resonated in terms of emotional depth of feeling but might not have been recognised as valid "data" for evaluation of the course or as a basis for continuing action. Someone told the story of a woman who after completing the course had managed to clear a room for the decorators to re-tile it. This had been an enormous achievement for her. I felt energised by these stories.

I wondered if patients had felt constrained by their diagnosis or "label". The trainer said that his "disease" had become his reason for not doing things; for things going wrong; for arguments with

his family etc. I reflected that talking with others, perhaps in these EPP groups, patterns and themes to do with illness which have become repetitive and possibly destructive, may potentially change.

Cult values? Are you one of us?

It was easy to be carried along by the positive atmosphere, however, it also felt constraining and suffocating at the same time. I felt on the margins of the group and not sure if I wanted to be involved or constrained by the emerging requirements of what being in this group meant. I noticed how in the moment values emerged which were becoming harder to speak out against e.g. the meeting being positive. My own use of ecclesiastical metaphors and the setting of the meeting reflect my sense of cult-like ideological values emerging. I felt a strong sense of needing to conform to the positive atmosphere otherwise it would need to be dealt with outside the meeting, or silenced as the nurse had been. On reflection, I wondered why I, a nurse, did not support the only other nurse, as I too was struggling without any allocated time to work on the EPP programme. I felt the need to conform, but also I realise I do not always want to identify with other nurses, or perhaps this particular nurse. Perhaps I am rejecting some ideals I hold about nursing being subservient. I stopped wearing a uniform several years ago, which for me had represented this subservience. However, for others, a uniform may be a way of maintaining distance, or represent other meanings such as "power", or even "sainthood" – for example when nurses wore "angelic" cloaks.

I wondered why the patient in the group irritated me. I felt a dissonance in what I was expecting from a meeting led by PCT managers, and the patient's contribution, mentioning her illness three times. Perhaps she needed to feel worthy or wanted to belong. In a similar way, as a nurse I also needed to feel worthy and to belong. I reflected on the way meetings of clinicians and managers often seem split off from patients and illness and yet this patient was bringing his reality into these normally very rational and detached meetings. At the end of the meeting, however, the patient's conversation seemed to me to be cut short, as the Chair said he wanted to set a date for the next meeting, which perhaps says something about how he wanted to establish his identity in the group.

I contemplated whether my irritation at this patient taking the "glory" threatened my sense of identity. If patients can look after themselves, where does that leave nurses and doctors? There was a threat to the current power relations and the ideology of health professionals caring for needy patients. Interestingly, a PhD colleague studying the EPP, later told me about her observation that nurses were less supportive of the programme, particularly where they were less sure of their own

role (Wilson, 2004). Any shift in ideological themes is anxiety provoking as it threatens current power relations and who is "in" and who is "out". If anxiety becomes too uncomfortable, there may be attempts to close down conversation – as I felt the Chair had done.

For me there was a real sense of understanding the power of cult values or ideological themes as they emerge in interactions (Griffin, 2002). However, I don't see this as in any way intended or pre-planned by anyone, rather, this is an unconscious self-organising process of inclusion and exclusion, which is essentially what ideology is about (Stacey, 2001). In other words are you one of us, following our ideals, or norms in ways of behaving, or not? I am also aware of the richness of themes which emerged for me in the processes of local interaction. However, there is no sense that these were the same for others present. As Griffin (2002) states, it is impossible to capture all the themes in a particular situation.

> "Whatever global themes one might want to articulate for an organisation or society, they have reality only insofar as they are expressed in local situations in the living present..... it must be remembered that none of these themes are stored anywhere but, rather, they are continually reproduced and potentially transformed in the on-going relating between people in the living present" (Griffin, 2002, p.170)

The theory of complex responsive processes views participation in ordinary conversation as our accounting to one another, as ethical and moral behaviour. Values or ideologies are not an end point or goal, rather "idealisations are functionalised in the everyday conflicts in which we are always negotiating the future on the basis of the past" (Griffin, 2002, p. 216).

Through these experiences and the writing about them I have become increasingly aware of how ideological themes emerge only in the speaking and acting of them, and can potentially change or stay the same depending on our ongoing conversation and action. Despite this, I am also aware of the risks involved in speaking in a different way or challenging accepted beliefs or behaviour and surviving in that context. The response of one of my supervisors when reading the above narrative was to say she felt like shaking me for not voicing my thoughts! I felt ashamed and wondered at this strong reaction and why I had felt silenced, or chose to remain silent.

> "If there is one thing that everyone knows about life in organisations....it is this: it is not possible to talk freely and openly to just anyone, in any situation about anything one likes, in any way one chooses, and still survive as a member" (Stacey, 2000, p.364)

Summary

Ideology is a patterning process which organises the way we make sense of what is happening, emerging as themes of power relating, and inclusion and exclusion, rather than shared or stored anywhere. Making sense of what is happening from a complex responsive processes perspective, therefore, helps me to pay attention to how I am continually responding in the context I find myself in, where ideology (or themes) can also be viewed as enabling constraints (Griffin, 2002). Furthermore, ideological themes emerge from complex responsive processes of relating at one level, and are not "things" that are shared or stored anywhere (Stacey, 2003a). Competing ideologies are continually bumping up against one another (functionalised) in ordinary everyday interaction.

The significance of this way of thinking for me feels liberating, and yet heightens my awareness of being responsible and taking risks, at the same time. Rather than feeling that ideologies are held by an external idealised whole (e.g. what government has prescribed), I now feel these themes are real only in how they are emerging as continuity and change in the ongoing flow of conversations. However, the way we *perceive* them as external and controlling inevitably affects how we think and act. My narratives illustrate the way "imposed" ideologies or policy serve as a focus of attention, although not necessarily in an intended way. I have the opportunity to choose how I respond - I can choose to conform or rebel within the enabling constraints of the situation I find myself in. However, there is no sense of being able to resolve the paradox as they are simultaneously enabling and constraining in a continuous dynamic. Ideology enables and constrains what I do and say, but also enables me to *choose* to constrain myself, or provide an excuse or absolve responsibility for doing, or not doing, something. In other words, abstractions divert attention from what we are doing, to a "whole", and we see ourselves as victims of a system. Strong feelings of shame and exclusion are evident when I don't conform to dominant ways of speaking and are also evident when I reflect on my compliance by asking why I didn't speak out. However, a "systems" way of thinking may serve as a defense against the anxiety of exclusion and uncertainty associated with changing identities and ideologies. In the next chapter I want to explore this aspect of change further by paying attention to what it is like to live with anxiety and risk.

Chapter 7: How I am making sense of anxiety and risk and how this may enable and constrain the possibility for change

In this chapter I will explore what it is like to live with anxiety in everyday working life. Inherent in my experiences of the previous chapters are strong dynamics of anxiety and other emotions, in relation to experiences of changing identities and ideologies in my work at the Practice and Primary Care Trust. My main focus here is what it is like to "pay attention to" (Stacey, 2003; see also chapter 4) how anxiety arises in the processes of everyday conversation, following a complex responsive processes approach.

Firstly, I notice my own response to feelings of anxiety when I became ill myself. I notice how labels and categories may serve as albeit transient ways of coping with uncertainty, thus alleviating feelings of anxiety, and also providing a sense of meaning or purpose to life. However, I found that some ways of containing anxiety are at the same time anxiety provoking. I also notice how my ability to cope with feeling anxious changes as I am relating with people and suggest that individual and social anxiety are each present in the other. Secondly, I explore attempts to "contain" anxiety due to uncertainty and fears – by monitoring, "managing risk" and "infection control". Therefore, I am questioning how anxiety is amplified in the themes surrounding health and ill health and how responses to, or defenses against, anxiety may allow or constrain the potential for change to occur. Lastly, I focus on my experiences of living with anxiety as a normal and necessary part of sensemaking or experience, as a positive feeling of energy and curiosity, and a prerequisite for change, and suggest what "containing anxiety" might mean from a complex responsive processes perspective (Noble, 2005).

A brief review of the literature

From a complex responsive processes perspective anxiety is an inherent aspect of change. Anxiety arises in processes of relating by means of protosymbols (bodily gestures) and significant symbols (language) – or our bodily communication with one another (Mead, 1934; Stacey, 2001). As human beings relate to one another identity continuously emerges as feelings of belonging to a group, or feelings of being excluded, which is anxiety provoking. Therefore changes in identity are inevitably anxiety provoking as there is always the threat of exclusion (Stacey et al, 2000). Stacey relates feelings of exclusion to biological processes whereby reducing opioid levels (calming

chemicals) in the brain increases anxiety or arousal. This feeling of unease is alleviated by the reassurance of being accepted as part of a group i.e. feelings of inclusion or belonging. Linked to this are feelings of shame, panic and guilt when one strays from socially learned behaviour (Aram, 2001; Elias, 1994). Since changes in themes organising our conversation (ideology) are also changes in power relations, or inclusion and exclusion, anxiety is an inherent aspect of change.

Anxiety has been recognised primarily in the domains of psychology and philosophy. A web search on the word anxiety revealed 9,900,000 hits, primarily with reference to anxiety self help groups, phobias and defenses against anxiety. In organisational change literature, anxiety is generally considered something to be minimised or controlled (e.g. overcoming resistance) by removing negative emotions before proceeding in a rational way (Upton and Brookes, 1999; Schein, 1985; Lewin, 1951). Spencer and Adams (1990) recommend de-sensitizing against anxieties, as do other management writers who recommend changing mental models (Davies et al, 2000; De Geus, 1997). Schein (1985) says it is inherently anxiety provoking to deal with randomness and meaninglessness, because we can't predict or prepare for the future. He suggests "the search for pattern and meaning and therefore reduction of anxiety seems to me to be how the search for ways to control and predict change have emerged" (Schein, 1985, p.27). It has also been acknowledged that there is unlikely to be any change or learning without anxiety (Vince and Saleem, 2004). Schein describes "learning anxiety" as a result of changes to one's identity which may produce "resistance to change", whereas "survival anxiety" results in change in response to threats to one's survival, for example being made redundant (Coutu, 2002). However, the dominant response is to try to eliminate anxiety when trying to effect change "externally".

From a health care perspective anxiety is often viewed as requiring control or management, something to be afraid of, dismissive of, or considered as weak (Wiener and Sher, 1998). Ways of dealing with or arguably denying anxiety are often though the use of medication, placatives, directives or instructions. Menzies (1970) observed how routines or rituals enabled nurses to avoid getting too emotionally close to patients and therefore avoid stress and anxiety where there were fears of incurable illness and death. Furthermore, Crawford (2004) argues that medical advances and knowledge of health hazards has precipitated a spiral of anxiety and control, which disrupts the very security of these advances, as people fear the possibility of becoming ill (the unknown).

It seems clear, therefore, that anxiety is inherent in everyday life, and even more so in situations with extremes of exclusion and separation i.e. death and fear of death, for patients and those

involved in providing health care. As an inherent aspect of change, ways of living with anxiety become an area of interest for me as I make sense of my experiences. Anxiety is also a strong theme present in my earlier narratives. Stacey (2003a) advocates focusing attention on the quality of anxiety and how it is lived with. In particular he suggests paying attention to what enables or disables us from living with anxiety. He suggests that when anxiety is lived with, it is experienced as the excitement required when struggling to make sense of what is happening, or searching for new meaning. Linked to this is the importance of trust between people engaging in difficult conversations, which allows people to engage in these conversations (ibid; Fonseca, 2002).

Feeling rather detached from what it might mean to pay attention to anxiety, I gave some thought to how anxiety may explain themes to do with reducing risk and trying to change health care. However, I felt very personally what it might mean to feel extremes of anxiety when I became ill myself. The feeling of being ill, uncertain and out of control, allowed me to reflect on the high level of anxiety it brought me personally and ways of coping with this. It also enabled me to reflect on how working in health care organisations, and being a patient, with life and death situations, may present extreme reactions, individually and socially.

Anxiety and health: an individual perspective?

The anxieties surrounding ill health affected me personally in the New Year of 2004. After a skiing holiday over Christmas, I returned home with a viral illness, spending New Year's day in bed. Having just been on holiday, I felt compelled by a strong work ethic to struggle to work the following week, despite still feeling unwell. I became increasingly fatigued and less able to do anything and eventually succumbed to two weeks resting at home. On returning to work, initially with reduced hours, the fatigue continued for some 3 months.

What was most frightening for me was the uncertainty surrounding this illness and my relentless need to discover a cause or a "label" to make sense of what was happening and "contain" my anxiety and shame about being ill. Whilst resting at home I rationalised that my normal identity of Nurse Practitioner, PCT Nurse, PhD student had changed to Jo as "sick". My anxiety about this increased and I was aware of searching for a reason for my ill health. Was I doing too much? Was this caused by stress? What were people at work thinking? Was I going to remain like this for the rest of my life? (a friend has ME which restricts what he is able to do). Was it something else more sinister? My internal conversations became rather repetitive – which is how Stacey (2001) describes extremes of anxiety as either paranoia (repetitive conversation), or psychosis, where

conversation becomes chaotic or fragmented. However, in this process of sensemaking I was discovering that my illness was not just about me. It depended not only on my own internal conversation, which became rather repetitive, whilst I was at home on my own, but also on my interactions with my partner, GP's, nurses, friends and family. I felt the need to talk with other people about how I was feeling in order to make some sense of it.

I went to see my GP, mainly in order to justify to others why I was away from work. However, he told me he was unable to give me a diagnosis. I later reflected on this seemingly honest response, but at the same time feeling a rejection of my anxiety and uncertainty. I accepted this at the time, but wanted to feel listened to and my own interpretation acknowledged. I wondered if my own interpretations challenged his authority, as Raine, et al (2004) have observed, or if he felt as anxious and helpless as I did. Perhaps his reluctance or inability to provide a "diagnosis" actually allowed me to consider other possibilities. As Heath (2004) suggests "the key skill here is to listen and in doing so to allow the patient to find their own pattern and explanation". However, this negates the co-creation of these emerging patterns and the doctor's part in that. Indeed, it seemed that this doctor didn't want to be a part of, or acknowledge my feelings by listening.

A friend, who suffers with ME (chronic fatigue syndrome), gave me references to a website on the condition. My assumptions about my own illness being "post viral fatigue" led to a focus on this as the problem. Looking at the website I recognised my own symptoms in the many described here, leading to my thinking and behaving "as if" I had this diagnosis. However, without an official "diagnosis", and fearing this as a possibility, I continued my search for meaning.

After several weeks, I visited another GP, as a "patient". He spent some time with me asking what I was most concerned about and what I was expecting from him, before giving me forms for further tests. I felt listened to and that he was "thorough" – another expectation that there needed to be a degree of thoroughness, not missing anything, or perhaps just being taken seriously. I relaxed, feeling there was nothing I could do until the tests had been done. I had been taken seriously and someone else was caring for, or sharing, my problem. Similarly a GP colleague at work told me she was worried about one of my symptoms saying it needed further investigation. Interestingly I did not feel fearful at this – I felt my illness was justified. I was being taken seriously and my own anxiety was being acknowledged.

I noticed how my relationship with my sister changed. Typical telephone conversations were about me supporting her. My inability to offer support at this time changed the nature of our relationship and I noticed we distanced ourselves from one another – telephone calls were shorter and less frequent. My partner, however, listened to me and challenged my thinking, asking what I really thought was wrong.

Feeling the need to look further for an answer or cure, I read a book on alternative therapies, with chapters from numerous different practitioners on enzyme imbalances; hormonal imbalances; emotional problems; aromatherapy; homeopathic remedies etc, which felt rather confusing. However there was a recognition of the complexity of illness and multiple interacting problems or imbalances, rather that one cause and one treatment. I tried a homeopathic remedy and meditation, which I felt enabled me to relax.

As I was beginning to feel better, a GP colleague asked again how I was and said "it all sounds very positive". I left him feeling positive, with a spring in my step. Maybe he was responding to me at that time. I was feeling better and he reinforced that. I wondered about his positive nature and how this effects patients. His positive response seemed to lessen my anxiety.

Throughout this experience I was questioning how much this illness was "in my head" and how much was physical. Heath, in her paper the "Mystery of General Practice" talks about the "striving to make sense of the human experience of illness" and argues that scientific medicine puts too narrow a definition on disease, which has tended to invalidate the individual's experience of illness which includes distress, tiredness, unhappiness, misery and grief (Heath, 2004). However, I easily fell into a traditional view of the mind and body being separate from one another. Psychosomatic illness is recognised as resulting from anxiety and is seen as separate from, but often leading to physical illness, thus perpetuating a mind body split (Weiner and Sher, 1998).

I became obsessed with trying to find physical evidence of something wrong, which could not be disputed - as "post viral fatigue" has been labeled as "yuppie flu". Raine et al (2004) suggest that GPs hold negative stereotypes for chronic fatigue syndrome due to the "lack of bodily location" or patients "failing to conform to the work ethic". I now relate this to my own feelings of shame about being ill. Blood test results felt like hard evidence, and yet having a "borderline raised white cell count" did not tell me, or the doctor, what was wrong, but rather continued to raise anxieties. The doctor informed me that my white cell count might always be at that level.

I was keen to use medical tests as a way to prove I was physically ill. Indeed, Green et al (2002) in their study of women at midlife also suggest they are happy to be tested medically, however, there was a complex interaction of other themes, such as being off work and feeling justified in being ill. Green et al (2002) describe this as health risk and social risk. There was certainly a complex mix of health and social concerns relating to how I was feeling, and justifying myself socially – or in Mead's (1934) terms, to a generalised "Other".

I began to make sense of the socially constructed nature of health and illness and how I was feeling depended as much on whom I had been speaking to. Blaming myself, I wondered whether I had been "talking myself" into a spiral of ill health. Focusing on illness, I wondered whether I was perpetuating this illness story, or whether acknowledging my current feelings helped the recovery process. Stacey (2003b) suggests that health is a paradoxical dynamic of stability and instability, with ill health a stuck pattern of stability in the silent conversation of a body with itself, i.e. the individual mind, and rigid, stable patterns of interaction between bodies, i.e. the social. Health is thus variable patterns of relating, both individual and social at the same time. Therefore, my solitary talk with myself took on a rather repetitive nature, until I began to talk with others whom I trusted, which had the potential to disrupt this pattern.

My response to the anxiety surrounding feeling ill was to search for certainty, clarity, a label or "container". This spacial metaphor assumes that anxiety is something external to experience which can be contained. Certainly, this experience gave me some insight into this response to the powerful feelings of anxiety which can arise due to fears of illness and disease, which at their ultimate conclusion may lead to death. However, I found my labels and "containers" only provided temporary relief from the anxiety, or led to increased anxiety. Accepting a label such as ME, whilst providing a "container" paradoxically also brought with it anxieties to do with what this might mean – a changing sense of self or identity – and a sentence to a certain future. Possibilities for new patterns to emerge came from a continued searching for meaning, however. The overwhelming feeling was one of wanting to relate to other people, to be heard and acknowledged in a time of confusion and uncertainty. In other words, feelings of anxiety provided the energy to keep relating and searching for meaning. Anxiety was "the source of energy that is inevitable as we try to make sense of what is happening" (Brown, 2002).

I am thinking about the response to anxiety which is to try to close things down, or provide certainty by giving a label, or diagnosis, for example, and how this may limit possibilities for new meaning to emerge, or even increase anxieties. Acknowledging anxiety or not giving a diagnosis may be anxiety provoking, but may keep possibilities open. Heath (1998) sheds light on the skills in relating in this way which arise for me. She talks about how "stories can accommodate suffering and give meaning to experience" and suggests that "stories which become too rigid close off choices and opportunities to move beyond traumatic experiences" (ibid). This resonates for me in my own experiences of being ill where a potential diagnosis felt limiting. Similarly, as the Expert Patient Trainer described in the previous chapter, being diagnosed as an "arthritis sufferer", his arthritis became a reason for doing, or not doing, things. Perhaps we become constrained by what is expected of that condition, or label, unless this no longer fits with our emerging experience.

In my work as a nurse practitioner, I am aware of how these strong emotions of anxiety, fear, anger or panic arise in consultations with patients and I am thinking about how I respond to their anxiety, which also becomes my own. Foulkes (1948) describes this as resonance, or the ability to feel the emotions of others. Stacey (2003b), suggests how ignoring the needs of others means ignoring one's own. Altruism in this sense is as much about relieving one's own anxiety as that of another (ibid). Emotional coping for patients also becomes emotional coping for doctors and nurses.

However, rather than taking time to talk with patients, giving a label such as "neurotic" or "difficult" may alleviate or act as a defense against the anxiety in dealing with troubled patients. For example, in Chapter 5, a female patient who was later removed from the practice list was later described as having a "personality disorder". Labeling in this way enables a feeling of justification for proceeding in a particular way, or excluding someone. As Raine et al (2004) argue, for the doctor, seemingly obvious physical causes with treatments requiring a prescription only, relieve the doctor from the time and emotional effort of having to deal with his own and the patient's emotions.

Menzies' (1970) seminal work, from a psychodynamic perspective explores defenses against anxiety in social institutions. She highlights how hospital routines such as temperature and bed-making rounds served as a way of removing the emotional contact nurses had with patients, thus reducing levels of anxiety and stress when dealing with patients with incurable diseases. Focusing on task lists rather than individual patients was also confounded by referring to patients as bed numbers or diseases e.g. "the liver in bed 15". Uniforms also serve to unify nurses in terms of

"operational identity" e.g. as a third year nurse, with equal levels of competence. This also helps to eliminate the necessity to make painful and difficult decisions about who does what. The nurse was expected to control her feelings, and frequent transfers to different wards discouraged attachment to wards or patients, despite recognition of the distress this caused. A hierarchical system enabled responsibility to be distributed upwards, thereby reducing the heavy burden of responsibility on the individual. However, junior or student nurses were labeled "irresponsible".

Menzies argues that any changes were threatening to these defenses against anxiety, and anxiety was likely to be more intense. Menzies further argues that these defensive practices were likely to increase anxiety when there were changes in workload, which required flexible working. The way responsibility for decision making was spread between several people made it difficult for a spontaneous decision to be made. She argues that management practice needed to improve to change this way of working – attributing control to the manager. Again bad management is seen as the cause of the problem – or responsibility is attributed to one person – such as the manager or therapist, for example, rather than a pattern which emerges over time from the relationships between people.

I recognise much of the above in my own experiences during my nurse training in the late 1970's. I remember temperature and bowel rounds and being "told off" for recording an abnormality for several days but not reporting it. I was merely "doing the task". As a trained nurse I became irritated by a nurse who sat chatting on the end of a patient's bed – seeing her as lazy and irresponsible in not getting the work done. My experiences of over two decades ago appear to have changed with the theme of "patient centred care" and the idea of a named nurse caring for a few patients. However, thinking about my current practice I am aware of habitual constraints which allow me to cope with anxious situations with patients.

"Doing something" to relieve anxiety?

I stared at the computer screen, recognising the name of a patient I had seen the previous week. I realised that this could take some time at the beginning of what was a full surgery. The young woman came into my room looking tired and pale. I asked how things were going. She felt slightly better but still very low. She had been feeling unwell for months, very tired, achy and seemed to be getting cold after cold. She had been feeling dizzy and nauseous but mentioned that she had felt like this before when she had been depressed. We chatted about this and she was clear that she did not want antidepressants. The previous week I had examined her and prescribed antibiotics for

what I thought may be a sinus infection. I had given her a possible "label" and yet suspected that her symptoms may be linked to her depression. However, she had felt able to return to see me. She told me she had taken some of the antibiotics, but not all, as she had also been seeing a herbalist. I asked her what she hoped for today. She seemed unsure of what she wanted but talked, and cried, and talked. I nodded and listened, staying silent when she was obviously thinking, her head bowed. I felt distraught myself but not wanting to interrupt, offer treatment, or solutions, which at that moment seemed woefully inadequate. I was at the same time aware of her need to talk and yet feeling increasingly conscious that I did not "officially" have more time. Other patients would be waiting. I gradually drew the consultation to a close by suggesting we do some blood tests, making a follow up appointment with her GP and offering to see her again myself if she wanted to talk some more.

I felt intense feelings of grief, which I imagined reflected how the patient was feeling, and yet recognised the boundaries which I relied on to distance myself from continuing with this consultation, which both relieved and increased my anxiety in different ways. Paradoxically the relationship emerging was one of intimacy and distance at the same time. I felt guilty and disappointed in the way I used the blood test form as a way of closing the conversation (a constraint which increased my anxiety), and yet recognised that I had given her time to speak, without being interrupted for half an hour, despite only having a 10 minute appointment. I felt I had to "do" something – and yet perhaps just talking was what she needed. In a medical setting I felt in conflict between what I thought was expected of me, and what I thought she might be expecting of me. I was also fearful that I may miss something and be blamed for being negligent. Not wanting her to feel I was rejecting her by passing her on to the GP, I had also given her the opportunity to return again to see me. However, perhaps by being open about the constraints on me and my time, I would not have needed to use the "tool" I chose to end the consultation, as a way of "doing something". This experience conceivably reflects a wider social need to be seen to "do something" by relying on "tools" such as risk management strategies and targets, which help relieve anxiety by being seen to be doing something. The value of talking and listening in relationship as an ongoing process is perhaps seen of less value, or seen as separate from acting / doing. However, tools also increase anxiety as perhaps there is a "falseness" or lack of authenticity to them too. Maybe expressing uncertainty and feelings, or facing issues such as lack of resources to treat everyone, would allow anxiety to be lived with in a different way.

I am also aware of feelings of anxiety and the need for a sense of identity and certainty about my role and purpose as a member of the Executive Committee of the Primary Care Trust. Having to survive organisational restructuring, where roles and responsibilities are uncertain, I experienced similar feelings of wanting to know what it was I was supposed to be doing as a PCT Executive member. Over time I have felt less anxious of not knowing what I am supposed to be doing perhaps because I realise we are a disparate, diverse group of managers and clinicians trying to find a sense of purpose and identity in a new organisation. However, a number of away days and more structured meetings appear to be attempts to contain our anxiety.

Searching for meaning – closing things down

At a PCT Executive Committee meeting away day to discuss the role of the committee, an Executive member suggested we should be there for our clinical input and what we were doing for patients across the organisation and feed back to people on the ground. I said we needed more space to brainstorm or chat, but that the Executive meetings have now become so structured there is little room for anything else. At the end of the meeting the Chair said that "any other business" needed to be given in advance. After the meeting, chatting to two PCT members, I said I felt that this stifled anything which seemed very current. The paper I had to report on was two months old. I noted in my diary a feeling of increasing anxiety and frustration which I couldn't sustain much longer. Others seemed frustrated too and blaming one another e.g. Directors and Executives.

The conversations are characterised by trying harder to find ways of clarifying the anxiety surrounding our role and purpose with firm agendas, objective setting and away days. However, anxieties are not discussed openly in these contexts. Anxieties about proliferation of targets and measures and who will be blamed or lose their job when work isn't done is not conducive to building trusting and productive relationships between people. Despite talking about "ticking the boxes" or "feeding the beast" in relation to producing evidence for meeting targets in both formal and informal settings, it feels as if we are meeting other people's targets rather than our own. We are trying harder and harder to produce some certainty and structure to what we are doing, but this has increased our anxiety and constrained the sort of conversations we are able to have with one another lessening the likely-hood of creative conversation.

I make sense of this as little trust between diverse members of the group, who are uncertain about their role (or identity) within the group, and thereby misunderstandings may be amplified, and experienced as frustrating – which can lead to closing down conversational exploration (Stacey,

2001). Shaw (2002) argues that when people understand what they are doing in conversation as formulating plans, clarifying information and capturing outputs, they lose awareness of the ongoing mutually constructive nature of what they are doing together. Overly planned and structured meetings whilst feeling safe and secure, thereby kill the spontaneity of ordinary conversation in which new meaning or change can emerge.

I also noticed in the previous chapters how rumour, blame and gossip seem to arise where there are feelings of anxiety in relation to uncertainties about one's own identity. This seems more evident where there is insecurity or lack of perceived status.

An element of fantasy (part 1)

One GP has a particular way of organising her surgeries, recognised by the reception staff. Anxieties surrounding this were perpetuated for me, when this GP was allocated to support me during one of my surgeries. I needed her to see a patient but I couldn't find her in her room. I eventually discovered she was talking to the District Nurse. I spoke to the nurse on the telephone leaving a message with her to ask the GP to see me about the patient. Half an hour later I found the GP sitting in her room. I was feeling very anxious by this stage (with patients queuing up to see me) so I asked her again to see the patient. I wondered whether I had been deliberately kept waiting.

As previously mentioned Elias observes gossip and fantasy as maintaining power differences (Elias and Scotson, 1994), thus alleviating the anxiety of exclusion. In talking with other colleagues, I was perpetuating a story about the GP, which alleviated my feelings of frustration and anxiety. Where there are high levels of dependency, for example, where I depend on the GP for my employment and her perceived superior knowledge and status, anxiety, and associated fantasy to cope with it are greater, as Elias and Scotson (1994) observed.

Social anxiety – closing things down

Viewed from this perspective, it is perhaps unsurprising that the response to social scandals in the NHS, such as the Bristol and Shipman cases, or fears about MRSA have resulted in attempts to lessen or remove the anxiety of uncertainty. One response is to try to minimise the chance of problems happening again by monitoring, measuring, imposing targets and "managing risk". The underlying assumptions of the above suggest that it is possible to avoid risk, and thereby anxiety, by tighter controls. The proliferation of Risk Manager positions in the NHS and other contexts

further specialises risk as something looked after by someone else "out there" who can be blamed when things don't go to plan. It also negates the ongoing negotiation of risk in everyday, messy clinical situations, and may challenge the "expert" status of those who have to make those decisions. It may also act as a defense in a litigious society, by being seen to be "doing" something.

In spacial or systems terms, it is considered the responsibility of those "in control" of an organisation to "contain" anxiety and initiate and bring about organisational change. Even writers on complexity and change in organisations point to the ability of leaders to push organisations to the "edge of chaos" (Lewin and Regine, 2000; Pascale, 2000), whilst recognising the anxiety this may cause. My own experiences, viewed as complex responsive processes with fears of shame, loss of face, needing to justify myself, and fears of uncertainty, are arguably individual and social at the same time, leading to ways of coping, in similar ways to my own. This provides a different way of making sense of what is happening institutionally, by focusing on individual and social processes, rather than on external systems or wholes.

My experiences of living with star ratings and targets has been explored in the previous chapter on ideology. In relation to anxiety, however, there is indeed a feeling of "containment" in the conversation about star ratings. At the Patient and Public Involvement (PPI) group meeting the manager announced that the PCT had been awarded 2 stars, but actually it was nearly 3 stars. I thought this is a seductive feeling that we are alright, and is a good place to be. It feels as if we need to be very good at producing evidence that we are doing well, under these measures, to escape censure, while the work carries on regardless. Back at the surgery, my work with patients seems unrelated to patient surveys and star ratings.

Cooper and Dartington (2004) describe their experiences of managers engaging in "manic activity" to meet targets, imposed on behalf of clients or customers, "but those delivering services may feel at times that these get in the way of responding to the real needs" (p.139). This resonates with my experience of targets being removed from the real work of everyday practice, and my frustration with the rollercoaster ride of more and more targets to meet. Cooper and Dartington (2004) also describe a crisis of trust, with a proliferation of systems to protect ourselves from risk and danger, but when these fail we attempt to produce systems to insure against failure, which also fail.

I explored the theme of targets further by looking at the NHS Alliance[7] web site and press releases. The latest press release is saying it welcomes the new report from the Cabinet Office and the DOH "Making a difference: reducing burdens in healthcare inspection and bureaucracy" (July, 2003). Frontline staff, who were interviewed by the Public Sector Team in October 2002, told of the burdens, duplication, and enormous amount of time that it takes for inspections and other bureaucracy – 1,300 pieces of paper were required of one PCT before an inspection. An advisory panel was set up and they have now made recommendations for action, including fewer inspections; fewer requests for data and information; empowerment of staff; and local bureaucracy Gateways and Champions to spread best practice. A Health Care Inspection Concordat is also being set up to consolidate good practice of inspection with fewer demands before inspection. Two Implementation Monitoring Taskforces have been set up to implement the recommendations and a Reducing Bureaucracy Team to co-ordinate bureaucracy reduction! This way of thinking splits planning from action.

It appears that the reduction of "bureaucracy" has required even more bureaucracy and formation of specialised groups and teams to aim to reduce the problem. Why is this? Elias (1939) describes "civilising processes" of increasing "state" control of functions, taking over responsibility for crime or health on behalf of others. As "chains of interdependence" lengthen, it becomes more difficult to understand or control what is going on. This leads to the formation of different groups or tiers and the tendency to view the complex configuration as "having an existence all of its own" (Hughes, 1998). For example, the NHS has an increasing number of specialties, groups and teams with responsibilities for more defined areas, such as those described above. This may thus remove the feeling of responsibility from individuals to some "other" abstract body or "whole" to deal with on behalf of us all. Whilst this externalising may feel comforting, it still comes back to haunt us in seemingly unrelated targets aiming to prevent failure and to try to control the "whole". Kinnvall (2004) also suggests that globalisation - or greater inter-dependencies, in Eliasian terms - has made individuals and groups "ontologically insecure and existentially uncertain", and thereby more likely to look to collectives which reduce this existential anxiety, for example religion and nationalism.

Crawford (2004) describes the current state of affairs thus

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[7] see Appenix 1

> "Anxiety about health, though over-determined, is aggravated by a medical culture compelled to identify dangers in order to control them. Anxiety is the collateral damage of a boundless ambition to extend life and eliminate the sources of corporeal harm. Control and anxiety are the twin siblings of health consciousness and action" (p.506)

He argues that this has led to risk ritual (ibid) whereby risk, as a kind of knowledge about potential hazards (as opposed to danger, which is more alive and fluid) is seen to be something which needs to be quantified and controlled.

Zeldin (1998) describes fears inherent in modern society. New fears have replaced old ones. Fears of goblins or wicked witches were replaced by religious fears, such as the necessity to be purged of one's sins. In health terms "popular health manuals spread the gospel of diseases hiding in every crevice, just like sin..... Invisible germs replaced invisible spirits" (p.175). New fears are continuously emerging, such as MRSA, cancer and doctors who kill people, where old ones such as syphilis or tuberculosis have become less concerning. Fear is felt in the stomach – the feeling of wanting to vomit, or "butterflies". The stomach has been observed bleeding, turning pale, refusing to work and burning in acid, in a patient who had to be fed by funnel into his stomach (ibid). However, fear is also what makes us feel alive in the human sense. In physical terms, however, chemicals produced to defend the body in fearful circumstances differ only by degree from those of curiosity. Therefore, anxiety allows us to feel alive, curious and responsive in the world.

Giddens (1999) describes a world where science hoped to provide answers and certainty for us all. However, "rather than being a stable, orderly world it feels like a runaway world". He argues that the very attempts to control the world have contributed to the uncertainty we face, as a result of globalisation and changes in family structures. He calls these external risks (such as nature), and manufactured risk (such as those created from our developing knowledge upon the world). The concept of risk is inseparable from concepts of uncertainty and probability, which arose in 16th and 17th centuries, as sailors charted unknown waters. Risk is a dynamic which can be both mobilising and something to protect against e.g. in terms of health to protect against hazards or failure. Risks are not removed, however, merely redistributed – for example, if a house burns down, compensation payments are made if the house is insured.

> "Risk was supposed to be a way of regulating the future, of normalising it and bringing it under our dominion. Things haven't turned out that way. Our very attempts to control the future tend to rebound upon us, forcing us to look for different ways of relating to uncertainty". (Giddens, 1999, Reith Lecture)

Giddens suggests, however, that we shouldn't give up on trying to control the runaway world. However, from the perspective I am taking, the focus of attention for influencing what happens can only be at one level of local interaction, as complex responsive processes. Risk is arguably an inevitable feeling of anxiety over the uncertainty about the future, experienced in the present as we continually negotiate competing risks individually and socially.

Risking upsetting the risk manager

I attended an Executive meeting having read a huge wad of papers about a Risk Management strategy and Adverse Incident policy for the PCT. It was very dry and I was amazed by the complexity of the terminology about the meaning of risk - that we had to minimise or eliminate it; we couldn't necessarily eliminate all risk; and how to categorise and assess risk. We now have a Risk Manager in post and a newly formed Risk Management Group.

I felt in despair and anxious about what I could say to reflect how I was feeling. The CEO wasn't present at the meeting so I felt I might be able to say, "do you think this will reduce risk". However, I said nothing, partly because I felt sorry for the new risk manager, who stuttered over his words. I felt I didn't want to undermine the amount of work he had put into this document by questioning what was in effect the purpose of his new role, or to see myself as harsh. However, my silence did nothing to challenge what seemed to be accepted as a way of reducing risk. He said we had to produce a strategy in this sort of format, and that there was a 250 page document to assess us on how we were doing on risk management as an organisation, and basically we had to get on with it. One of the Directors also said it was one important area we had to work on. A GP seemed to support it (in the break later he said his practice manager was working on it at the practice as that was what he had done in a previous job, and liked doing it). Another GP sat looking completely vacant. I felt silenced as I could not relate to what appeared abstract, which didn't resonate with my experience in practice, and appeared to be reifying "risk" as a thing to be quantified, controlled and eliminated, even though it is so hard to define.

My reluctance to challenge the Risk Manager, perhaps arose from the lack of an established relationship and therefore feeling of trust between us which would make it "safe" to do so. Fonseca (2002) describes how feelings of trust, or bodily resonance and proximity and feelings of a supportive relationship allow anxiety to be lived with, and allow conversations which are characterised by high levels of mis/understanding. Remaining neutral and trying to maintain an objective observer stance, however, he found were counterproductive to the relationships he was

developing – which was interpreted by others as "indifference" (ibid). This has challenged my thinking on my own response, which was more to do with my own history of fears of upsetting people, and fears of rejection, which arose again in this context. I felt silenced perhaps by my own expectation of what it might feel like to be criticised, or have one's work rejected. My silence, however, may suggest I am in agreement with the document, or that I do not have a view on it. In this sense I was experiencing risk in an individual / social sense, as fears of the unknown and fears of shame if I risked saying something.

In organisational terms one may therefore question what it is those in government or those responsible for producing policies think they are doing by restructuring organisations, setting stretching targets and measures and measuring risk. It has been suggested that politicians have given responsibility to PCTs leaving the blame with them when things go wrong (McDonald and Harrison, 2004) thus absolving them of feelings of shame. Targets and measures will undoubtedly have some effect but not necessarily the desired one (Dobson, 2004; Ferriman, 2004). When things don't go to plan there is a feeling of having to do something, or of trying to prevent the same happening again. Perhaps the illusion of being in control and having someone to blame alleviates some of the anxieties of unpredictability and defers responsibility to one person or organisation who can be blamed. By producing a Risk Management strategy, we would be seen to have done what we were supposed to do, and avoid being blamed if something went wrong. However, this may divert attention from a sense of ongoing responsibility for what we are doing. I experienced conflicting risks and a feeling of having to be seen to be doing something in relation to infection control at the practice.

Infection Control Meeting: "managing risk"

I met with a GP and a new nurse colleague who were leading on infection control issues in the practice. The new General Medical Services contract (2003a) requires quality targets be met in order to perform minor surgery. Arising from national fears surrounding control of infection such as MRSA, BSE and Hepatitis C, for example, there has been a rise in monitoring of infection and policies aiming to control the spread of infection. We were making sense of this for our own practice. There were huge implications if we were to follow the new guidelines and I was feeling as if I didn't know where to start. I was aware that the other nurse and the GP were feeling equally overwhelmed. I assumed the GP had asked me along to the meeting as the nurse manager in order to agree changes in the way we practiced.

The new guidelines suggested that our present steriliser no longer met the standards required for sterilising equipment for use in minor surgery procedures. The hospital sterilisation service had also been denied the required certification which would allow us to use their services. The GPs had decided to trial disposable instruments for 2 months. I had previously expressed my concerns to this GP about the level of waste which would need to be disposed of, if this became standard practice for surgeries. I raised this again at this meeting and the GP agreed saying that the minimal risk of a prion infection to one patient was deemed more important than the social and environmental effects of more waste on us all. However, rather than face the implications of continuing to use our current steriliser, which required daily checks (meaning less time for seeing patients), I agreed. There was a complex mix of issues arising and the prospect of a "trial period" enabled the possibility to review and negotiate alternatives. I felt confident and spoke with authority, summarising what was agreed.

I was aware of personal risk in voicing my concerns here. However, I have been at the practice for 7 years now, as a nurse manager and nurse practitioner, and feel respected, valued and trusted. Feeling a strong sense of identity in my position at the practice and in that moment enabled me to contribute in a confident authoritative way. This contrasted with many other situations I have described where I have stayed silent, feeling less powerful or less certain in the group, or where there is little trust or relationship. Stacey (2003a; Fonseca, 2002) recognises the need for trust between people, as a way of living with the anxieties surrounding change. Personal anxiety and taking risk is therefore inseparable from the social context in which I have to survive.

I thought about the theme of social anxiety and risk. We were negotiating with competing risks and there seemed no one right way to proceed. The risk of one person becoming infected after a minor operation seemed in conflict with the global risk to the environment. The imposition of guidelines and measurable targets enabled us to have these conversations about "infection control". As we were discussing the guidelines they were constraining our action and the risks of not following them were seen as costly in terms of possible litigation, reputation and survival as a practice. The implications of trying to eliminate all risk of acquired infection are also costly, and impossible. However, the need to be seen to be doing something was important to protect us from blame or litigation. In the meeting, the conflicting anxieties and risks were also intertwined with personal risk of shame or rejection, when negotiating a way forward which made sense in the moment. Individual and social concerns such as not upsetting people – not being shamed politically, being efficient, and being supportive, among others, are being played out at the same time as we are

forming and being formed by each other. Focusing on reified themes of "infection control policies" and "risk management policies" risks a focus on ticking the boxes, thereby absolving responsibility, rather than focusing on the personal and social responsibilities in our day to day conversations. I was concerned to act in a way which did not close down other possibilities.

Exploring the literature further I wondered what was written about how organisations cope with uncertainty and anxiety. Weick and Sutcliffe's (2001) study appears to show an alternative way of dealing with uncertain and anxiety provoking situations. They note characteristics of how organisations such as nuclear organisations and emergency departments within hospitals cope with uncertainty and risk – which they call "mindfulness". Acknowledging that this is a mouthful, they define mindfulness thus

> "...the combination of ongoing scrutiny of existing expectations, continuous refinement and differentiation of expectations based on newer experiences, willingness and capability to invent new expectations that make sense of unprecedented events, a more nuanced appreciation of context and ways to deal with it, and identification of new dimensions of context that improve foresight and current functioning" (Weick and Sutcliffe, 2001, p.42)

This initially seemed to resonate with the idea of "paying attention" to experience as complex responsive processes. They contrast this with mindless planning, which "guides people to search narrowly for confirmation that the plan is correct" rather than being attentive "to the front line where the real work gets done. The "big picture" is less strategic and is more situational". (ibid, p.13)

Furthermore they suggest that plans and procedures give people the illusion that they have things under control, blinding people to "the very real possibility that each new formalised procedure makes it that much harder to do the work that is required" (ibid, p.68)

> "Knowing that the world they face is complex, unstable, unknowable and unpredictable, they position themselves to see as much as possible.....they encourage....diverse experience, skepticism towards wisdom and negotiating 'tactics' that reconcile differences without destroying the nuances that diverse people detect.....commitment to resilience...capabilities to detect, contain, and bounce back from those inevitable errors that are part of an indeterminate world" (Weick and Sutcliffe, 2001, p.14)

Whilst I find myself agreeing with much of what Weick and Sutcliffe have observed, I have a problem with this as a "how to" book. Whilst Weick and Sutfcliffe say their purpose is to "make these processes more visible, accessible and available" (p.23), they also propose organisations can

act more like a high reliability organisation, providing a checklist by which to measure your own organisation. This assumes an external observer who can design desired changes for a whole organisation, rather than the aspects they have observed emerging in complex responsive processes in a self organising way. However, what they are perhaps pointing to is the way people *are* able to cope with and respond in uncertain situations. In Griffin's (2002) terms, they are noticing how anxiety and uncertainty are *functionalised* in day to day experience.

Kostenbaum (2003; Kostenbaum and Block, 2001) takes an existential philosophical approach to leadership and managing change in organisations, suggesting that we need to learn to "become contented in it, as you would swimming in cool waters" (p. 180). He contends "Anxiety is not a disease, but the normal feeling of transitions." Kostenbaum's and indeed the existentialist view focuses on the individual, with free will. He argues that the realisation that we have free will, or choice, is inherently anxiety provoking. I have certainly felt the anxiety surrounding the choices I am making, and how they may limit the potential for change, or may keep possibilities open - although I cannot know how others will respond. I would suggest that this awareness of our own choice or responsibility arises from being self conscious, and is an inevitable implication of a complex responsive processes perspective (see Chapter 8). However, I would argue that Kostenbaum (2003; Kostenbaum and Block, 2001) neglects the relational aspect of anxiety, and how anxiety is also social.

Streatfield (2001) uses the idea of paradox from the complexity sciences to make sense of his experiences as a manager as being paradoxically "in control" and "not in control" at the same time. In other words, being "in charge" but not "in control" (Brown, 2002). Streatfield (2001) points to work which explores what it is that managers do, in a similar way to Weick and Sutcliffe, such as Mintzberg (1973) who describe the process of muddling though, or "garbage can" decision making. Streatfield argues that this is not an inferior way of practicing as a manager, but rather the only way of living with paradox. Rather than adopting a defensive laissez faire approach, or alternatively striving to "be better" and "get it right", in an idealistic way, which lead to frustration at not being in control, he speaks about his experience of valuing the confusing struggle to make sense of what is happening (ibid). Recognising that this is the way things get done has lessened feelings of frustration, disappointment and incompetence (ibid).

I am increasingly aware of living with the struggle to make sense of what is happening, or in other words living with anxiety.

Living with anxiety

My experiences above reflect perhaps defensive ways of coping with anxiety. I have experienced anxiety where attempts to frame, control, fantasize are evident, individually and socially. Stacey's (2003) suggestion about refocusing attention, by paying attention to the quality of anxiety seems rather passive or simplistic at first glance. However, paying attention to anxiety in this way, I have become more aware of how I am feeling and notice occasions where I have expressed this, or acknowledged the feelings with others. I am not sure whether this has arisen where there is supportive and trusting relating with others, or whether this has enabled such relationships to develop – perhaps both. I will explore this below in the context of my work at the practice.

We recruited two new nurses to undergo training to work as nurse practitioners like myself. I compiled an initial two week induction plan for them to work with members of staff in order to get to know each other. It was a busy time as the GP who had trained me also had two GP trainees to look after. My timetable only coincided with the two new nurses once a week, and each week they would ask how long it would be before they would be fully trained. I felt anxious, feeling I had to do something to help. However, I remembered my own feelings of anxiety when learning this new role and suggested that there was not a definite end point at which time they would be fully trained. I said I was still learning, and that it was normal to feel anxious in a new and different role.

We talked about how patients expected certainty or a diagnosis from us, which differed from what was expected in a traditional nursing role. I felt that the nurses were asking me for certainty and reflected on my own anxieties at times during my PhD, wondering when it will be finished. I was also aware that I was able to speak to them in a different way about anxiety, and felt able to voice it. I lived with my own anxiety about whether I was responsible for providing certainty for them and risked feelings of not doing what was expected of me as their manager. A complex responsive processes perspective bumped up against my traditional view of the manager being expected to know or provide the answers or to "contain" the anxiety. Perhaps this comforting illusion, of the manager being in control, is a defense against anxiety and an excuse to blame, or not take responsibility.

Both nurses, who had also observed the GPs working, wanted to know exactly what one did for each "condition". For example, what was the standard treatment for ear infections? I began to realise that I had learned to cope with the messiness of everyday practice, where a way forward

emerges from a negotiation with each patient. Despite having guidelines and protocols, I learned that each GP practices slightly differently and they often admit to me that they do not know what the patient's problem is. I told my colleagues that it depends on a whole range of complex things for each patient and how this emerges in the consultation. For example, our own and the patient's expectations, how they view their illness, whether they are on holiday next week, as well as our own anxieties about what is happening. I said, the more experience you have, the more you will recognise patterns and respond to each patients needs, and your own, in each consultation. After a few weeks, one of the nurses told me – "I see what you mean, there is a lot of ambiguity, there isn't a right or wrong way to treat someone – as much depends on them as on us and you go with your gut feel and sometimes take risks". I reflect now that relating is about being flexible and responsive, living with the anxiety that brings and making judgements and sometimes taking risks in the moment. I hoped that by not trying to provide absolute certainty, I was allowing the nurses to come to the realisation themselves.

My response to the trainee nurse practitioners at the surgery challenged my assumptions about whose anxiety it was and whether I was responsible for "containing" another's anxiety or responsible for "causing it". A traditional management perspective suggests that it is the leader or managers responsibility to manage or "contain" anxiety, which is a spacial metaphor and assumes that this is indeed possible (Stacey, 2003a; Brown, 2002). I reflected that a complex responsive processes perspective suggests paying attention to the quality of anxiety and how it is lived with (Stacey 2003a). I felt anxious too as I was participating in these conversations and I was not able to provide the certainty they were perhaps hoping for. However, perhaps the conversations themselves were continually "containing" anxiety, in an ongoing, rather than fixed sense (Noble, 2005). Perhaps there was enough trust in a supportive environment which allowed this to happen. There was no sense that trust could be controlled or manufactured in any way, however.

I am acting and responding to others in the moment - of being "on the edge" – or in a state of alertness in the moment. There is no sense of being able to "contain" or "hold" their anxiety or remove it, but rather a feeling of sharing and acknowledging it in ongoing processes of relating. Anxiety is not an "it" which could be put in a container with the lid on - rather, a process of everyday experience. However, I am continuously aware of how dominant approaches to management and being in control are present in my internal conversations with myself, as I bump up against what I perceive to be the expectations of others. Nevertheless, this way of making sense of anxiety enables me to regard it as a necessary, dynamic dimension of experience, which can

sometimes be paralysing, and yet at the same time provides the energy and curiosity needed to continue relating.

More recently, I have struggled with handling questions from my employer about when my thesis will be finished, and how much study time is required. Initially the anxiety surrounding the threat of loss of study time felt paralysing. Feelings of panic were disabling, as I was unable to concentrate on my work with a pervasive sense of urgency. As I talked with other people about the situation my anxiety lessened as we were relating to one another. I also recognised a need to provide a level of certainty to my employer which was "good enough" to enable me to go on working, and yet which allowed flexibility in an unpredictable situation. I was able to agree a review date which seemed acceptable at that time, but which kept possibilities open. The sense of anxiety then became more tolerable and also provided the impetus to keep working. I was aware of how my choice of action was influencing the emerging interactions as I was considering the options with myself and in conversation with others.

Summary

In this chapter I have explored themes of anxiety and risk as they emerged in my own daily life working in primary health care, as well as aspects of my own personal life. I recognise that life becomes meaningful when there is recognition of pattern and order, rather than feelings of randomness and mess. I think my narratives show the continuous dynamic of ways of coping with uncertainty through interaction with others, which also has the potential to change the way they think about anxiety and change too.

Whilst I noticed my search for meaning and certainty when I became ill, I also found ways of responding to another's and my own anxiety by acknowledging the feeling as I was relating to others. Empathising, and naming feelings enabled an ability to live with anxiety, rather than closing down conversation or providing certainty when this is elusive. I suggest this relates to what Stacey (2003a) means by paying attention to the quality of anxiety and how it is lived with. I am arguing that the "containing" of anxiety is in the ongoing processes of relating with those I trust, where anxiety provides the energy required for an ongoing search for meaning. Often it is at those times that the greatest opportunity for change or new meaning has occurred.

I also have a better understanding of responses to anxiety, amplified as social and organisational themes such as managing risk, defining roles, "doing something", diagnosing illness and

fantasizing about and blaming other social or political groups. These ways of coping with anxiety are based on assumptions about "external" systems under our control. This can lead to feelings of devolved responsibility and corresponding victim and blaming ways of thinking and acting.

However, my experience is of anxiety as a continual dynamic and necessary for change to occur. Control in this sense is an ongoing search for pattern and meaning. How we respond to anxiety may enable or limit the possibility for new themes, or change, to emerge. This final example shows how I am paying attention to anxiety as it arises and living with it sometimes in a different way.

Element of fantasy? Part 2

I continued to think about my experience where I made assumptions that the GP deliberately kept me waiting. This seemed likely to me, based on stories by some practice staff. It was easy to perpetuate these stories by describing my experience. However, I began to wonder if these stories perpetuated fantasies which lessened our anxieties about her superiority. I nervously asked the GP if I could have a word with her. I said I wanted to discuss how we could improve the running of the emergency surgeries, as some patients had complained about the length of time they were kept waiting. She looked uncomfortable and I felt very anxious. However, I gave the example of the patient who had waited half an hour to be seen, despite my message to her, and therefore other patients were kept waiting. After some discussion the GP remembered the occasion, and that she had been confused about the message, which she thought was asking her to speak to a patient on the telephone. Following this discussion, we agreed some improvements in the way we could run the surgery. I noticed how this new way of speaking had shifted the sort of conversations we were having and dispelled some of the fantasies I had concerning the GP. Keeping the conversation open allowed the possibility to change the pattern of thinking and speaking.

Here I have been paying attention to anxiety and risk arising in my experiences and how this has changed from a complex responsive processes perspective. My experience has also included feeling and emotion in a wider sense, including the environmental context I find myself in. I will develop this theme further in the next chapter, where I want to argue that this aspect of sensemaking has been given less attention by writers exploring a complex responsive processes perspective. In the next chapter I will also build on the themes of responsibility and process language as implications of making sense of my experience as complex responsive processes.

Chapter 8: How I am making sense of my research - some emerging themes

In this chapter I will draw together some key themes which have emerged as I experience change in primary health care from a complex responsive processes perspective. It is interesting that these are areas which challenge me most personally, and are thereby a source of energy for my continuing curiosity. Firstly, I want to expand further on the theme of responsibility. Paying attention to what I am doing in my day to day working life, from this perspective, means that I am also aware of a heightened sense of responsibility for my own contribution. Secondly, I am conscious that what I say has the potential to perpetuate, or otherwise, a process way of thinking and how I am paying attention to the words I am using as I speak and write to reflect this. Lastly, I turn to the simultaneous aspects of experience including emotion, feelings and the inseparability from the environment I find myself in. I have been increasingly aware of how my actions and responses are affected by the way I am paying attention to how I am feeling, which includes the environmental context I find myself in.

Living with responsibility

Here I want to review a theme which troubled me before starting my PhD and which has changed for me as a result of thinking from a complex responsive processes perspective. As previously discussed in Chapter 1, my initial response to complexity ideas was to feel devolved of responsibility, when thinking about self-organisation as something happening outside of and in spite of my own participation. I believed that I could not be responsible for perceived "failures" when it depended as much on others as it did on me. Indeed, a social constructionist perspective resembles this view by maintaining that individuals cannot be responsible for their actions - "discourse of individual blame is divisive"– and calling for a *relational* responsibility (Gergen, 1999; Shotter, 1993). Their use of the word relational gives primacy to the social over the individual, however (ibid).

A systems way of thinking can lead to blaming other individuals or the "organisation" as a whole, and thereby absolving responsibility. Griffin alerts us to this:-

> "(Systems thinking) abstracts and distracts from our ordinary everyday experience of interaction with each other in the living present. Such abstraction distracts our attention from our own responsibility for what we are doing and what happens to us in

> organisations. It leaves us feeling that we are simply the victims of the system" (Griffin, 2002, p.206)

A complex responsive processes perspective points to the paradoxical (simultaneous) nature of individual and social responsibility at the same time, rather than splitting the individual and social.

My own experiences have led me to think about responsibility as paradoxically not being in control, or not knowing what will happen, and yet responsible for my own actions or responses to others at the same time (i.e. not collapsing the paradox) (Streatfield, 1998). However, I often encounter people (including myself) devolving responsibility by blaming others for something, (e.g. the manager, the PCT, or the government). It is then easy to conclude that "nothing can be done" as "it's already been decided what will happen" and that someone is in control of the situation and must be blamed if it goes wrong. Perhaps this explains how responsibility is devolved to others, and behaviour continues and is ignored in "whistle blowing" cases such as the Bristol case, or Shipman case. And yet at the same time people often do make a stand or speak up, perhaps risking being ridiculed or losing their job.

Ford (1999) addresses the idea of conversational responsibility suggesting that an unwillingness to speak, for whatever reason (e.g. fear of the consequences) is therefore different from inability to speak. "Conversational responsibility makes it possible for us to own both our speaking and our silence as choices we make rather than attribute either to the persistence or absence of forces outside ourselves" (p.494). Conversational responsibility raises such questions as "what will I say, to whom and for what purpose?" and "What are the consequences of my speaking and listening?" (ibid). However, whilst I can consider my intention or consequences of my speaking and acting, a complex responsive processes perspective acknowledges the unknown in our participation with others. I cannot know in advance exactly how another will respond, even when I know them well.

Is my sense of responsibility a value and if so what is a value? Joas (2000) describes values as arising in experiences of self-formation, as a feeling of "I can do no other", as the highest expression of our free will. This resonates with the *feeling* of responsibility I have for acting or participating in the moment. When I don't respond to my feelings I may feel a sense of shame and guilt at not acting. In this sense responsibility can also be viewed as a norm – i.e. expected behaviour in a group. However, responsibilities can be conflicting and have to be functionalised, or negotiated in the moment. For example, I may feel responsible for acting on my feelings of dissonance in a meeting with a focus on a risk management document, by saying something.

However, at the same time I am conscious of the effect this may have on the new Risk Manager who has worked hard to produce the document.

A recurring theme for me has been a feeling that I "should" speak up, reinforced many times by parents and school teachers. This is perhaps an example of feeling responsible as a norm – or expected behaviour. I often prefer to listen and observe what is going on before contributing verbally. Arthur (1999), describing his own experience of regularly moving house as a child (similar to my own), suggests this preference for observing others arises from a sense of being an outsider. Not speaking is paradoxically also a response, yet is often shameful, particularly in Western society (ibid). Paradoxically, saying the wrong thing is also shameful. The ability for individuals to choose with forethought also brings with it a feeling of responsibility and risk in making a wrong choice. I recognise the way that apathy, boredom or distancing myself from others are ways of remaining detached which may be a defense against anxious feelings of rejection or fears of being disliked. Elias (1991) links the paradoxical need to stand alone and the need to belong, to the way the individual and society have co-evolved as discrete and separate.

> "The feeling of participating, being involved, is frequently mingled with one of being uninvolved, detached – "What is all that to me?".....the aim to be something unique and incomparable is often accompanied by the aim not to stand out, to conform" (Elias, 1991, p.149)

I notice how it is often a strength of *feeling* that propels me to speak, which relates more to the ideas of a value as "motivating voluntary compulsions to perform one action rather than another" (Stacey and Griffin, 2005). There is also a feeling of not knowing how I am going to respond until I have done so. I relate this to Mead's (1934) notion of the "I" and the "Me". The "I", the subjective, is the source of the novel, the creative, whereas the "Me" makes me an object to myself. In this sense I cannot know in advance how I will respond, which can sometimes be surprising, and yet I am also responsible at the same time.

This way of viewing responsibility differs from thinking about responsibility purely in terms of those assigned in our roles at work (accountability). Griffin (2002) argues that roles are created as a continuous expression of identity, as a way of protecting us from the uncertain, in interaction with one another. However, roles and accountability have been reified, or in many ways split off from ourselves, in the form of job descriptions; development plans; and Knowledge and Skills

Frameworks[8] (DOH, 2004), in much the same way as ethics. This can distract from what I am doing now, onto something outside of myself. From a complex responsive processes perspective the focus is on ongoing processes of accounting for ourselves, in the movement of what I am now experiencing a much "larger" (or living) present. I am continually responsible and yet cannot know how others will respond to my actions at the same time, however. In this sense responsibility is personal and shared, as the individual and social are forming and being formed by one another at the same time.

Responsibility is thereby also social, as I am constrained by real and imagined expectations of others, and by their responses to my actions. I have noticed how constraints enable us to feel devolved of responsibility, for example, when I tell a patient it is "practice policy" not to prescribe a particular drug. Rules are both enabling and constraining at the same time. Whilst recognising the way in which I may try to detach myself from being responsible to relieve myself from anxiety, I am also noticing how I might act in a way to keep conversation and possibilities open.

Griffin (2002) argues

> "What each of us does matters even though we cannot know what the outcome of our actions will be. It is possible that small actions can escalate to transform global situations. For me, this is an empowering perspective and also one that makes it impossible for me to escape the responsibility I have for my own actions" (p.87)

My own experience builds on this by highlighting how the theme of responsibility has emerged in my own experiences as an *implication* of a complex responsive processes perspective, where I am aware of the importance of my own individual actions and responses which have the potential for transformation, or change. This can be explained in terms of purpose or teleology, which I referred to in Chapter 4. Responsibility can be viewed from a Rational Teleological perspective – for example, I can choose what I do as an individual and therefore I am responsible for my actions. It can also be viewed from a Formative Teleological perspective as I conform to roles I have to perform such as leading on Patient Surveys to reach organisational and societal goals, where the outcome is laid down (or predicted) in the rules themselves. Here responsibility and blame is termed "institutional". These two ways of viewing responsibility lead to blaming individuals (Rationalist responsibility) or organisations and groups (Formative responsibility) and thereby feelings of devolved responsibility. However, the sort of responsibility arising from a complex

[8] The KSF describes the knowledge and skills which NHS staff need to apply in their work (DOH, 2004)

responsive processes perspective is of a Transformative Teleological kind, where I am paradoxically responsible for, and yet cannot know the effect of my actions, and responsibility is individual and social at the same time. Responsibility from this perspective is ongoing in the processes of relating, and has the potential for continuity and change at the same time.

It is interesting to me that the theme of responsibility seems to be where I started 4 years or so ago. In a sense I feel I have come full circle, from initially viewing complexity as a relief from feelings of responsibility, to now feeling that I am a responsible for my own responses. For me then, responsibility is being aware of an ability to respond - *response-ability* - arising as the ability to respond in any situation, yet at the same time aware of responses of a real or imagined "Other", and also limited by my own history. In that sense responsibility is simultaneously individual and social rather than an external "thing" which would allow me to blame someone or something outside of myself. Responsibility is a sense of being accountable for my actions, but also feels liberating in that it is "worth" speaking and acting from this perspective, as there may be some effect, large or small, whether I perceive it or not. I am aware of the responsibility for, and the potential of, my actions arising from a complex responsive processes perspective.

The way of thinking about responsibility as living responsibly points to another focus of attention which has emerged as an implication of this way of thinking. Paying attention to the way I have been speaking and writing has the potential to change the way I make sense of experience as processes rather than as forming wholes. I will now expand on what I mean by this, as I focus on the theme of process language.

Living language

My father is a keen gardener. I grew up helping him with weeding, sowing seeds, collecting worms (when I was a toddler) and helping to rake the bowling-green standard lawn. When I first had my own garden, I followed my father's example by digging up weeds and tending the lawn. I felt uneasy if the lawn hadn't been mown each week. More recently, however, I have become very keen on wildlife and enjoy watching the birds in our small garden. I realised that my gardening standards were not particularly wildlife friendly. I began to feel more comfortable with leaving moss between the brick paving and mowing my lawn less and less often. Now I don't see a lawn but a small meadow, with long grass blowing in the wind and wild flowers such as buttercups and clover in bloom and looking surprisingly pretty. This summer, my parents are coming to look after our house and cats while we are away on holiday. I look at my "meadow" and wonder what my

father will think. Will he wonder where he went wrong, seeing his daughter's garden going to ruin? Do I now cut my meadow in an effort to make it seem more lawn like, or do I try to convince my father that I have grown a meadow? Or is my father also changing the way he thinks about his lawn?

The reason I am telling this story is that it resonates with feelings I have experienced with this new way of thinking and acting from a complex responsive processes perspective. My thinking and acting resonates with others who talk in a similar way but bumps up against my old way of thinking. I see myself from the perspective of another e.g. my father in the above story. How I speak about something whether as a "lawn" or a "meadow" changes the way I perceive that reality and thus how I think and act, and always in relation to the imagined or real "other". In situations such as with colleagues or patients, and in writing this thesis I have been thinking about the words I am using – I consciously change my language to suggest the nature of process rather than fixed states. I am continually negotiating this difference in my own head and in relation to the "others" I am imagining, or relating to in the moment.

The subtle change in language and meaning in this continual conversation changes the focus on how I am making sense of my experience and how I am acting, and what it is I think I am doing. This to me is one of the most significant new ways of thinking, about time as a continuous process with a circular / iterative, rather than linear, character to it. Whether I think I am in control of what happens, or participating in a continual process, affects how I act. Whether maintaining (controlling) a lawn or enjoying a wild flower meadow, managing a change project or paying attention to my own participation in conversations about an intention e.g. carrying out patient surveys, I am continually bumping up against how I see myself from the position of the "other". It seems important to try to reflect the way I am experiencing change in the way I am speaking and acting, which I argue has the potential to change this reality.

I am suggesting that the language we use may perpetuate a particular way of thinking and acting. However, this differs from syntax, as seen by objectivist linguists such as Chomsky (1957), which is pure in form, and independent of context or meaning. The conduit metaphor, suggests this - where meanings are objects and a speaker sends a fixed meaning to a hearer; or meanings are in the words, therefore failure of communication is due to wrong words or subjective error.

However, a complex responsive processes perspective focuses on context, history and intention as contributing to meaning which arises in the continual gesturing and responding (Mead, 1934) – see Chapter 4. This continuous flow or process way of thinking is not reflected in our use of spacial language which tends to categorise and therefore constrain other ways of seeing things. Every statement therefore necessarily leaves out what is downplayed or hidden by the categories used in it. Lakoff and Johnson (1980), working with metaphors we live by, acknowledge that categories are not fixed – rather they are contextual and relative to purpose.

> "Understanding always involves human categorisation - a function of interactional rather than inherent properties and of dimensions that emerge from our experience.....categories are neither fixed or uniform" (Lakoff and Johnson, 1980, p.165)

Lakoff and Johnson (1980) propose that all language is metaphor.

> "The great idea that metaphors can create realities goes against most traditional views of metaphor....(metaphor has been) viewed as a matter of mere language rather than primarily as a means of structuring our conceptual system and the kinds of everyday activities we perform" (p.145)

By this they are suggesting that language emerges from physical experience, for example spacial metaphors refer to physical space e.g. up or down. Happy is up – "on top of the world", "on the up", or the opposite feelings of depression, "feeling low", "she looks down". Container metaphors create barriers where there are none, such as "the fog is in front of the mountain" (p.162). A linear view of time is perpetuated by the "life as a journey" metaphors. These metaphors which stand for experience have the potential to change the way we make sense of the world.

To demonstrate what they mean by this, Lakoff and Johnson provide an example of an Iranian student, who when hearing the phrase "the solution of my problems" (p.143) made sense of this using a chemical metaphor. He understood this as floating in a chemical solution - living with day to day problems in an ongoing process, rather than living with a "puzzle" metaphor of constantly striving to find a solution or answer to one's problems. They write "....the way you would understand your everyday life and the way you would act in it would be different if you lived by the chemical metaphor" (p.144). However, they assert that

> "it is by no means an easy matter to change the metaphors we live by. It is one thing to be aware of the possibilities inherent in the chemical metaphor but it is a very different and far more difficult thing to live by it. Each of us has consciously or unconsciously identified hundreds of problems and we are constantly at work on solutions for many of them - via the puzzle metaphor. So much of our unconscious every day activity is structured in terms

> of the puzzle metaphor that we could not possibly make a quick or easy change to chemical metaphors on the basis of a conscious decision" (Lakoff and Johnson, 1980, p.145).

Perhaps this way of thinking explains my ongoing struggle to make sense of experience as continuous process as opposed to surviving in a context of a linear view of change and the possibility of objectively changing a system. However, Lakoff and Johnson write

> "New metaphors have the power to create a new reality. This can begin to happen when we start to comprehend our experience in terms of metaphor and it becomes a deeper reality when we begin to act in terms of it (New metaphor) will alter that conceptual system "e.g. Westernisation of cultures throughout the world is partly a matter of introducing the Time is Money metaphors into those cultures" (p.145)

Paying attention to language as metaphor has been helpful in the way I am making sense of how taken for granted ways of speaking affect our sensemaking. As stated above, one of the most significant changes in thinking for me is the idea of process. However, there is potential for misunderstanding of what process means from this perspective. It could mean for example the process I undertake to complete a PhD. This appears to be linear process with an end point or whole. However, the complex responsive processes concept of process is the continuous, endless processes of interaction. This way of thinking has been evident for me in the way I am constantly choosing my words carefully when I write and speak with others, trying to use process terms, to reflect the continuous self organising, emergent process of conversation, rather than spacial terms as wholes. For example, I was initially aware of mechanical metaphors used in relation to change such as "levers". I later realised that even when using words such as participation, this can suggest participation in a "whole". Talking about an "outcome" also suggests an end point rather than continual process.

As Elias argues, it makes no sense to talk about human behaviour in terms of containers, or having an inside or outside. Similarly, speaking about the split between the individual and the social, he argues that language maintains dichotomies

> "caught in the trap of so unreal a conceptual polarity as this – that we are tempted again and again to speak and to think as if one could escape from postulating individuals without society only by postulating societies without individuals cannot be circumvented simply by the assertion that one knows the polarity is fictitious. Many linguistic and semantic traditions drive our speaking and thinking again and again into the same groove. Even academic institutions such as the strict division between two disciplines, psychology and sociology, the one supposedly only concerned with "individuals", the other supposedly only with "societies", are based on, and resurrect again and again, the fictitious

> polarity.....What is baffling in all these cases is the persistence with which we go on speaking and thinking in terms of a dichotomy" (Elias and Scotson, 1994, pp. 168-9)

Even when I pay attention to the words I am using, the meaning I intend may not be the same for the person I am speaking to. Using temporal words, meaning emerges in the response, or in the context, not merely in the intention I have in the moment.

I have already described how increasing divisions in society, and normative controls of state institutions, such as health services and schools, perpetuate the feeling of individuals watching and being watched, creating a spacial distance between the self and Other, and between the mind and body (Elias, 1939, Burkitt, 1999). Thus spacial metaphors of inside and outside of the body are perpetuated. The body is viewed as a machine, with events such as the menopause where the female (re)productive system goes wrong (Green et al, 2002; Seibold, 2000), or metaphors of illness as warfare - a "battle" or fight against an invading organism or virus. Metaphor and language thus affects how we make sense of and therefore act, in relation to health and health care.

Language is also constraining and including or excluding, evident in the previous chapters. For example, labeling someone as "difficult" or "having arthritis" is both including and excluding them at the same time. Not only this, but labeling in this way is constraining and limits the possibilities for change. I now notice where labels or stereotypes are used and question what is meant by them. For example, at a recent appraisal it was suggested that what was needed was more "directive" leadership. By questioning this, a more open discussion ensued about bringing people along with what needed to be done. Being "directive" does not necessarily mean that people will conform to the directive.

Despite being aware of language and selecting my words carefully, the very process of speaking about one "thing" or "theme" excludes others. Furthermore, it is impossible to have a conversation about the NHS or the Primary Care Trust or practice without apparently reifying them. However, this way of thinking has heightened my awareness of what I am saying and in particular what may be constraining the possibility for change.

Another theme present in the preceding chapters is the simultaneous aspects of experience including emotion and feeling. I have increasingly been aware of how feelings often propel me to speak, and thereby affect what I do and say.

Living with emotion, feelings and environment

I remember feeling very uncomfortable when a member of the PCT spoke assertively whilst also visibly near to tears as we were making an important decision at a Board meeting. Someone challenged her, asking if she disputed the "facts". I noted in my diary at the time that I was surprised by my reaction to the display of emotion. This experience, among many, challenged my thinking about emotion and how it is lived with, expressed, felt, or denied. Increasingly, I have become aware of how I am feeling and how my own involvement and detachment, responding or staying silent often depend on feelings. Feelings are likely to propel me into action or enable me to reflect and thereby allow or constrain the possibility for new ways of thinking and acting to emerge. Similarly, as I am focusing on my experience, I am aware of the importance of context, or the physical environment I find myself in, which also affects my mood and how I am likely to respond in the moment.

My experiences above have alerted me to the complex interplay of the rational and emotional as decisions are made, particularly in formal situations such as Primary Care Trust meetings.

The Executive Meeting: rational decision making?

As we all settled into our seats around the oval table in the small meeting room I noticed how uncharacteristically quiet the co-chair seemed, head hung low and slumped as if under weight, I felt.

The main theme was the annual allocation of money. The finance director spent some time explaining the figures and how, as presented, it would mean we would have a deficit. He wanted us to agree where we should take this from in order to meet our responsibilities to break even. He had a deadline of "this time tomorrow", when he needed to present the figures at the next meeting. There followed a long debate about where this deficit could be taken from. The Finance Director wasn't keen to reduce the prescribing budget, as once drugs were prescribed there was nothing you could do about it. The GP co-chair re-stated what we were accountable for and that we had to meet these areas first i.e. financial balance and national targets. Although he had stated the principles to follow, one GP commented that the principles weren't that straightforward. Different people had different perspectives.

The co-chair didn't want primary care development money touched, as we needed to reward practices for meeting Access targets. He was concerned not to let the practices down. I said that if

the government wasn't giving it to us we couldn't protect the practices from that. The Head of Corporate Affairs agreed. I felt this was being paternalistic and protective of practices when we hadn't been given the money ourselves.

Someone said counselling would be the first to be hit and this would cause public outcry. One GP said people who were employed by practices would need to be given some notice. He looked appalled and said he wouldn't like to be the one to give that message. He also commented that his practice had always stuck to all of their budgets, apart from prescribing. Someone pointed out that if that was also linked to his or her own take home money, then they might make sure they came within budget on that too.

I was feeling increasingly frustrated in what seemed an impossible situation. Time was running out and I was concerned that we needed to come up with something. One of the directors then sharply said he was going to propose where to take the money from and proceeded to list figures of deduction, firstly from prescribing. This felt too premature to me and people disagreed with the figures. Someone got up to get a flip chart. While there was some disruption, I heard one GP say that her partners had had to take a cut in salary this year. She began to look tearful.

As we made a list of areas where we could deduct money – it seemed as if we were plucking figures out of the air. Someone commented "the dice rolls under the wardrobe and comes out the other side and you say 'oh look it's a six'. I think this reflected how I was feeling, that it was as much a matter of chance as anything else in the decision making process. I said "it really depends who is sitting around this table in terms of what money is deducted from where" – for example, no-one was there to represent heart disease or mental health. A GP said, "but we have already cut our own throats, at the decision to cut in-house services".

I began to feel energised at this point. It felt we were getting somewhere and we were beginning to work together. It seemed easier to "cut chunks" from areas which seemed somehow distant and detached from reality, and felt like more of a game. When we reached our target there was a sense of relief. The meeting ended half an hour late but at least we seemed to have reached an agreement.

This meeting resonated for me with Streatfield's "Budget Meeting" (Stacey, 2000), showing the complex interactions involved in a decision making process. We imagine what happens is rational when the reality of my experience was of messiness. Similarly Streatfield said "all desired to

maintain credibility and power" (in Stacey, 2000). These issues were evident in the ongoing conversation. Implicit in the conversations between us was a wide range of emotions in addition to remaining credible, preserving our identity and surviving. However, bouncing off one another from diverse perspectives we were able to be creative in ways of moving forward together.

On other occasions where there have been emotive issues such as the closing of a hospital ward, there was a suggestion that we needed to "deal with" the emotions and then move on and make a rational decision. This denies the presence of emotion at the same time as apparently rational conversation and decision making as Shaw (2003) notes "I felt acutely alive at that moment to the webs of conflicting feelings in which so-called rational decisions are made: self protection, honesty, concern, anxiety, hope, determination" (p.446). The dominance of the rational, seen as above and separate from emotion, is evident here. As previously discussed, complex responsive processes of relating are human bodies relating to one another – as protosymbols and significant symbols (Mead, 1934). Rational and emotional aspects of communication are *simultaneously* present in our interactions – evident in my experiences above.

Whilst I have argued that the theoretical basis for this is argued in the literature of complex responsive processes, this area has perhaps been given less attention in management narratives from this perspective, until more recently (Tobin, 2005; Williams, 2005). Is this a gender issue? Am I more aware of this because I am a woman and a nurse? A doctoral colleague studying the Expert Patient programme suggested that nurses were more likely to be able to handle patients' emotions than doctors, no matter what the gender of the nurse or doctor was. Doctors describe their worst "heartsink" (difficult to deal with) patient as an "emotional female". Goleman (1998) suggests this is not necessarily to do with gender. Whilst he says research has shown that women tend to be more empathetic and recognise and match feelings more than men, he clarifies this by saying that there is a huge overlap in this ability by men and women – i.e. some men will be more empathetic than most women. He suggests that any gender differences may be more to do with motivation – or due to being socially acceptable. Lutz (2004) suggests that women are perceived as showing emotion more overtly and for longer. Furthermore, Kovecses (2000) shows how culture, emotion and biological-physical processes are all part of an "integrated system". I find Elias's (1939) notion of shame emerging in civilising processes to be a helpful way of making sense of how the degree to which emotion can be expressed is socially learned.

I remember on a counselling course many years ago, we were given "homework" to record our feelings over the course of a week. I found this difficult. Labeling and noticing feelings was not something I had been encouraged to do before, and was not always consciously aware of. Rather, as a child, I learned to hide my feelings, responding to subtle messages such as disapproving looks from my parents and others. Indeed, as previously discussed, Elias (1939) links emotion with processes of socialisation, whereby children are taught how to behave, and feel shame if they don't conform. Similarly in nursing, it is recognised that nurses learn to remain detached or to cope with emotional work, or "emotional labour", such as caring for the dying (Smith, 1992; Hochschild, 1983; Menzies, 1970). Hochschild's (1983) work, initially studying air hostesses, shows how emotions are "managed" by hiding negative feelings. Those who are not able to divorce their feelings suffer from burn out or leave their job. However, it has been questioned how people *feel* about the emotion work they do (Williams, 1998) and it is suggested that viewing emotion work purely from the perspective of commercialisation may be limiting. For example, from an Eliasian perspective, the way people express emotion has emerged as a wider social process of self restraint (Williams, 1998).

There has arguably been a shift in the theme of rationality to a recognition of emotion with the rise of feminism (Reissman, 1994) and individuality (Burkitt, 1999). In nursing literature, there is recognition of the importance of emotion and emotional intelligence (Bunting, 2004; Smith, 1992). McQueen (2004) says nurses require skills of emotional intelligence i.e. self-awareness, self-regulation, motivation, empathy and social skills.

From an organisational perspective Vince and Saleem (2004) argue that individuals and groups manage and organise on the basis of emotional responses as well as on the basis of avoiding them. However, they acknowledge that

> "Despite advances in thinking about emotion in organisations, there remains an unwritten rule in many organisations that it is inappropriate to bring emotions to work. The idea that emotion is "not part of the job" and can "get in the way" of effectiveness is pervasive. Also in one sense it is true, our emotional responses – particular fears and anxieties – can and do get in the way, but they can also provide the basis for learning, both individually and collectively" (Vince and Saleem, 2004, p.137)

Bunting (2004) argues the contrary however, suggesting workplaces are now accepting the inevitability of emotion and often actively encourage it. She argues that in an individualistic society

the consumer wants a personalised service. Nurses are now given responsibility for a small number of patients, and are expected to develop a relationship with them (Bunting, 2004).

The view that emotions are separate from ourselves is revealed above. Furthermore, some writers believe that emotional intelligence or management of emotion needs to be taught. McQueen (2004) calls for a "structured, rigorous approach to teaching" and argues that the use of reflective practice and self-evaluation are key in nurse training. Similarly, Smith (1992) argues that "the emotional components of caring require formal and systematic training" (p.139). She also suggests that it is the responsibility of the ward sister to make emotion visible (ibid). Including emotional intelligence (EI) in curricula for nurse training assumes this is a "thing" which can be taught or applied (in a similar way to reflective practice - see chapter 5) by a sender receiver model, rather than emerging in direct experience

These perspectives continue to see emotion as split off from everyday experience. This is particularly evident in some Western cultures where expression of emotion is less socially acceptable. Feelings are always present, yet often unconscious, however, it is possible to control to some extent the expression of emotion (Damasio, 1999). This is paradoxical when seeing patients, as I am responding to intimate personal concerns and fears, and yet at the same time I can remain detached in the sense that I rarely show emotion. A recent experience with a patient struck me as saying something about the issues raised above.

Permission to feel

I noticed from my appointment list that there was a young woman coming to see me who had cancer. I felt fearful and uncomfortable in my stomach, wondering whether I would be able to hide my own fears and wondering what I could possibly do to help her.

Her sister came into my room first, holding the door open as I watched the young woman slowly approaching my room. She walked very slowly with a stick, bent over, and I thought she could have been mistaken for a woman in her nineties. She managed a half smile as she sat down. I was aware of the contrast between her beautiful sister, smartly dressed and made up, with her sister the patient who looked bloated and tired, with a woollen hat covering what must have been a balding scalp, caused by the chemotherapy. Her mouth was swollen and she was unable to eat, she told me. I gave them both eye contact, allowing them to talk and acknowledging how she must be feeling.

As our conversation continued, we were able to talk about sobbing, not sleeping and feeling wretched. I was aware of feeling "on the edge", not wanting to show any of my own fears or horror for what she must have been experiencing, yet feeling surprisingly calm and yet alive at the same time.

When they left the room, I shed a few tears before composing myself for the next patient. I realised I had been unaware of a sense of time, and I glanced at the clock to see I was now running 30 minutes late. The next patient came in telling me "I've got a sore throat". How long have you had that for? I asked. "Well I woke up with it this morning".....

I did not want to tell this story. It is what I do, and what nurses and doctors are dealing with every day to a greater or lesser degree. It feels difficult to talk about something which I feel may be seen as gloating, "do-goody" and exposing the very personal and private difficulties of people like the woman above. It also feels self-indulgent, as I am able to feel my own feelings of sadness and fear through those of another person. Where I may have tried to hide my feelings of sadness and grief after painful experiences in the past, I feel legitimate in feeling them now. My role, in a sense allows me permission to feel, when in many situations it might be seen as "shameful" when not following socially accepted behaviour. Patients likewise often apologise for showing emotions. Perhaps expressing emotion becomes legitimate through the sorrow of the "other". In the way that activities such as sport allow "compensatory expressive outbursts" of excitement and "emotionality", as Elias (1986) describes, clinical roles, such as nursing, also allow feelings "tempered by civilised restraint".

My experience of emotion is therefore not something split off from experience, rather arising as I am experiencing feelings either consciously or unconsciously. There is no sense that this is a "thing" that can be taught. As the neurosurgeon Damasio (1994) suggests, awareness of emotion as feeling comes with being a conscious human (which he calls the autobiographical self). "Only along with the advent of a sense of self do feelings become known to the individual having them" (p.36) and, he argues, these feelings cannot be ignored or suppressed (ibid). Furthermore, feelings are experienced bodily, even when there are attempts to hide emotions such as anger or sadness.

Damasio (1999) proposes that until now, the history of research has not trusted emotion, "largely relegating it to the dismissible realms of animal and flesh" (p.38). However, research on the brain has revealed that emotions assist reasoning and "are complicated collections of chemical and neural

responses" (ibid). Whilst we can suppress expression of emotion, depending on cultural influence, we cannot suppress them entirely – and the feelings we have inside "are a testimony to our lack of success" (p.49). In terms of health, paying attention to bodily feelings is arguably more healthy than ignoring them - trying to contain emotion is the stress which can make us physically ill.

More recently Tobin (2005), from a complex responsive processes perspective, has stressed the role of emotion for leaders of organisations. He suggests that an awareness of emotion and feeling enables leaders to be aware of what others may be feeling, yet also remain detached when making rational decisions, to guard against the more destructive potential of emotion (ibid). Whilst I recognise this ability to suppress emotion, I believe that this misses the aspect of emotion I have described where awareness of feeling has enabled me to respond "with feeling" or more convincingly or passionately. Being aware of how I am feeling allows me to pay attention to situations where I feel a sense of dissonance or resonance, and are a source of energy for a response which may shift habitual patterns. As Williams (2005) suggests, a complex responsive processes methodology and Elias's (1987) theory of involvement and detachment develop an ability for reflexivity, questioning "how I feel about how I feel" which has the potential to change one's personal narrative. Walker (2006) describes the importance of what he calls "now" moments in terms of leadership, whereby paying attention to the moment is crucial. He argues that it is perhaps in these moments of awareness of feelings or thoughts where our response has the most potential to shift patterns of conversation. I suggest the increasing reflexivity, which this approach implies, develops skills in awareness of feeling and responsiveness *in the moment* and thus the potential for change.

Damasio (1999) also describes feelings as reflections of body state changes in interactions with the environment and these background feelings help define our mental state and colour our lives. A more acute awareness of the environment has arisen as I focus my attention on my experience from a complex responsive processes perspective.

Complex responsive processes and the non human? Responding to the environment

During the process of undertaking this PhD, I have been aware of how the environmental context appears in my narratives, such as the setting for a meeting (for example the Expert Patient meeting in Chapter 6). I have also been aware of focusing attention on the environment, wildlife, the design of my home and clothing, and my cats. This may be a welcome distraction from academic work, or say something about my personal history. However, I wondered how this relates to the theory of

complex responsive processes. As an embodied human being I am also continually responding to the environmental context I find myself in, either consciously or unconsciously (Damasio, 1999). I am aware of how the weather affects how I am feeling and my ability to work or think. I notice my reaction to colour, sounds and touch. I have sometimes needed to clear out my study, clear my desk, clothing or home and at other times I have needed to feel warm and secure in my garden in the sun or in front of the fire. Kinnvall (2004) refers to the importance of feeling "at home" in one place more than another and a place where one is "safe" from intruders, on "solid ground", as a way of removing anxiety. Hunter, below reflects on this aspect of experience.

> "I think space influences thoughts, actions and how these two play out between others is something that has not been studied very much. Think of how you feel when you visit a favorite building/house from your childhood. I do not think buildings are static things. I think that if you extend the philosophy of complexity there is a connection to what we have traditionally conceptualized as static, non-feeling, and non-human forms" (Hunter, 2003).

Whilst I would not go so far as to imbibe a building with its own feelings, I am often aware of my own responses to how I am feeling in a particular environment. My work environment seems almost sterile, in a room without a window – somewhere you would not want to linger – and perhaps reflects the sense of pace needed to see so many people in one day. However, I have a bouncy toy to entertain young children and a screen saver which reminds me of my holidays. Other nurses performing different tasks play music or the radio. These aspects of human experience cannot be ignored, and as some of my narratives have shown, the physical environment of meetings and conversations has an effect on how I am participating.

In health care, the importance of the environment on health and recovery of patients as well as the sense of wellbeing of health care workers has been recognised. Florence Nightingale herself found that recovery from illness would be improved by introducing light and fresh air to the dark early hospitals. Ulrich (1984) discovered that recovery from surgery was hastened by looking onto a natural landscape. Mizan (2004) argues that the "built environment" - such as the doctor's surgery, with a maze of corridors, and doctors rooms with posters of various "innards" adds to the stress of feeling ill. Furthermore he suggests that these environments reinforce the power imbalance between clinicians and patients. Being separated by a desk and a computer and different heights of chairs may also serve to alienate patients. Mizan comments that little research has been done on the built environment and primary health care (ibid). However, more recently it as been acknowledged that hospital design is important for patient recovery (Knutt, 2005).

How does this link with complex responsive processes? Is the way we respond to the environment also complex responsive processes? An area not yet fully developed in the complex responsive processes literature is what Elias calls the third dimension of experience i.e. "the relation of social human beings to events in the non-human world" (Elias, 1991, p.97). Stacey (2001) refers briefly to the impact of the physical environment which both enables and constrains interaction. The action of animals, for example, eating vegetation which is replaced by other kinds of vegetation, thus alters the physical environment. Drawing on Mead, he argues that mind or consciousness and interaction are processes which act

> "within and between individual bodies characterised by biological rhythms that constitute feelings, within an environment of other organisms and the material world within which people operate using tools in order to transform the environment" (Stacey, 2001, p.86)

Stacey also provides the example of music, and how this is felt as changes in body rhythm. In a similar way it is recognised that colour has an effect on mood.

Burkitt (1999) argues that the human world is always intermingled and interdependent with the non-human world, which emerges in various ways in our relationships and practices. He suggests Elias's dimensions of experience cannot be separated, rather exist at the same time. He uses the term "thinking body" (p.67) or "bodies of thought" to demonstrate what I believe him to be describing is the paradoxical nature of this multi-dimensionality of human experience. Burkitt, in a similar way to the theory of complex responsive processes, asserts that language is not the only mode of creation of knowledge. Human beings create and develop artifacts including language, tools and other instruments or inventions (Burkitt, 1999). Furthermore, he describes emotions as complexes, irreducible to social structures, discourses or the body.

> "we must take account of the part played by human embodiment within the ecosystem when considering experience, language and knowledge. We cannot convincingly maintain an extreme ontological skepticism, concentrating only on communicative relations and discourses....There is no absolute separation between nature and culture, body and mind, materiality and knowledge, for these can be understood as dimensions, interconnected through relations and practices mediated by artifacts, involving the thinking bodies of persons and selves" (Burkitt, 1999, p.89)

It seems, however, that we lose our ability to pay attention to our environment when focusing on something outside of ourselves and our everyday experience. This detachment from experience whereby, according to Crawford (1997) "our eyes isolate us from the living world: we are

observers rather than participants" and we pay less attention to our other senses. Paying attention to direct experience resonates in some respects with the perspective of the Gestalt approach to therapy (Perls, 1957). Although an existentialist approach which aims to maintain equilibrium or balance, the focus is on sensing, feeling and thinking on a moment-by-moment basis to complete "gestalt's" or unfinished business, often due to social constraints. However, less attention is paid to the historical aspects of how individual and social constraints are simultaneously emerging or the potential for creativity where there is an ongoing search for meaning.

Elias (1991) proposes that individuals, society and the non-human world are co-dependent on one another. He argues that nature, social control and self control form a triangle of interconnected functions which cannot develop without the other. However, increasing control of natural forces by humans (electricity, animal muscle power, nuclear power) has reduced the level of attention paid to the non-human world. "The feeling of....an invisible wall between person and person, self and world, is expressed very frequently in the recent history of the West" (Elias, 1991, p.118). Abram (1996) further makes a case for how the emergence of writing and the alphabet in Western cultures distracts attention to "ideals" or abstract ideas, thereby distancing ourselves from direct experience with the environment and animals, which have remained so important in oral cultures.

Elias (1991) also points to the way nature and the inner self are increasingly seen as "good", whilst "society "out there" stops us from enjoying an authentic or natural life. The more idealistic perspective of complexity (Wheatley, 1992, Lewin, 1999) and environmental concerns such as sustainability and ecology (Sachs, 1993, Capra, 1991) perhaps reflect this. Arguably, environmental concerns such as global warming alert us to our ultimate inability to control the environment, and may indicate a shift in focus of individual and societal concerns to global issues such as these. However, a systemic view of a global whole where human beings are split off from the environment, which they can then stand outside of and control, ignores a complex responsive processes perspective which points to the simultaneous, iterative human and environmental processes of continuity and destruction, emerging from local interaction.

The above writers acknowledge in abstract terms the embodied nature of experience and the environmental context. I want to highlight how focusing attention on my direct experiences has heightened my awareness of the environmental context I find myself in, as an *implication* of making sense of experience as complex responsive processes. For example, responding to the environment, such the feel of a room, or emotional responses to often unconscious hormonal

changes, diet or the weather, as Damasio (1999) describes. Paying attention to the environmental context in meetings, or with patients, for example allows me to work more effectively. Rather than feeling split off from the environment, I am aware of my responsibility and interdependence with paradoxically spacio/temporal processes. I suggest that environmental aspects of experience are often ignored or taken for granted in the same way that ordinary everyday conversation is often taken for granted or devalued. Although we may be beginning to notice our effect on the environment, this is arguably with "intellectual detachment" (Abram, 1996, p.259) based on notions of control, rather than by paying attention to direct experience and therefore responsibility for what we are doing.

I conclude this section with my recommendation for focusing attention on the *quality of feelings* and the *quality of the environment*. Whilst Stacey advocates focusing attention on anxiety and how it is lived with, this does not go far enough to explain my experiences. Other writers focus on the dynamic potential of conversation (Shaw, 2002). Whilst a complex responsive processes perspective acknowledges emotion and feeling as protosymbols in communication, the focus on conversation may distract from this important aspect of experience. I suggest we have lost our focus of attention on feelings and environment and give primacy to the visual and therefore spacial sense, above other bodily senses. In this way we become "out of touch" with what we are doing, as we exist with, and affect, our environment and ourselves (Crawford, 1997; Abram, 1996). By paying attention to how I am feeling, I am more able to respond in the moment.

Moving, then, from a process of making sense of the theory of complex responsive processes, I have developed above the key themes of responsibility, process language and emotion, feeling and the environment, which have arisen during the process of reflexively paying attention to my experiences. The final chapter will reflect on my original question "What it is like to experience change in primary health care from a complex responsive processes perspective?" and conclude with how I see my contribution to knowledge from this perspective.

Chapter 9: How I am answering my research question "What is it like to experience change in primary health care from a complex responsive processes perspective?"

This final chapter returns to my research question *"What is it like to experience change in primary health care from a complex responsive processes perspective?"*. The substantive part of this chapter will concentrate on the main themes which have emerged for me as I reflect on my own transition, or movement, in the process of making sense of my experiences. Finally I ask what is my contribution? I will propose my contribution to knowledge from a perspective which sees knowledge *as* experience.

I notice now what seem to be overlapping phases in my research. Firstly, my attention was focused on making sense of the theories of complexity and the theory of complex responsive processes, which was an emerging new theory when I first began my research (Stacey et al 2000; Stacey 2000). Secondly, I increasingly used the theory with hindsight to make sense of my experiences – which felt rather clunky and arguably reified the theory and the experience as an "it". Latterly, however, arising from this perspective, I have noticed how I am paying attention to my experiences in the moment. These are by no means distinct categories, as I am still reflecting theoretically as much as I pay attention to emerging themes in the moment. However, the feeling of being disabled has lessened, as I will elaborate on in the section below "startled by headlights".

I begin with reflection on how my sensemaking has changed since completing my first degree in 1997.

How has my sensemaking changed?

At times I have felt as if there is an expectation that I will have changed during the process of the PhD and that this is required to justify both the theory and the time of study. Whilst I am aware that my understanding of the theory has shifted the way I make sense of my experience, having to survive in this context I find I am bumping up against ways of thinking and speaking about change, which earlier on felt frustrating. It is difficult to remember how I might have been thinking previously, as I am influenced by how I am thinking now. However, reading the reflective diary I wrote when studying for my first degree, I notice some of my conclusions about change and how it happens:-

"Learning by failure to produce clear recommendations at one presentation resulted in a realisation that I frequently became "stuck" in the implementation phase of the learning cycle.....(however) by producing clear recommendations in an innovative second presentation using flip charts, the GPs were happy to go ahead with my recommendations. Positive feedback from GPs and Practice Manager reinforced my new beliefs that by being prepared and clear, ideas are more likely to be accepted" (Excerpt from "Profile of Learning", Poole, 1997)

I read this again with some amusement at the implied beliefs about linear cause and effect and feedback loops, surrounding managing change and learning. However, I am also aware of how I needed to prove myself as competent in order to obtain my degree, and to fit with models and theories of change and leadership used on the degree course (Kolb, 1984, Schon, 1983).

I felt that "failures" were something to do with my own performance and that I only had to learn how to get better at managing change in order to guarantee success. This view was perpetuated by a "success" at one practice, as described in Chapter 1. However, I also remember a feeling of unease about what I was interpreting as my own success in "applying" these ideas, or trying to fit my sensemaking into these models. I was working with many other people who made the new "elderly health workshops" possible – not just me. In a new role at another practice, I felt I had failed in my attempts to introduce change, despite pursuing the same process I had followed at the previous practice.

With hindsight, my first diaries of experience in the practice and PCT felt like "clunky" links to the theory, using metaphors,

> I suppose this is all healthy in that bringing in diversity is likely to cause some misunderstanding and provide opportunities for novelty to occur. However, I also wonder how it was that someone who is obviously from a hierarchical background ended up at our practice. I have my suspicions that some of the doctors feel that this is how the practice needs to be run. I wonder if Andrew noticed this or if he was even aware of what sort of person he was looking for.
> My reflective notes at that time:
> Here I am beginning to make sense of what was happening from a complex responsive processes perspective. I am beginning to acknowledge that diversity and misunderstanding are necessary for novelty to occur. Issues about constraint are emerging, as I believe that the doctors have the power to decide which practice manager to appoint. There is also a feeling that a repetitive pattern is emerging with themes around checking and blame. (Excerpt from diary, 3/7/01)

I was making assumptions about complex responsive processes having implications for the sort of organisational structures which are preferable, and hierarchies being bad. I became frustrated at the dissonance between what I saw was the "right" way to operate from a complexity perspective, and what people were already doing (also see below).

Heroes and villains: an idealistic perspective?

My introduction to complexity theory initially inspired my idealistic thinking, as a way to make things "better", and was a relief from feelings of disappointment at what seemed like my own failure in managing change. In some of my earlier writing, my PhD supervisors noticed a theme in my narratives about heroes and villains. I saw myself as the "fairy godmother" who had come to save everyone! I even experimented with writing fairy stories, which had a happy ending and were a way of expressing emotional hurt, without having to speak directly about it.

> *"And so this is the story of how the Fortress became a happier place, where the magicians, elves, fairy godmother, wolves and the people lived happily together, telling the stories of how things used to be and stories of how things really are today" The Tale of the Fortress* (see Appendix 2)

Whilst organisational life is characterised by fantasy and gossip and idealistic conversation, I understand this now as arising from power relations or who is "in" and who is "out", and the inevitable accompanying anxiety this brings. I also suspect some of my earlier writing was to an "other" such as the "medical profession", the "government" or the "PCT" with some of my frustration and blame detectable. After reading Donaldson's thesis on the part played by writing in organisational conversations, I became alert to the notion of audience i.e. who I was speaking to in my writing, and how the tone of writing can be felt by readers (Donaldson, 2003). As a reader of Donaldson's work, I too became the "audience" and this aspect of experience contributed to the process of sensemaking. In my later writing I am concerned to express how I am making sense of experience which may help others to make sense of their own experience. I also realise that the theory of complex responsive processes points to the simultaneously creative *and* destructive aspects of experience.

At a recent away day with the Nursing and Services Directorate team, we talked about the impending strategic alliance with a neighbouring PCT. The organisational structure would be changing and this was the last time we would meet as a group. We talked about what we wanted to take with us into the new "structure" and what we wanted to leave behind. As some people expressed their sadness about the group disbanding, others feared the future. There were rumours

of dictatorial bosses and a more "businesslike" PCT we were due to be allying with. The facilitator in our group said it was normal for teams to speak like this about other groups. I too acknowledged the way we were fantasising and gossiping about the other "PCT" and individuals in it, "like a fairy story about the wicked witch". The members of my group laughed. At the same time the group expressed what they wanted to leave behind – "blame"; "gossip", "control" in, what I reflected on later, as a rather idealistic way. Despite recognising these as less desirable aspects of human nature, I realise that a complex responsive processes perspective has helped me to understand that difference, fantasy and gossip are necessary for transformative change and continuity. This is where I see a fundamental difference from other approaches which either aim to control or predict what will happen, or to idealise a future state.

Seizing up, thinking and acting: startled by headlights

At times a dissonance with traditional and new ways of thinking has led to feelings of being immobilised by my own thinking. Being consciously aware of what is happening in the moment I have tried to make sense of what was happening from a complex responsive processes perspective. This has felt similar to when I was learning new skills on my counselling course. Practicing speaking in a particular way, for example asking open rather than closed questions, summarising and reflecting on feelings in the moment, felt very difficult at first, and seemed "unnatural". A bodily feeling of tension and anxiety often led to a rather "clunky" or forced response to what was being said. So much so that my partner became irritated by my constant "open questioning" as I was practicing!

I have noticed this in other PhD students (and recognise myself) in coming to an understanding of complexity for the first time, grasping at metaphors such as "emergence" or "self organisation" in attempts to use the theory to make sense of experience. What are often unconscious ways of sensemaking were now at the height of my awareness. I am suggesting that, like learning to drive or trying to write with your other hand, making sense from a different perspective is like learning anything new. It feels unnatural, difficult and requires effort and attention. I think this is why in situations where I am required to make a contribution as a Board or Executive member, the dissonance I am experiencing often feels immobilsing as I have an internal conversation with myself. Other researchers have recognised this feeling (Donaldson, 2003) and a member of my PhD group described the feeling of "living with the handbrake on". Shaw (2002), who writes about her experiences as a management consultant, describes feelings of dissonance with traditional management perspectives and yet finds ways of expressing what she means, although not

necessarily using complex responsive processes terminology. Gradually, I have been able to focus more on the conversations I am having with others, without having to scrutinise my own thinking and response from this new perspective.

My experience at a complexity conference, in 2004, differs from the example above in that many people there were familiar with complex responsive processes ideas and the conversations and sensemaking resonated with my experience. Bumping up against traditional ways of sensemaking and the dominant voice in organisations feels wearing. It is comforting to be with people who share the same ideas. I also think about this feeling of identifying with and belonging to a new group, which feels positive. However, comments or intakes of breath when people used "systems" terminology alerts me to the possibilities of cult values emerging, where it can become difficult to disagree – and where you are either in or out (Elias, 1994). The strain of being with people who are not speaking similar language, or who I do not identify with feels stressful. Similarly, my experiences of the PhD process bumped up against different traditions, with supervisors from different schools of Health and Human Sciences, and Business. However, sometimes the negotiation of meaning and difference in views has helped to challenge my thinking.

How "useful" is the theory for others?

Having studied the emerging theory of complex responsive processes for 5 years, I am suggesting that the theoretical basis of complex responsive processes requires considerable attention in order to understand the concepts suggested. I have found the process sometimes theoretically challenging. Indeed "complex responsive processes" is a "mouthful" in itself, requiring considerable explanation. Using terms such as the "living present" sounds unusual and requires theoretical interpretation to make the significance of the words clear (Stacey et al, 2000). Whilst recognising the definition of the "living present" (Stacey et al, 2000), as the detail of the movement of the present which encompasses past, present and future, rather than a "here and now" point in time, I notice how I have avoided using the term "living present" in this thesis. Instead, I have searched for a way of expressing what this means which feels more "acceptable", when I imagine speaking to a lay or professional audience. Similarly ideas such as paradox and causality are abstract ideas which need some explanation of specific meanings in a complex responsive processes context. However, meanings are continuously negotiated and may change. I remember Jose Fonseca telling the story of how he missed one PhD group session, and at the next one he realised from the discussions between people that the meaning of a concept had changed.

Anecdotally, members of the complexity in primary care e-group have shared experiences of how others have responded with "blank faces" or of looking as if they were from another planet when they have spoken about complexity theory or complex responsive processes. Despite explaining the theory, many people question "well what do you do about it?", or "what are the tools to manage change?" It is easy to resort to dominant ways of thinking. Perhaps this explains why Stacey et al (2000) go to considerable lengths to explain what is different from existing theories.

Whilst my initial focus has been on understanding the theory, my purpose has been to explore my own experience from this perspective, rather than to explain the theory or concepts to others. My experience with this process has highlighted that complex responsive processes explains what we are *already* doing and not what we "should" be doing. Arising from this perspective the focus on my own experience has inevitably changed the way I am acting and responding to others in my daily life which offers the potential for change even *without* explanations of the theory.

As Glyn-Pickett (2004) argues (referring to complex responsive processes)

> "to talk about CRP in organisations is not helpful (definitely my experience), because we shift then into conceptual /explanatory mode. When we work perhaps with CRP as an informing frame, then we can focus our attention and engagement on what is emerging in the conversations in this moment, which is always novel and by definition creative (as Stacey et al point out)" (Glynn-Picket, 2004)

Some time ago, a GP Executive of the Primary Care Trust asked me if I could summarise my PhD thesis for him in a few words. I stumbled around trying to explain the connection with complexity science and emergence to make sense of experience in organisations. He said he had tried to make sense of what was going on and that it all boiled down to "not upsetting people". Feeling relieved I said, that's about it! This resonates with the need to survive, or maintain a sense of identity in the interactions of the moment, however the outcome is unknown.

I recently asked my partner how complexity ideas influence his practice. Working as an organisation consultant I am aware he is constantly bumping up against traditional management ways of thinking. He acknowledged a feeling of having to cope, sometimes colluding with clients, although finding ways to speak about the profound yet subtle thinking of complex responsive processes which explains how things are, rather than how they "should" be.

Stacey et al (2000) suggest " the question is whether the concepts resonate with lived experience". I have found that ideas such as unpredictability and anxiety often appear to resonate with others, without needing a full theoretical explanation of the theory. In this case, then complex responsive processes concepts seem to offer an explanation which people recognise and accept. It was my experience of trying to initiate change which resulted in feelings of *dissonance* with traditional change models. What seems to be at odds with the traditional ways of thinking in organisations based on systems approaches is that sometimes pèople seem to know intuitively that these don't work, but carry on with a pretence (formally) that they do. Perhaps this is because theoretical bases for action are often unquestioned and habits and ways of thinking are often unconscious or routine. Furthermore, it provides us with a defense against the anxiety of not knowing, and an illusion of control. The theory of complex responsive processes *does* resonate with my experience. What seems like common sense is also a radically different way of making sense of experience which challenges current ways of thinking in systems terms. The importance for me of this thesis has been in finding ways of speaking which reflect this difference and challenge established patterns.

My experience has increasingly been about refocusing on what it is I am doing as I am participating with others (and conversations with myself), rather than trying to "apply" the theory. Instead of viewing the way things get done as "wrong", for example with conversations about strategy or policy, the importance is not the document, but rather the processes of interaction surrounding the discussions about strategy which are valuable and important. Futhermore, I make sense of my own experiences of feeling I "should" be doing something as reflecting the constraints of having to conform to expected ways of behaving, or those imagined as being necessary for the approval of others, rather than this being "wrong". Recognising this opens possibilities for acting in a different way which offers the potential for change.

To illustrate what I mean, I noticed my reaction at a recent meeting held by the current practice manager to communicate the Practice Strategy to the practice team. The doctors had already agreed "the strategy" at a previous meeting. At a similar meeting two years ago, I had felt uneasy and frustrated about the possibility of deciding on a 5 year strategy as complexity ideas suggest that it is impossible to predict what will happen, particularly in the longer term. I wanted to "rubbish" what was being said but not knowing what to say instead. However, on this recent occasion I noticed with some surprise a feeling of calm and acceptance of what was being said as a gesture of *intention*. Indeed, the practice manager said that things might change, but that a strategy enabled us to make decisions in everyday working life. For example – knowing that we wanted to "grow" the

practice, would help us if a new patient wanted to register with us. Previously, the focus of my attention was on complexity ideas as a way of changing what we do in organisations – such as to stop planning. In other words, I took an external observer stance on how to "apply" these ideas in "practice", which splits theory and practice. More recently, my focus has changed to focus attention on my own participation, my feelings and my contribution in the present, as complex responsive processes of relating. Furthermore, I am now able to make sense of my previous experience of frustration and irritation in terms of power relations and anxiety. I felt simultaneously an "outsider" to the practice members and an "insider" with those who share an understanding of complexity concepts. I felt more anxious at the practice and fearful of being excluded further if I expressed these ideas. More recently, I recognise a feeling of trust, being valued and shared responsibility which has emerged more recently in life at the Practice. My focus is now on making sense of these patterns of power relating and the associated anxiety as it is arising. How I speak, listen or stay silent has the potential to change these patterns in some small or larger way, although I cannot know what will happen in advance.

Refocusing attention

Research and practice are intertwined, as a continuous process of sensemaking. I am unable to make a split between the two. Being a "researcher" perhaps alerts me and enables me to make connections and links and ask questions - being able to stand back and distance myself whilst also being involved and fulfilling my professional role (Elias, 1987). Research from this perspective requires the ability to distance one-self – or detached involvement, and to be critically reflexive. These skills are learned whilst participating fully in the experience of researching and practicing.

Research from this perspective explores my own experience whilst inevitably including others in my narratives. Writing in this way has made me aware of being ethically responsible as an ongoing process whilst trying to disguise the identities of others, as I have previously discussed in chapters 1 and 2. I have reflected that my anonymising has often meant distancing from them as real people when I refer to them by role rather than name, and perhaps also highlights a sense of power relating where I am describing them as "doctor", "nurse", "manager" or "patient".

In answer to the question what do I "do" differently, I believe this is a subtle and yet significantly different way of making sense of my experience of change. Is this merely "common sense", or common knowledge, and therefore not valid, as Olner (1999) and Martyn (2003) have argued? I am arguing that when change is seen as emerging from our own local interaction, it is important to

value and take seriously, rather than ignore or dismiss, one's own experience in the continuous processes of relating which are perpetually creating the future in the movement of the present.

Valuing the ordinary: meetings about meetings

Some time ago, I arranged a lunchtime training session for the practice nurses. The nurse representative providing the training session soon left and we continued to chat informally while finishing our lunch. I noticed the energy level rise as the nurses spontaneously discussed concerns they had about a patient's leg ulcer, which was troubling them. One of the nurses said it was helpful to get together to discuss problems, asking if we could continue lunchtime meetings in the future. The other nurses agreed. I said I would try to arrange this with the new practice manager, who I felt was very developmental and supportive. It was soon agreed that we would meet once a fortnight, with lunch provided. Feeling I had to make good use of the meeting, perhaps surprised and grateful that we had been "allowed" to meet with lunch, I sent an email asking the nurses what they wanted to discuss at the meeting. I made notes of a few issues I wanted to raise. However, I noticed that this meeting was rather quiet and stilted compared with the spontaneity of the last occasion. Feeling uncomfortable with the silence, I spoke about the new management meetings we would be having with two of the GPs. One of the new nurses commented on the number of meetings we would be having which took us away from seeing patients. She felt we were having "meetings about meetings". Another nurse suggested we could meet less frequently. I felt as if I couldn't get anything right. Firstly they had all asked for regular meetings. Now they were complaining about meetings for meetings sake!

I thought about how it is impossible to predict and control spontaneous conversation, which just "happened" following the formal training session. Trying to recreate this lead to my formalising the meeting we were having, because it had been formally agreed. My need for an agenda and taking notes seemed to stifle to spontaneity. I realised I was imagining the response of the "other" (such as the practice Manager, or the nurses) to my role as "chair" or "manager", which might value formal conversations and devalue informal ones. Spontaneous ongoing conversations I have with the nurses on a day to day basis often appear to be disregarded when they complain that they "had not been told" about something, which I am at that moment telling them informally. I have reflected that this perhaps says more about feelings of exclusion and power relations between the nurses, as new team members with perceived higher status have joined.

More recently I have become increasingly aware of the value of ordinary everyday sort of conversations, where new ideas often emerge. As the nurse meetings have continued, they have become more spontaneous – with conversation which jumps about with concerns, ideas, challenges and laughter, which although might seem messy, seem to have a quality which allows free thinking in a trusting environment. One of the nurses recently commented that we had ended the meeting talking about something "important" – when were discussing child protection issues. I wondered whether she needed to justify our meeting as having value – when perhaps the meetings are viewed as unstructured and messy – or perhaps too much fun for a work environment. Kettle (2005) argues that the quality of conversation between trusting people has become subordinated to "egotism, adversarialism and melodrama" in modern day society. I suggest that this has arisen from a society where we contain and protect our "selves" from society "out there" (Elias, 1991), to justify what we are doing but which may lose the sense of spontaneity and freedom of talk from where the novel may emerge.

I thought about how I can say more about these sorts of conversations which may appear to have value at times, but not at others, and how that's OK. However, it is impossible to predict or create the conditions in advance, as many writers advocate (Mitleton-Kelly, 2003) to produce desired "outcomes". I may think about the room layout, or which room to use, and experiment with different formats for the meeting, which may provide opportunities for more spontaneous and informal forms of conversation. Even when there appears to be the constraint of an agenda, there is always the potential for conversations which challenge the way things are done, for example when the nurses challenged my "meetings about meetings". For me it is more about being aware of what is happening as I am reflecting and participating, by asking questions and acknowledging and acting on feelings, which may shift the conversation. I am also more aware of the potential for what I say in my position at the head of the nursing team, as perhaps having more influence on others who may perceive me as more powerful than them.

I have come to think that what I will call "emotional knowing", evident in my narratives, which is a rich sense of experience which has a profound effect on what I think and do. When I have felt a strong sense of feeling or emotion, at those times I feel I have a greater sense of knowing or learning. Studies have shown that learning is greater where there are higher levels of emotion (Damasio, 1999). This awareness of feeling has allowed me to act and reflect on experience in the moment – rather than ignoring or denying feelings. For example, when I am seeing patients I sometimes feel that there is dissonance between us. Instead of trying harder and harder to explain

what I mean or give firm advice, I consciously stop and ask what the patient is thinking or feeling. Often they will express a fear or concern which I had not been aware of, allowing us to discuss this some more. In other words, I am aware of responding to the patient in the interaction whilst being aware of the enabling constraints of time or professional procedures.

This way of sensing how to respond in the moment by being aware, rather than forcing, or rushing, or trying too hard, perhaps reflects the paradoxical quality of thinking, feeling and acting, where change happens spontaneously in certain conditions which cannot be "manufactured" in advance. The quality of being aware "in the moment" arose for me recently in a work situation where the energy of strength of feeling enabled me to think and respond quickly "on my feet" to a difficult situation with my boss at work. This felt risky as I challenged patterns of "rational" decision making at the Practice. It was a new way of responding to gestures of rationality and therefore of power, which provided a greater diversity of response available to me, with the potential to change the feeling of being "stuck" in my usual pattern of behaviour. However, I cannot know if it will have wider reaching effects.

There is also a feeling of being "on the edge", in the moment, as I have described in my narratives. I compare this to the feeling of exhilaration when skiing at speed, where I am alert and responding quickly to changes in terrain. I imagine this is a similar feeling to surfing waves or sailing in strong winds. Moving too slowly there is a feeling of lack of balance and instability, or too fast of destructive chaos. Again, despite being acutely alert, the responsiveness has a quality of almost effortlessness. I suggest, therefore, that a complex responsive processes perspective leads to an ability to focus on a wide range of paradoxical qualities of knowing, in the ongoing process of relating with others.

Reflecting on my work with the Primary Care Trust, however, I have at times felt disappointed about my contribution over the years. I wondered why this is so. I am reminded of a pattern recurring in my own history, whereby I am conscious of feeling a "should" speak up and say something, and feeling criticised and guilty for not doing so, as I have mentioned previously. These personal constraints (which are also social) have the effect of making a spontaneous contribution less likely as I have an internal conversation with myself, with accompanying feelings of guilt, fear of ridicule and concern for approval. The implications of a complex responsive processes perspective has also highlighted a sense of responsibility for my own contribution and expectations of myself. I am able to participate more spontaneously in situations where there is greater trust

between people and where I feel I have more influence, at the practice, for example. The Primary Care Trust executive committee meetings are characterised by feelings of powerlessness and "being controlled" by "external forces". The dominant discourse is about meeting targets and maintaining financial balance, with increasing debt and threats of redundancy (Mooney, 2005) and an increasing sense of frustration and feeling out of control.

Perhaps this reflects a wider crisis in health care, pensions, the economy and the environment where all are seen to be under rational management control (Sachs, 1993). Challenging this way of thinking in a highly anxious situation where people feel their jobs are under threat feels risky. My perceived position in this context is of having limited power, as a nurse executive member. As Kettle (2005) describes, politicians are trained not to answer questions, the expectation is of "towing the party line", and behaving in a "corporate way", similar to my own feelings. I have become aware of feeling tired with it all, and perhaps this also reflects how others are feeling. This does bring into question, in terms of stress and human cost, the effect of the dominant way of thinking which views individuals as responsible for failures and where the illusion of being in control is maintained. At the same time, I am conscious of finding ways of speaking in the moment which offer a different perspective and challenge these ways of thinking, rather than "giving up" or blaming something or someone outside of myself. I do not hold what could be considered to be a powerful position at the "top" of the organisations I have described. This is one of the strengths of this thesis, where my sphere of influence is more limited than that of the Chief Executive, for example. However, those in "top" positions, whilst potentially having influence over many people, also depend on others for their survival. What I "do" differently is recognise that the only ability I have to do anything is in the movement experienced as "now"– so realising the value of that, whilst also recognising the limitations, becomes important.

Implications for Primary Health Care

I have already stressed that my focus cannot be to provide prescriptions for primary health care, or change in a global sense from a systems or outsider perspective. Indeed, a complex responsive processes perspective challenges the fantasy that it is possible to be "in control" of changing global patterns. Rather, the perspective I have taken enables an understanding of what is *already* going on in the messy, everyday experience of change as it is happening. This focus has significantly changed my awareness as I reflexively make sense of my own participation. I have drawn attention to a number of implications of this way of thinking, such as the sense of responsibility for my actions; the language I am using; and how I am feeling, implicit in this way of being. What this

means is noticing my own feelings, and sometimes risking participating in a way which challenges the dominant way of thinking. I try to keep possibilities for conversation open, rather than blaming what is happening on something or someone outside of myself.

What I am proposing from this perspective is that a changing focus for my own practice can serve as a way for primary care professionals and managers to make sense of their own experiences and refocus attention on what it is they are doing. I suggest that this way of thinking challenges the way we think about change, and therefore has the potential to change what we say and do. By paying attention to my own contribution and how I am able to respond, or "response-ability", new themes may emerge. My focus is – *how do I / we make sense of what is happening?*

I want to propose that change, in the way it is often spoken about, expresses *intention* in the movement of the present, rather than something external to what is already happening, which requires planning and *then* implementation. Furthermore, my intentions may differ in large or small ways from others' intentions. What may emerge is a pattern which no-one has intended or predicted. It makes no sense, therefore, to ask how we can change things, rather the focus is on what is changing and what we are doing as we are participating in processes of change. A different focus has been to ask *what is my / our intention in contemplating this action?*

Working in primary health care with a proliferation of structures, agendas and plans, "problems" and "solutions", labels and "diagnoses", I recognise that they may serve as defenses against anxiety, with an illusion about control, and sometimes as a way of absolving responsibility. Abstract tools and measures can distract from what is it we are aiming to achieve, such as better patient care. Furthermore, they are unlikely to produce the desired "outcome". Holding tools "lightly" and recognising them as temporary ways of making sense of experience, attention becomes focused on everyday spontaneous conversation and an ongoing search for meaning. Noticing how conversation and action is closed down by using labels and categories, I try to participate in a way which helps to keep the conversation open by asking *what am I / are we thinking and doing that may be limiting the possibility for change?*

I understand complex responsive processes as a way for primary health care professionals to pay attention to and value ordinary everyday experience. Sometimes the more ephemeral or ethereal qualities of experiences in organisations get lost in the focus on tools and models. It also seems to me to be important to acknowledge anxiety and feelings which are always present in our

conversations, rather than something to deal with, and put to one side. I think about anxiety as the excitement or curiosity necessary for new pattern to emerge and pay attention to – *how am I / are we feeling?*

What is my contribution?

The purpose of this study is to explore what it is like to make sense of change from a complex responsive processes perspective. My contribution is in the particular way of thinking about change arising from a complex responsive processes perspective, in a primary health care setting in the UK. I therefore make a novel contribution to a body of literature on change in primary health care. As I have sustained this way of thinking, a number of insights have emerged, which I believe make a significant contribution in a number of areas relating to change and primary health care.

Change from this perspective is perhaps an oxymoron. I have argued that from a complex responsive processes perspective change can be viewed as *intention* in a relational process. It is a desire for, and a focus for meaning making in the living present and an expression of how we currently would wish things to be. However, rather than viewing change as planning then action, the change is in the relating in the moment as we are making sense of the past with intention for the future.

Secondly, I have argued that change is experienced as *movement*. Change is happening all the time, yet what we notice are shifts in pattern with hindsight. Change is also experienced as the movement of the present, which is charactersied by feelings of movement in those patterns. This sense of movement is evident for me in this thesis and my experiences of undertaking a PhD. Change and continuity are thereby paradoxical.

Furthermore, I think about "control" as searching for pattern and meaning. Rather than focusing on controlling change externally, which is impossible, my search is for pattern and meaning in the processes of relating. This is a transient and dynamic process. At times I feel stressed with many thoughts I notice how a process of clearing things out allows new ideas and patterns to emerge. Often creative thoughts arise spontaneously as I wake in the morning, or while away on holiday when there is less of a feeling of having to "hurry up". What enables or constrains the possibility for shifts in patterns, or change, however, seems to me to be characterised by an over-riding theme of containing or embracing the anxiety associated with change, evident throughout the thesis.

The overall theme is the potential this perspective gives for challenging the ways we constrain ourselves which may limit the potential for change. Paying attention to the ways we contain anxiety, emotion, or use tools, labels, diagnoses, targets, habits etc, I am more aware of noticing and challenging ways of thinking and acting, by questioning assumptions which may change these patterns. Whilst enabling us to go on with a sense of meaning, constraints such as these, where they become too fixed or rigid, may block the potential for change. There is a balance between taking a risk in saying or doing something different and paradoxically the risk of saying or doing nothing. This theme is reflected in a number of ways throughout the thesis – such as risking offending someone or saying nothing of meaning; ticking a box to meet a target and risking not listening to a patient; to the risk of infection of one person to the risks to society as a whole. These paradoxes in everyday life are irresolvable but being aware of and accepting them, I am more able to live with the associated anxiety.

My earlier work explored what it is like to live through change in my work at a practice and Primary Care Trust. At the GP Practice I showed how the use of models and tools to produce culture change were useful in some ways – but perhaps not in the way they were intended. Tools enabled different sorts of conversation, however, focusing on the tool sometimes constrained the sort of conversations we were having, arguably distracting from feelings and issues of power relating. I was also able to show some of the messiness of change as it is occurring in practice, where culture was emerging in the stories I was telling and others were telling me, rather than being split off from my experience.

Reviewing my work as a nurse practitioner in relation to change, my contribution lies in a challenge to traditional ways of thinking about reflective practice. The particular way of viewing time has implications for what reflecting *on* the past, or viewing a video means. Although I can reflect on the past, this is always in the present, as I am reconstructing the past in the context of intentions for the future. Reflecting then becomes an ongoing aspect of sensemaking. In a similar way, I offer a contribution to the way medical consultations with patients are viewed. Rather than looking for cause and effects, or fixing and solving problems, providing fixed diagnoses, or even a model of listening to patients' narratives, I argue that consultations are *emerging relational processes* as we negotiate meaning together.

Living with the theme of PPI or ideology arising in my daily work, my contribution is in my argument that the way we *view* ideology affects how we think and act. Viewing ideology, as arising

in ordinary everyday interaction between people, rather than as imposed by someone "in control" affects how I think and act. I also notice that ideals can be used to *choose to constrain* ourselves – or as a way of not doing something. For example by saying it is not practice policy to prescribe a particular drug. Paying attention to ideological themes in this way inevitably changes how I think and act, by sometimes challenging established patterns. However, it can sometimes be very difficult to speak in a different way to the dominant discourse, especially where the risks of being excluded are too great.

In relation to anxiety my experience was of the temporary relief when using labels, diagnoses or routines (constraints) which at the same time may increase anxiety – such as being given a diagnosis or using a blood test form to end a consultation. My contribution lies in my lived experience which suggests that acknowledging and living with anxiety by relating with others, the *containing* of anxiety is in the processes of relating. Paying attention to anxiety in this way allows me to live with it in a way that may allow change, or question the "containers" we use which may temporarily relieve anxiety and yet lessen the potential for change.

Themes also emerged throughout the thesis, which I am arguing, develop the theory of complex responsive processes. Firstly, I have highlighted the implicit sense of potential and also responsibility which emerges from this way of thinking, and the potential of my contribution, however large or small. I am aware of the ability I have to choose to respond within the constraints I find myself in, which feels liberating whilst at the same time sometimes risky. Secondly, I notice the importance of the way we speak as perpetuating particular ways of thinking. I am aware of using process language, which I argue has the potential to change how we think and act. Lastly, I highlight the importance of noticing feelings and emotion as implicit in this way of thinking, which does not separate the physical and the emotional. I add to this the way we perceive our environment which also affects how I think and act. I argue that additional areas of focusing attention from this perspective are on the qualities of feeling and environment, as simultaneous dimensions of experience, and thereby important in understanding how we do or don't change.

I anticipate, but cannot know in advance, that it will resonate for other practitioners and managers working in primary health care. My experiences and writing has resonated with others (for example in my PhD group at the University of Hertfordshire and my supervisors), and in this way helped them to make sense of their own experiences. Whilst this is a very personal and unique perspective,

my self emerges from relationships with other clinicians, managers and patients in primary health care and therefore also reflects the social.

As research and practice are complex responsive processes of relating, research becomes a process of transformation of individual and social identities. Knowledge from this perspective *is* experience and further research becomes a process of reflexively exploring one's own experience in different contexts which include aspects of the past, present and future. My own experience has drawn attention to the simultaneous aspects of experience which cannot be separated, such as feelings and emotion, the inevitable sense of responsibility implicit in this approach, and the concept of continuous process. Further research would arguably provide a contribution to questions which are fundamental to human experience which ultimately concern our emerging identities - who am I / are we and what am I / are we doing?

My thesis has focused on my own experience in primary health care. In the final chapter, I consider the wider implications of this thesis, in terms of method, organisational theory, what is generalisable about the research, and what implications there are for change and policy in the NHS.

Chapter 10: Concluding themes: method, perspectives on organisations, and implications for change and policy in the NHS

This final chapter addresses some concluding themes. Firstly, I provide an exposition of my research "methods", and show how they are similar and different to other qualitative research methods, to enable this approach to be taught to others. Secondly, I will explore further how the perspective of complex responsive processes is similar and different to other organisational perspectives in the literature, in particular in relation to anxiety. Finally, I will ask what is generalisable about my research, what implications there are for change and national policy in the NHS, and what, if anything, it is possible to do globally.

Fundamentally, I suggest that all three of these areas are intertwined and arising from the philosophical underpinnings of this approach i.e. ontology (the nature of reality), epistemology (the nature of knowledge) and methodology, or how we come to know what is known. In other words, I am arguing that this perspective which sees reality and experience as complex responsive processes of relating has significant implications for how we view method, organisations, and generalisations about change in the NHS.

An exposition of my method

Method arises from both the research question and the underlying world view taken. A complex responsive processes perspective sees the individual and the social as aspects of the same processes of human interaction. There is nothing tangible produced by these processes at any other level, only further processes of interaction, which are in themselves pattern forming. The focus of attention becomes one's own experience of relating with oneself and others, as this is where patterns, themes, or change is continuously emerging. Other qualitative approaches maintain a dualism, giving primacy either to the social or the individual, and maintaining a split between the individual and the social, which complex responsive processes does not do. I will explain later why this is important. I will focus on how my own "methods" arose from this philosophical perspective *as* complex responsive processes, then compare this with other qualitative approaches which appear similar, such as autoethnography and narrative methods, in order to make this approach accessible to others undertaking research from a complex responsive processes perspective.

There is an inherent tension in describing research method when, from a complex responsive processes perspective, "method" is continuous processes of sensemaking. This differs from reifying "research methods" as something to be *applied*. What I have been doing is writing about what *is* happening in my experiences of sensemaking, *as* "method", rather than what *should* be happening, which is consistent with a complex responsive processes approach. Indeed, trying to describe this process makes messy emergent processes seem more linear. The balance, therefore, is in saying enough about the processes without trying to remove the messiness and uncertainty of making sense of one's own experience as it is emerging in day to day processes of interaction. At the same time, there is a need to communicate, share and debate what it is we are saying and doing when speaking about or teaching research method from this perspective.

Descriptions of method often do appear linear, neat and orderly and can lead us to think that research does proceed, or should proceed, in a linear, orderly way. Perhaps this is partly due to having to write in an ordered way, or to justify one's approach in a rational way. However, this does not prepare people for real life, messy, disordered experience and can only increase our anxiety about what we are doing when it doesn't fit with experience. Whilst descriptions of method may provide an illusion of control which may be more reassuring, they may also limit the potential for creativity.

In chapter's 2, 3 and 4, I described how my methodological stance emerged during the process of the research, and how I moved from initially recording interviews, to focusing on my own experience, whilst keeping a diary and writing narratives and stories of my experience. At that time, there was an absence of literature on methodology and method from a complex responsive processes perspective. More recently, Stacey and Griffin (2005) have written on this subject, describing their approach with students from the Doctor of Management programme, whilst comparing with, and differentiating their stance from, an action research approach. Several DMan students give examples of their work in their recent book (ibid). My own research funded by the Faculty of Health and Human Sciences, with two supervisors from a nursing background and one from the Complexity and Management Centre provided a tension in how one carried out research due to differences in these two stances.

Later I became involved in a PhD group at the Complexity and Management Centre, which was part of the Business School at the University of Hertfordshire. This group emerged around an

interest in narrative and complexity, and ran alongside, but apart from the University's Doctor of Management (DMan) programme (Stacey and Griffin, 2005). As I began to attend this group I was aware of a change in my focus. Instead of primarily focusing on literature searching, I was advised to start with my own experience and write about that. Many researchers start by interviewing, and struggle with the idea of focusing on their own experience, later beginning to realise – as one supervisor observed – that essentially the thesis is about yourself (Bentley, 2005). For me this emerged from my experience of sensemaking from this perspective. The focus is on making sense of, and valuing, the ongoing processes of relating in our daily life in organisations. A trusting and supportive environment in the PhD group made it feel safe to continue.

Locating experience in wider historical themes, and challenging assumptions as they are emerging is also important to considering how global themes arising in local experience are in turn affecting local interaction. Similarly, locating this approach in theoretical ontological, epistemological and methodological perspectives grounds the work in a particular ideology – that of complex responsive processes is to value one's own experience, and to take one's own experience seriously (Stacey and Griffin, 2005).

From this perspective it is important to start with one's own experience and focus on what seems interesting or puzzling. I had been inspired and curious when discovering the theories of complexity, while at the same time feeling a sense of unease and disappointment with models of change and leadership. It is these feelings or compulsions which, I suggest, are interesting in understanding why and how one undertakes research, and which are often ignored or sparsely mentioned in research methods literature (Conle, 2000). Focusing on experiences of puzzlement, strong feeling or curiosity and writing about this, enables greater reflection and reflexivity by asking "what is interesting about this?" or "why am I choosing to write about this?" or "why was I feeling like that?". It also alerts me to how I am responding to and operationalising themes emphasised by those in powerful positions.

Writing, talking with others, reading associated literature and re-writing as ongoing processes draws attention to emerging themes. The processes are thereby reflective and reflexive, messy, uncertain, and sometimes exciting, intriguing or confusing. Whilst other researchers may *recognise* these experiences, a complex responsive processes perspective makes these processes explicit rather than an unspoken given in other qualitative work such as autoethnography or narrative methods.

My aim was to reflect the feeling of the messiness of everyday life and also show the progression of my thought and sensemaking. Working with my diary notes to form narratives, parts were continuously removed and reinstated as themes evolved. Rather than being a formal, daily diary, I wrote down my experiences spontaneously, as soon as, or soon after I was struck by something puzzling, or when there was strong feeling. Rather than this being a daily occurrence as in writing a diary, this may occur after a few days or several weeks. In this way my own experience *is* the "data", rather than trying to eliminate myself or my feelings. These initial stories captured my experience and I worked with them to reflexively ask questions about what made them interesting, whilst making links with the theory. My supervisors read these drafts which eventually became chapters, and later drafts were read by members of the PhD group. Further questioning by group members, or the connections they made with their own experiences also challenged my thinking and inevitably influenced later drafts. There were highs and lows, feelings of anxiety and uncertainty about whether I would ever "get there". It was difficult to define what exactly made a good piece of writing, but there was a feeling of relief when it seemed "right".

De Vault (1997) talks about writing a "good story", arguing that "criteria for evaluating personal writing as sociology have barely begun to develop" (ibid, p. 224). She describes this as being like "jazz" – "it swings", "it works". She states that "these judgements are learned over time, although not always articulated in abstract form, and are based partly on assessment of how others will respond to a performance or text" (p. 224). In a similar way this is what I experience in the conversations with myself and others. I have no way of explaining in a linear way how to do it, or describing tools for what works. However, I am suggesting that qualities of trust and openness with oneself and others facilitate this change of focus. I am aware that my reflexivity and writing have changed, and that others perceive it as being so. I believe this emerges from a reflexive change of focus onto one's own experience in organisational and other social contexts.

An encouragement to keep writing in this way and to question why one is thinking and feeling in a particular way encourages greater reflexivity. I have found that the conversations, challenges and support of others doing similar work helps greatly. Becoming isolated with a particular way of thinking, without the challenge of other perspectives, is likely to limit and close down further thinking, or change. For example, if the group becomes too supportive, there is less chance for critical thought or learning. Ideas about identity and belonging have helped me to think, in an Eliasian way, about my own PhD group. Where this becomes more supportive and less challenging

the group may become more cohesive, with a stronger sense of identity, whilst at the same time becoming insular in its thinking, and excluding or critical of other ideas.

Having described my "method" as processes of reflexive sensemaking, by paying attention to one's own experience, I want to move on to explore what is similar and different about this approach compared with other qualitative research methods.

How is my approach similar to and different from other qualitative research methods?

My "methods" appear similar to qualitative methods such as autoethnographers and narrative researchers who pay attention to human experience. However, there are also differences in how other approaches view the Self and the Other, how they use their research "data", and the perspectives taken on reflexivity, which I will consider here.

There appears to be a nervousness in other sociological approaches about using personal experience as a method (Conle, 2000, Ellis and Bochner, 2000, Ellis and Flaherty, 1992), although this is beginning to change. Organisational research perhaps does not have such long held traditions or underlying assumptions about knowledge and how it is created, and therefore has found it easier to accept new ways of researching organisations. A complex responsive processes perspective, rather than merely acknowledging the researchers presence in the research, takes a firm stance in valuing experience or taking experience seriously (Stacey and Griffin, 2006) in order to understand what is happening in organisations.

Savage (2000) suggests that postmodern approaches signify a shift "towards greater subjectivity, more reflexive authorship" (p.1494). Similarly, Seibold (2000) notes "social researchers... are increasingly becoming aware of how the researcher's self is actually part of the research process" (p.148). Autoethnographers, for example, often combine or interweave their own experience with writing about others' experience (Ellis and Flaherty, 1992). Their purpose is to provoke feelings in their readers that they have experienced or could experience the events being described (p.11). This is arguably similar to the concept of resonance from the perspective I have taken. There is, however, an allusion to the different roles of researcher and participant, and of "tacking back and forth" between an "insiders passionate perspective and an outsiders dispassionate one"(p. 6). In other words, research becomes split off from ordinary, ongoing processes of relating. From a complex responsive processes perspective, research/ practice is simultaneous processes of detached involvement (Stacey and Griffin, 2005). Reflecting on my own experience I am paradoxically

aware of bodily feelings or emotion while interacting with myself and others, whilst at the same time reflecting in a rational or propositional way, rather than shifting between different roles of researcher and participant or insider and outsider.

Whilst feminist writers such as Oakley (1984) emphasise the social construction of the research encounter and the research process as lived experience some writers still aim to exclude themselves from their "data". For example, Seibold (2000) states "I wanted to ensure that the information I obtained was as untainted by my opinions and experience as possible". This clearly differs from complex responsive processes where one's own experience is the focus of attention. Furthermore, this split between the researcher and the research subjects or "natives" as Steier (1995) describes, arguably gives the writer a form of covert power, claiming to represent others' truths or choosing what to write without acknowledging the researcher's decision in that.

Other researchers do use their own experience as the subject of the enquiry. For example, Ellis and Bochner (2000) start with personal experience. This involves writing a story of experience retrospectively, or what they call "a systematic sociological introspection and emotional recall" (ibid, p. 737) to recall a past event, which suggests a different view of time from the living present of complex responsive processes (Stacey et al, 2000). Conle (2000) writes her thesis as a narrative of her own life. She says this differs from the dominant use of narrative, in that the way of writing "in or of itself puts in motion a particular mode of enquiry". She continues "the problem, although it may be connected to some sort of unwellness is primarily an impetus for inquiry". "In personal narrative inquiry the body of knowledge to be explored is the writers life" (p. 194). Drawing on Dewy, Conle talks of how her stories rhythmically moved between yielding, or surrender and reflection in a dialectic. For me, this was a dynamic between exposition and vulnerability or the risk of baring all whilst maintaining distance. This is similar in some respects to my work, however, my own "life" is not my primary focus, rather my experience of working in primary health care which inevitably includes some of my own personal history as it is arising in the present. One's "life" could arguably become a thing, or "data" to be analysed, in a similar way to "narrative" becoming something out there, rather than my focus on the ongoing, emerging experience in processes of relating with others.

I do not aim to speak for another, other than in the way the "other" is forming my own experience. Rather my experience of the "other", or the social, is in the way we are all forming and being formed by one another. Does this seemingly subtle difference matter? I believe it does. When we

claim to speak for or represent the "other" in a context in time, we are taking a systems view where our attention is on something outside of ourselves. It is then easy to assume we can control what happens to a system, or to blame something outside of ourselves for the state we are in, and remove the focus from our own responsibility in reflexively participating in the interactions in the contexts we find ourselves in.

Reflexivity as research process or on the self as separate?

From my experience of supporting students writing on degree or Masters courses, I am struck by the reluctance to write in the first person. Students are rarely present in their writing, relying on the "third person" and references to the literature as justification of valid truth or knowledge. My comments in the margins ask "what were you feeling?" or "what are *your* thoughts about this?" Giving "permission" to do this arguably needs to come from those who are judging or examining student's work. Permission to value one's own experience is a key aspect of method from a complex responsive processes perspective.

Most social constructionist approaches are also concerned with reflexivity. As Steier (1995) suggests, however, "many have adopted a constructivist label on a package whose contents are defined by "objectivist" inquiry" (p.3). He adds that researchers must be included in their research (p. 5) and research is conversation (p.6). Hertz (1997) describes reflexivity as the "scrutiny of what I know and how I know it" (p. viii); "it permeates every aspect of the research process, challenging us to be more fully conscious of the ideology, culture and politics of those we study and those we select as our audience". This perspective separates the researcher from the researched and from the audience of the research. From a complex responsive processes perspective reflexivity not only permeates the research process, it *is* the research process which includes me among "subjects" and as "audience" at the same time.

Hertz (1997) continues "since researchers are acknowledged as active participants in the research process, it is essential to understand the researcher's location of self...in order to produce less distorted acts of the social world". Here Hertz slips into a more positivist view of the research process, suggesting that the researcher's view can distort reality "out there". Reality for me is likely to be different from and similar to others' experience, at the same time. My experience of the social emerges as my own resonance with others, and my own reflecting on themes such as "Patient and Public Involvement", as they are emerging.

Qualitative researchers use reflexivity when thinking about their own part in their research. However, the focus is primarily on capturing the experience of the "other" in the form of writing their stories or capturing their experiences from interviews or narratives. What is denied is the inevitable relationship with other/s. What they are doing, or their method, is also complex responsive processes of relating, although the focus is on the experience of the "other" and the ideology one of objective reality. The value of a complex responsive processes approach or the ideology of valuing one's own experience, I would suggest, is that the very matter of paying attention to one one's own experience enables greater reflexivity and therefore potential for critical self awareness and change. Furthermore, focusing on one's own experience arguably leads to greater reflexivity, by the very nature of the focus, rather than diverting attention to the Other/s.

From a complex responsive processes perspective all "research" is complex responsive processes – in other words ongoing interaction, forming and being formed as themes, and power relating. Reality is the individual and social themes accepted as truth at that time in that context. By focusing attention on these ongoing processes and our part in them, I have argued in the thesis that there is a greater sense of responsibility and awareness of our own participating and contributing to what is going on, rather than a focus on an external whole or system which we try to control, or blame when things go wrong.

Method, from this perspective is focusing on and valuing one's own experience *as* complex responsive processes of relating, rather than a set of tools or process to be applied. Whilst there are similarities with other qualitative approaches such as narrative methods and autoethnography where the focus is on experience of the self and others, these approaches maintain a dualism between self and other in a way that a complex responsive processes perspective does not do. Focusing attention on one's own experience, or "method" as implied by a complex responsive processes perspective, enables greater reflexivity and awareness of one's own responsibility and contribution in processes of relating with ones-self and others at the same time, in organisational and other contexts one finds oneself in. In the next section, I will explore similarities and differences between the perspective of complex responsive processes and organisational literature, in understanding organisational life.

Locating a complex responsive processes perspective in relation to similar and different perspectives in organisational literature, and organisational perspectives on anxiety

What distinguishes a complex responsive processes perspective from other organisational, social and psychological perspectives is that individual mind and the social are understood as the same process. Individual mind is the private and silent action of a body directed towards itself, while the social is the public and vocal actions directed by bodies to each other. This is "an action theory, which does not require spacial metaphors of mind inside a person and social outside" (Stacey, 2003, p. 167). Complex responsive processes also takes a very different view of organisations with an explanatory theory based on transformative teleology or causality. Here I want to compare approaches in organisational literature which also take a human and processual view of organisational life, with a complex responsive processes perspective. In particular I will explore what teleological (view of causality) they take, what psychological approach they implicitly or explicitly adopt and how they deal with the concept of anxiety. The way one makes sense of life in organisations ultimately has implications for the way one acts, as I have shown in previous chapters.

Since the early 19th century, organisational literature has predominantly taken a systemic view of organisations and what happens in them. It was expected that systems thinking and the methodology of systems engineering would help engineer real world systems to achieve their objectives (Checkland and Scholes, 1999). For example, Taylor (1911) aimed to remove emotion and other forms of irrationality from organisational processes – so the organisation could achieve its goals. This is also reflected in a cognitivist psychological view where mind is seen to store representations or mental models of reality which can be changed. Other perspectives are more critical of this hard systems approach, arguing for a more human perspective on organisations, such as Wenger's (1998) communities of practice, soft systems methodology (Checkland and Scholes, 1999), learning organisations (Senge, 1990) and psychoanalytical approaches to understanding organisations.

Checkland and Scholes (1999) who describe a soft systems methodology, found that the management situations they were working with were too complex for straightforward application of a systems engineering approach (p. A6). Defining the systems they were working with, or its objectives (ibid) also proved problematic. They therefore distinguish between hard systems, arising from engineering, and soft systems thinking and move towards thinking about soft systems as an inquiring process, working with a problematic situation by using models as ideas. They describe

soft systems methodology as "emerging as an organised learning system" (Checkland and Scholes, 1999, p. A8). Whereas in systems engineering the word system is taken for granted as being something outside of ourselves, Checkland and Scholes (ibid) argue that soft systems methodology has different assumptions

> "The world is taken to be complex, problematical and mysterious. However, our coping with it, the process of inquiry into it...can itself be organised as a learning system" p. A10

Soft systems methodology involves building a rich picture; drawing systems from the rich picture and problem situation; and construction of systems models to debate change. The stages of inquiry involve analysis of the current situation i.e. roles, norms and values, seen as a socially constructed reality. The second stage recognises "commodities which embody power in the organisation" i.e. role, skills, charisma etc – i.e. what is the culture and what change is feasible. Modeling is then intended to "lift the thinking in the situation out of its normal, comfortable grooves" (p. A22). Whilst soft systems methodology does recognise power, values and roles, or more human socially constructed aspects of experience, power is seen as residing in "commodities" within individuals.

In hard systems thinking, process means the interaction between parts to produce a system. In human terms, process is therefore interaction between people to produce a system of which they are the parts. In soft systems thinking, process means interaction between ideas, values, power position etc, to produce whole conceptual and value systems or paradigms (Stacey 2003). In complex responsive processes, process means the interaction between human bodies that simply produces further interaction – the word process doesn't mean the production of some whole outside of direct interaction itself (ibid). Experience is thus thought about differently.

> "In soft systems there is a difference between the socially constructed changes of social relationship/ problems in the real world and the socially constructed systems models used to explain that real world. There is a distinction between experience or practice and explanation or theory" Stacey, 2003, p.193.

There is no such distinction in complex responsive processes. Furthermore, soft systems methodology takes an ideological purpose of improvement, liberation and respect for diverse views. The focus is on what should be done rather than describing what people are doing and feeling. Whilst valuing human experience as the focus of attention, a complex responsive processes perspective does not make any claims that this will lead to improvement, or positive outcomes. The nature of complex responsive processes is that there is simultaneously creativity and destruction associated with ongoing processes of relating.

Whilst recognising human experiences of power and values, Checkland and Scholes (1999) implicitly assume a rationalist causality, but one which also includes emotion, and a cognitivist psychological approach, where the individual is seen as primary. This differs from a complex responsive processes perspective which sees the individual and the social forming and formed by one another paradoxically at the same time. Little attention is given to anxiety from a cognitivist psychological approach. The human mind is seen as an observer of an external world, with the human brain similar to a computer, processing information, and producing mental representations that may distort reality.

Whilst a soft systems perspective of organisations takes a more processual view, individuals are separated from systems in a dualistic way, with a sender receiver view of communication which creates a social system which structures the internal world of individuals. Systems thinking therefore struggles with a dualism whereby people are free to choose what they do as individuals and yet are also supposed to be acting as part of a system. On the one hand the individual is seen as primary, and autonomous, with a rationalist causality (teleology) and mind comprises mental models of an external reality. On the other hand the system is seen as primary, as a whole formed by the actions of individuals, with a formative causality (teleology). It is this duality which complex responsive processes argues against

> "The point I am making about the difficulty of systems thinking with human freedom is not ideological at all. It is a point about explanation. If you have a population of free individuals making their own individual choices in the ordinary course of their lives then the behavioural patterns they together produce will differ from those of a population of individuals acting as part of a system. If they are parts of a system they will be acting to the systems' imputed intention. If you use an explanation modeled on this assumption and apply it to the population of exercising ordinary freedom you will not understand what is going on" Stacey, 2003, p 203

In other words, a dualistic way of thinking cannot explain human experience. Learning organisational theory (Senge, 1990) also takes a systems view and has been influential in organisational literature in the NHS (Davies, 2000, Garside, 1999, O' Sullivan, 1999, Starkey, 1998). The aim is to ensure the success of an organisation and to help individuals understand the effects of their actions on the whole system. Individuals are required to be committed to lifelong learning and to work together to share mental models as stored in individual heads, or in other words a cognitivist or constructivist psychological perspective. Senge (1990) also stresses the need for a shared vision in order for the organisation to succeed. Teams are required to have dialogue, or

a special form of conversation where the group is seen to be able to do more than individuals alone. Mental models are, often unconsciously, stored in the brain about the world, and there is pressure on individuals in groups to conform to mental models.

Argyris and Schon's (1978) theory of mental models and single and double loop learning underlies learning organisation theory. They propose that it is possible to reflect on and change one's mental model with double loop learning, where one reflects on one's assumptions and changes them. In other words it is possible to take an objective position by standing outside mental models and changing them. Game playing takes place as a defensive routine as it is difficult to discuss changes in mental models, as it may threaten power relations and create anxiety. Argyris has reported that it is difficult to change mental models in reality. The question is then how do organisations change if changing mental models is such a rare occurrence.

Learning organisation theory thereby gives the individual primacy over the group. People are assumed to be the same and deviance or eccentricity are not recognised as essential to creativity (Stacey, 2003, p. 126). In terms of causality, there is a conflict or duality between rationalist and formative. Mind is seen as a model or system (formative) which the individual can choose to change (rationalist). Rather than explaining what happens, it explains what should happen and cannot explain freedom and novelty.

Some other writers also see the individual primary to the group. For example, Kostenbaum (2003) argues that the two great intellectual movements of the 20th century were systems thinking and existentialism. Kostenbaum (2003) advocates standing out as an individual.

> "If I surrender to the culture, the culture will take care of me, I feel secure, and my anxiety is low. But if I stand out as an individual, then I must take care of myself, I feel insecure, and my anxiety is high, but I am my own person!" p. 161

For Giddens (1991) "anxiety derives from the capacity – and indeed, necessity – for the individual to think ahead, to anticipate future possibilities counterfactually in relation to present action...anxiety in a certain sense comes with liberty, as Kierkegaard says: freedom is not a given characteristic of the human individual but derives from the acquisition of an ontological understanding of external reality and personal identity" (ibid, p. 47).

From an existentialist perspective Kostenbaum (2003) argues that anxiety is due to realising we have choice – "you do not get rid of your anxiety; you become contented in it as you would swimming in cool waters" (p. 180)...One cannot ignore this anxiety but should welcome it as a sign of one's leadership growth" (ibid, p. 47). He suggests courage is the merger of free will and anxiety. Kostenbaum maintains a duality between the individual with free choice (rationalist teleology) and the organisation (formative teleology) and the individual is primary with a rationalist causality. However, he does pay attention to anxiety as being a necessary part of being human, albeit residing within the individual.

Psychological approaches also maintain this split or dualism, and influence the way anxiety and power are thought of in organisational literature. Human Relations theory aims for group harmony and the importance of conformity – added to by the development of cognitivist psychology. McGregor (1960) focuses on styles of management, either autocratic or participative, and empowerment of individuals with missions and visions. Organisational writers on complexity and complex adaptive systems (see also chapter 3) maintain the notion of the autonomous individual. For example, Wheatley (1992) and Lewin and Regine (2000), hold an idealised view of caring relationships and harmony. Prigogine (1997) and Goodwin (1994), however, differ in the way they view entities resonating with one another and evolving collective ensembles.

Psychoanalytic approaches to organisations challenge a cognitivist, rationalist perspective and draw attention to how anxiety is experienced and dealt with in organisations. This perspective pays attention to the unconscious aspects of humans and defenses against anxiety, which are seen as arising from inherent drives or instincts in the early development of human beings. Menzies (1970) seminal work (see also chapter 7) takes a psychoanalytical approach to understanding the defenses used to handle the anxiety associated with organisational life by nurses in hospitals. She argues

> "The objective situation confronting the nurse bears a striking resemblance to the phantasy situations that exist in every individual in the deepest and most primitive levels of the mind" Menzies, 1970 p. 5

From a psychoanalytic perspective, when humans are confronted by high levels of anxiety, such as changes in what is required of them, or uncertain conditions, they revert to infantile ways of behaving. They are likely to regress to split the world and themselves into good and bad, based on the inherent drives of libido (the drive to live) and morbido (the fear of death). Experience then

takes on a fantasy-ridden quality, little to do with reality. These drives are constrained by society, and this clash between drives and social prohibition structures the mind.

The importance of relationships is therefore recognised from this perspective. However, the individual is seen as primary and forms the group or the social. As Stern (1998) observes, "Freud's developmental progression from oral to anal to genital stages was seen as the sequential reorganisation of drive, or the nature of the id" (p. 18). In other words, the development of the infant is seen to follow inherent drives, progressing from one stage to the next, rather than seen as a particular way development has emerged in the West. Stern (1998) argues that "the terrible two's are not terrible in all societies" (p. 23). Inter-subjectivity theory and relationship psychology take account of the relationships between people, rather than focusing on the individual. However, whilst recognising the relational aspect of development, Stern's inter-subjective psychoanalysis doesn't see the social in the same way as complex responsive processes does. He makes a Kantian split of humans from the study of wholes ("as if" they are a system) with mind as representations and society as a system, rather than a Hegelian (a paradoxical / dialectic) view emerging simultaneously (Stacey, 2000).

Bowlby's (1969, 1973) attachment theory sees anxiety as a response to the threat of losing an attachment object, rather than based on innate fantasies. However, he still views mind as an internal world. From a complex responsive processes perspective, evolution has produced the human body to require attachment / separation behaviour for physiological regulation. Anxiety is bodily arousal triggered by exclusion / separation, and inclusion / attachment regulates anxiety. As inclusion / exclusion are related to the shame and panic experienced and associated with exclusion from a group, the regulation of anxiety is thus a social, rather than a purely individual process. Furthermore, these patterns of behaviour are learned rather than innate, arising as they do in interaction and relating.

A complex responsive processes perspective is therefore similar to psychoanalytical approaches in the importance that is given to attachment / separation and unconscious processes. Paradox is also recognised by both perspectives. However, complex responsive processes does not view the unconscious as something separate from ongoing experience which needs to be uncovered, nor is there a recognition of regression, defenses and repression. Also, attachment / separation is not due to an inherent drive, but rather emerges in relation to ongoing gestures / responses which are continually emerging. The individual is not primary from a complex responsive processes

perspective as the individual mind is socially constructed within the constraints provided by biological inheritance (Stacey, 2003, p. 154). However, both perspectives recognise anxiety and ways of understanding it.

From a complex responsive processes perspective, anxiety is the inevitable companion of shifts in themes, leading to uncertainty and changes in identity (Stacey, 2003, p. 418). "Anxiety is not a substance but a pattern of brain processes" (Stacey, 2003b, p. 278). The importance from this perspective is to pay attention to what makes it possible to live with the anxiety as there is a continued search for new meaning in a similar way to a psychoanalytical perspective. However, from a psychoanalytic perspective the therapist, or the manager, is responsible for "holding" the anxiety of the group, whereas from a complex responsive processes perspective it is the quality of the conversation which enables the "holding" of anxiety, or the sort of conversation, with characteristics of trust, which enable anxiety to be lived with.

Stacey (2006) argues that the stress associated with meeting targets, for example, makes it less likely for the type of conversations which enables people to live with anxiety to develop.

> "some patterns of relating enable those interacting to continue productively with each other while living with anxiety, while others do not....for example, those having the quality of trust enable people to go on together despite the anxiety they feel while patterns of suspicion and mistrust exacerbate feelings of anxiety to the point where the thematic patterns of e.g. aggression or apathy might be triggered. Instead then of thinking of the therapist or anyone else as "holding" or "containing" anything, it is the qualities of relational patterns that account for the capacity to live with anxiety, uncertainty or other potentially debilitating effects" Stacey, 2003b, p. 278

Furthermore, Stacey (2000) argues that the themes triggered by anxiety may well have to do with re-patterning the dynamic of inclusion and exclusion, with shifting power relations (p. 149). Without such disruptions, triggered by anxiety, there would not be any change at all.

> "anxiety is thus an inevitable companion of change and creativity and so, it follows, are disruptive interruptions of communication.... When one expects the unexpected generated by these processes it all makes sense and anxiety levels drop as one accepts that change cannot be controlled by anyone" Stacey, 2000 p. 156

I suggest that this way of understanding that anxiety is an inherent and necessary aspect of relating and change enables us to live with that anxiety. From a relational psychological perspective Stacey concludes

"If one assumes that the mind is an "internal world" inside a person, then one focuses on internal objects and universal patterns of interaction between those objects – innate universals such as infantile sexuality etc. As soon as one sees the notion of internal world simply as a social construction produced in the last few 100 years in the West, this way of thinking about therapy and therapy groups becomes problematic. If one assumes that mind and social are aspects of the same process of relating, then one focuses attention on the direct, ordinary experience of relating to one another" Stacey, 2003b, p.8

Similarly when thinking about organisational life, the focus of attention changes from observing and trying to change organisation wholes, to the direct and continuous processes of relating with others.

Organisational approaches such as soft systems, learning organisation theory, pyschoanalytic theory and complex responsive processes therefore have some similarities in the way they take account of human and relational aspects to understand organisational life. In particular, psychoanalytical theory points to the importance of anxiety and ways of dealing with it. Whilst some approaches aim to minimise, contain or hold anxiety, within an individual or individuals, a complex responsive processes perspective sees anxiety as arising in processes of relating, as an inherent and necessary part of change (Walker, 2006). Where the theory of complex responsive processes differs is also in the way the individual and the social are aspects of the same processes of relating, giving primacy neither to the individual nor the social. Instead of focusing on the "other" or the system, the focus of attention then becomes the experience of the ongoing process of relating with simultaneously stable and changing identities, power relating and the inevitable anxiety which this brings.

In the next section I will explore what this perspective implies in terms of making sense of what is generalisable from the research, implications for policy and change in the NHS, and what, if anything it is possible to do globally.

What is generalisable in the thesis? What are the implications for change in the NHS and for national NHS policy? What is it possible to do globally?

My approach in this thesis has focused on my own experience in primary health care. My purpose has been to make sense of experience from a complex responsive processes perspective which enables others to think about their own experience differently, rather than focusing on global patterns from an outsider perspective. Global patterns are evident as themes emerging in my narratives and day to day interaction, and these global themes exist only as they emerge in these

ongoing interactions with one another. The global and the generalised arise in the way they are taken up as themes in ongoing local interactions. My "local" experience includes interaction with individual patients, groups and committees as well as responses to political directives, hence this is local and global at the same time.

The answer to the above questions of generalisation and global implications from this perspective can only be to pay attention to one's own local interaction, in which global patterning is continuously emerging in the ongoing interactions, conversations and feelings of which we are all a part. For example, themes about what it means to be a doctor, nurse or patient and what it means to talk about the NHS are continually arising in the local interactions we are having with one another. I have shown that this way of making sense of generalisation and global themes also implies a particular way of thinking about what it is possible to do in terms of policy and change in the NHS. Indeed, from this perspective changes in global themes arise only in the local processes of interaction. I have argued that when we speak about change, we are expressing our intention in the local interactions we are having with one another. Themes arising in the local interactions of those in powerful positions emerge as directives or policy which speak to large numbers of individuals and groups, where they are operationalised with the potential for many, many different responses with unpredictable results. The focus of attention, then, is on ordinary everyday experience where global themes are continuously emerging.

From a complex responsive processes perspective generalisation can be understood as themes emerging in our conversation as ideology which orders our experience. Generalisations are what are considered true for me and true for us and are emerging in ongoing conversation. For example, I may talk about the theme of "Patient and Public Involvement" but what this means is always emerging in the conversations I may have with a "patient" or on a committee. The theme of "compliance", for example, may be operationalised very differently in these two contexts.

The theme of responsibility in my thesis may resonate for others as they focus on their own experience and may continue to arise in ongoing relations with others. The themes about change and how it is emerging in the ongoing conversations at the practice or Primary Care Trust may be generalised in the way they may resonate for others who reflect on them in their own practice and may change the way they are participating. Generalisation, from the perspective I have taken, therefore, is in the way themes emerging as experience resonate for others in their own

paradoxically similar and different experiences. Themes are then paradoxically changing and stable at the same time.

Global themes are only present in the way they are continually spoken about and always with the potential for change in the ongoing local interactions we have with one another. What, then, can be generalised when thinking about change in the NHS? What do policy makers need to consider? In other words, what are the implications of this perspective? My narratives expose the messiness of change and how this depends on emerging power relations and ideologies with accompanying feelings of anxiety. In other words, responses to policy statements have to be played out, or operationalised locally. This inevitably challenges the implied assumption of policy makers that their actions are making changes to a system. Therefore one key theme arising from this way of thinking is that "policy" is a gesture to many people, however, how they respond depends on their own local capacity to respond. What is changing is arising in the ongoing themes as we are relating with one another in our own local context.

Making sense of what is happening from different perspectives effects the way we speak and act. This includes historical aspects as they arise in the present, for example, how the history of the NHS influences our interactions in the moment. I have taken an Eliasian perspective, where the current state of affairs is seen to be emerging as increasing specialisation leads to a greater need to account for what we do on behalf of others. This has also led to the impossibility of those trying to control what happens to see what is really going on despite continued attempts to stay in control. Stacey (2006), drawing from Kant, argues that the assumptions about change and "managing change" have arisen as a mistaken belief in an "it", or reified whole, which we can control rationally, forgetting that is it only a hypothetical system.

My experience highlights how on the one hand "the work carries on regardless" (p. 143), where consultations with patients happen as a day to day activity, whilst meeting quality targets is often a *separate* activity. This may call into question the amount of time, money and stress involved in trying to make improvements, which is arguably impossible from this perspective. Indeed, rather than producing improvements, there is an ideology of compliance, at great emotional cost, in order to get the work done (Stacey, 2006).

So what do we do instead? Stacey (2002) argues that the starting point would not be how to improve things, but how to make sense of what is happening differently. Making sense differently

may lead to doing things differently, or provoke further thinking. Stacey (2003b) later says, (talking about therapy) that he doesn't have answers about what to do instead, but that this shouldn't stop us challenging the way we think. Neither do I propose to say what we or others should be doing, only what I myself have found myself thinking and doing from this perspective. My narratives of my own experience have shown how making sense differently allows me, and therefore us, to act differently.

What is it possible to do globally?

From the perspective I have taken, the above question is a tautology. Since all interaction is at one level, it is not possible to globally manipulate or change themes or patterns from another "level". Indeed, insights from the complexity sciences suggest that global patterning cannot be determined locally. In other words, it doesn't make sense to suggest how we might change global patterns in any predictable way. As Stacey argues

> "it is only in the experience of local interaction that a global pattern is to be found. Global patterns are understood to be social objects and cult values, iterated over and over again in many, many local interactions, and as they are iterated they evolve because of the human capacity for spontaneity and the property of nonlinear interaction of amplifying small differences"
>
> "A very important conclusion follows from this way of thinking, namely that it is impossible to design global patterns of order simply because such patterns emerge in local interaction" Stacey, 2005. p.13

So what is it that leaders and those in government are doing? As Elias (1991) describes, it is possible to observe global patterns by taking a detached view. Stacey (2000) similarly suggests "humans are able to reflect on and articulate something about the widespread patterns that are emerging" (p. 334). This ability is not at some higher level, however. When taking a detached view, we are at the same time participating in the ongoing interactions as human beings ourselves. Therefore, that is all we can do. The dominant view is that ministers and policy makers are in fact designing changes to the whole through policy statements and structural changes. However, there is little evidence that this mode of governance works (Dobson, 2004, Ferriman, 2004). I have shown in the thesis that what happens in the messiness of everyday working life is a response to an infinite number of competing and conflicting ideals; values; constraints; roles; policy statements etc arising in the moment, in the multitude of endless interactions between people. My thesis cannot change global pattern directly, other than in the ongoing conversations which emerge and continue to emerge unpredictably from what we are all saying and doing. Whilst policy makers offer gestures

of greater power to many people, these need to be operationalised locally in responses constrained by both the local context and power relations.

Global change therefore arises largely uncontrollably from these interactions. What then is the role for, or is there a role for leaders, policy makers and those in government or managerial positions? Those in powerful positions, or in other words, those who have many others dependent on them for survival, are able to speak out to a large number of people and do have the ability to influence the sort of conversations we are having, but are never totally in control of the responses. People do have some choice in their response even in situations where one is apparently wholly dependent on another. For example, I have recently been working in prison healthcare, where prisoners are required to behave in a particular way, otherwise there may be severe sanctions, such as a denial of visiting rights or a lengthier sentence. Prisoners do, however, make choices about actions and how they respond to a prison officer, who then chooses how to respond, depending on many competing constraints such as their emerging relationship with this particular prisoner, or whether they fear reprimand themselves from the prison governor or a colleague. Power is thus not a commodity held by specific individuals and groups, but emerges in processes of relating as we are enabled and constrained by one another.

What can those in powerful positions realistically do? I suggest that a recognition of the limitations of policy, and the expectations of change that this will bring, the unpredictability of response and their ultimate inability to be "in control" – rather than "in charge" are the insights that the perspective of complex responsive processes brings. The potential of this way of thinking is in paying attention to our own experience in our own local interactions and recognising the potential of changing the conversation, although the response can never be known in advance. The value of leadership, rather than merely the roles we ascribe to leaders, is arguably in their ability for detached involvement (Stacey and Griffin, 2005), in a similar way to a researcher practitioner, by noticing, observing and articulating global patterns. The skill is in participating in ways to keep the conversation open which may allow shifts in patterns of relating (Griffin, 2002). Setting stretching targets, based on an assumption that the NHS is a system which can be manipulated, demands a response but may distract from the original intention, such as quality care. This leads to anxiety and frustration, game playing, deceit and counterfeit quality (Stacey, 2006, Williams, 2006). My own narratives highlight the anxiety around feeling the need to conform and enabling and constraining power relations (see Chapters 6 and 7). Leaders, and those in powerful positions, do have the potential to speak to, and request a response from, large numbers of people. They have the potential

to shift the conversation and focus on particular themes, such as "evidence based practice". By facilitating more open debate and conversation about what this theme may mean or themes such as lack of resources, or what we mean by quality, there is the potential for a more "adult" conversation. Furthermore, making sense of experience as complex responsive processes of relating would arguably focus more attention on what it is they are trying to do, and what is unrealistic, and might help in developing skills of reflection and reflexivity.

I have shown in this thesis how by focusing on my own experience from this perspective, I have been alerted to a sense of responsibility – an ability to respond and the potential this may have. Rather than maintaining a perhaps comforting, but rather childlike illusion that someone is or must be "in control" and therefore blamable, a complex responsive processes perspective is arguably a more adult way of making sense of the world. What is generalisable about my research is therefore in the way themes in my narratives resonate for others and help them to make sense of their own experience. The implications for change and policy in the NHS arising from this approach are in the way change is seen as arising largely unpredictably and uncontrollably from local interactions. Policy is seen as a gesture to many people and responses come in the many, many local interactions between people in their own local context. What it is possible to do globally arises only at one level of local interaction where global themes are continuously emerging.

Summary

The theory of complex responsive processes is a theory of how things already happen. But more than that it implies a way of living, in an inquiring, reflexive way which values ordinary everyday experience. Noticing my own feelings and responses allows me to pay attention to my own contribution in the moment, rather than focusing on or blaming something outside of experience. Making sense from a complex responsive processes perspective has shifted my own sensemaking and practice, and there is no going back. A complex responsive processes way of thinking leads to a realisation of the potential for one's own contribution or participation in the continuous processes of interaction. I hope that as a health care practitioner, I have illustrated, with my narratives and stories, a different perspective to enable others to make sense of their experiences.

My thesis therefore makes a contribution to knowledge in a number of ways. It provides a unique and rich exploration of the theory of complex responsive processes in a primary health care setting in the UK. I also explore what it is like to experience change in primary health care from a complex responsive processes perspective, as I am participating in my own daily work, and therefore make a

contribution to the understanding of what it means to be a researcher from this perspective. Furthermore, the thesis makes a contribution to knowledge in the way my narratives highlight the wider implications of a complex responsive processes perspective in making sense of change and policy in the NHS, by challenging the dominant view of change as something to be applied. What becomes important is paying attention to one's own participation in the local interactions of which we are a part, and where global patterning is continuously emerging.

Stand still. The trees ahead and the bushes beside you
Are not lost. Wherever you are is called Here,
And you must treat it as a powerful stranger,
Must ask permission to know it and be known.
The forest breathes. Listen. It answers,
I have made this place around you,
If you leave it you may come back again, saying Here.
No two trees are the same to Raven.
No two branches are the same to wren.
If what a tree or a bush does is lost on you,
You are surely lost. Stand still. The forest knows
Where you are. You must let it find you.

(in Whyte, 1997)

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Appendix 1

Glossary

Attractors

Attractors describe global patterns of behaviour in a system, for example depending on levels of speed or energy interaction in the system. At certain ciritcal levels between equilibirum and instability, behaviour is drawn to strange attractor. An example of this is the weather system with patyterns of air pressure, or the human heartbeat with regular irregularity. Strange attractors thus have paradoxical properties of stability and instability. Short terms predications can be made as to the behaviour of such systems, such as the weather behaving within predictable limits in a particualr geographical area. However, long term, behaviour cannot be predicted since small changes (or sensitivity to initial conditiona) can escalate to produce major changes in behaviour. These ideas from chaos theory suggest it is not possible in human organisational terms to try to predict or change behaviour.

Chaos theory

In 1963, the meteorologist Edward Lorenz provided the first example of dynamical systems involving only a few variables which could present chaotic behaviour afrer a few bifurcations from a reference state (Nicolis and Prigogine, 1989). Chaos theory describes the properties of systems that can be modelled by recursively applied nonlinear equations, such as weather systems or "bounded systems". The ideas grew out of many disciplines simultaneously, such as mathematics, theoretical physics and chemistry and popualtion biology. They have led to prototype equations that give rise to chaotic behaviour (ibid).

Complex Adaptive Systems

Complex adaptive systems (CAS) are in essence systems that behave like dissipative structures but with one significant difference: whereas emergence in dissipative structures arose out of non-average behaviour between similar agents, in CAS, emergence arises out of the local interactions between agents that may not be similar. This allows for the computer modeling of emergent behaviour using non-linear equations.

In these simulations, the agent is a computer programme which follows a set of rules. These rule based agents can be programmed to interact with each other within the memory of the computer. The behaviour of how they interact can then be explored. An important feature of Complex Adaptive Systems (CAS) is that they invite a different understanding about where change might come from. Whereas in cybernetics or systems dynamics change is perceived as needing to come from outside the system, in CAS it is understood that novelty can arise from within the system itself in the interaction between agents. This is a radical departure from classical systems thinking.

A favourite example of CAS is the simulation of bird flocking. Reynolds (Reynolds, 1987) was able to simulate this group activity through using three simple rules in a network of moving agents that he called boids. The behavior of flocking emerged between these digital birds without any plan for them to do so. It arose out of the process of interaction between the boids functioning under the digital rules that had been prescribed. This example is important because of how the idea of simple rules has been subsequently interpreted as a way of directing complex behaviour in organisational change in human interaction.

Complex Responsive Processes

The theory of complex responsive processes is a theory of human relating which draws analogies with the interaction of symbols described by the complexity sciences. Interaction between human beings is *complex*, or paradoxically stable and unstable, known and unknown, certain and uncertain at the same time (Stacey, 2005). Human interaction is also *responsive* rather than adaptive, as human beings are able to choose to respond co-operatively or competitively, rather than in a merely adaptive way. Human relating as also seen as continuous, self organising, local interactions or *processes*, not forming any sort of "whole" or anything inside of or outside of these interactive processes.

Complexity Science

The complexity sciences are therefore a name given to a number of theories from diverse disciplines such as biology, physics, mathematics, and chemistry, studying the nature of complex adaptive systems ie. systems made up of a number of agents with non-linear interaction (Kauffman, 1995, Holland, 1998, Prigogine, 1997, Waldrop, 1992). Key insights from agent based (computer) modeling of such systems has shown:-

- order and chaos, or stability and instability exist paradoxically at the same time, and is a requirement for the emergence of novelty
- self organisation and emergence arise spontaneously and unpredictably from local interactions between agents without any blueprint or overall programme
- unpredictability at the "edge of chaos" – radical unpredictability and uncertainty is inevitable in an evolving system
- diversity is required for the emergence of the new ie agents are different from one another - microdiversity

Dissipative Structures

Prigogine, a physicist and chemist, received a Nobel Laureate for his work on dissipative structures. He points to the potential for spontaneous and coherent activity of structures (eg a fluid) where multiple agents (such as molecules) are far from equilibrium. He showed that through small fluctuations (eg in energy at the molecular level) new (molecular) dissipative structures could emerge. He argues in his theory that not only can dissipative structures maintain a stable state far from equilibrium, but they can also evolve. His theory accounts for the emergent behaviour of both living and inert structures. Emergent structures manifest the paradoxical activity of both stability and instability, order and disorder, equilibrium and disequilibrium at the same time.

Edge of chaos

This is where the number of connections or interaction or diversity are at critical levels associated with self organisation and emergence. This happens through the internal dynmaic of a system rather than being created or planned.

Emergence

Emergence are regularities of behaviour which trancend their own ingredients, or a collection of interacting componants which can spontaneously develop collective properties which are not implicit in any way in the original pieces (Cohen and Stewart, 1994). Patterns emerge unpredicatbly from local interaction eg. the way towns or cities emerge, or how themes emerge in conversation, for example at a dinner party, around the themes of holidays or sport, without any overall plan.

Fractals

This term was suggested by the French mathematician Benoit Mandelbrot, describing topological manifolds, which he was able to reproduce by a compuerised representation based on simle mathematical equations. A fractal is repetitive patterning at many scales. In nature an example is the detail of the leaf pattern of a fern is similar a many scales of magnification. In human terms this might be where individual anxiety is reflected socially, or where a theme about animosity between people is played out in wars between different societies.

General practitioners (GPs) Department of Health website:-

http://www.nhs.uk/thenhsexplained/glossary

These are doctors who provide family health services to a local community. They are usually based in a surgery or GP practice and are often the first port of call for most patients with a concern about their health. GPs refer patients who need more help to specialists, such as hospital consultants.

Health authorities Department of Health website:-

http://www.nhs.uk/thenhsexplained/glossary

England's 95 health authorities were replaced by 28 larger health authorities, known as 'strategic health authorities' since October 2002. They are responsible for developing strategies for local health services and ensuring high-quality performance. They manage the NHS locally and are a key link between The Department of Health and the NHS. They also ensure that national priorities, such as programmes for improving cancer services, are integrated into local plans

Ideology

Ideology is the conscious and unconscious processes by which people choose to act and what makes that action appear normal and acceptable. This helps to maintain power relations between people or who is "in" or who is "out" and is therefore simultaneously related to individual and social identity. Griffin (2002) describes Mead's theory of how idealised "cult" values emerge in interaction eg "patients must receive the best possible care". However, a value such as this has to be negotiated or functionalised in daily interaction, for example whether treatment is affordable (Stacey, 2003). This is where conflict arises and is negotiated as people interact with one another.

NHS Alliance

The NHS Alliance is a values based organisation supporting PCTs, originally set up around local commissioning groups in the early 1990's.

Primary care groups and trusts Department of Health website:-

http://www.nhs.uk/thenhsexplained/glossary

Since 1999, GPs and community nurses have been able to join together to form 'primary care groups' or 'primary care trusts' along with other health professionals. This means they are given the funding to work together to plan and commission health services for their local communities - a role previously carried out by health authorities. It also means that decisions about local services are made at a local level, by those best placed to make them. (Replaced GP Fundholding, introduced in 1990, which allowed individual GPs to hold the budget for their own practice staff, certain hospital referrals, drug costs, community nursing services and management costs)

Primary care trusts (PCTs) Department of Health website:-

http://www.nhs.uk/thenhsexplained/glossary

PCTs are the cornerstone of the NHS, responsible for the planning and securing of health services and improving the health of the local population. For example, PCTs must make sure there are enough GPs to provide for their population and that they are accessible to patients. PCTs must also ensure the provision of other health services including hospitals, dentists, mental health care, Walk-In Centres, NHS Direct, patient transport (including accident and emergency), population screening, pharmacies and opticians. In addition, they are responsible for integrating health and social care so the two systems work together for patients. The 303 PCTs in England are given the funding to plan and commission health services for their local communities - a role previously carried out by health authorities and control 75 per cent of the NHS budget. It also means that decisions about local services are made at a local level by those best placed to make them.

Primary Health Care

Primary health care is provided by GPs, pharmacists, dentists, opticians, practice nurses, community nurses, health visitors, therapists and a range of other health professionals

Strategic health authorities Department of Health website:-

http://www.nhs.uk/thenhsexplained/glossary

England's 95 health authorities ceased to exist from April 2002 and passed many of their responsibilities to primary care trusts. They have been replaced by 28 larger health authorities, known as 'strategic health authorities' from October 2002.

These new health authorities are responsible for developing strategies for local health services and ensuring high-quality performance. They manage the NHS locally and will be a key link between

The Department of Health and the NHS. They also ensure that national priorities, such as programmes for improving cancer services, are integrated into local plans.

Self organisation

Agents interact with one another based on their own local princuples or rules, and coherence or pattern emerges without an plan for the overal pattern itself. In human terms this is where in the interactions between people social objects or cult values emerge and are particularised in these local interaction between people.

Teleology

Teleology, or final cause, answers the question "why" or "for what purpose" does something become what it becomes. Stacey (2000) identifies five forms of teleology and argues that the dominant way of speaking and acting currently uses two conflicting teleological frameworks to make sense of our experience, namely Rationalist and Formative teleology. Rationalist teleology is based on the premise that we have a choice in determining autonomously chosen goals. However, we also adopt the belief that in nature, there is movement towards a mature state (Formative teleology) eg an acorn becomes and oak tree. This thinking originated with Kant, who argued that Formative teleology could not be applied to human beings who are autonomous. This dualistic thinking splits our experience of being both part of a system and being an individual with free will. Stacey et al aim to resolve this by offering Transformative teleology, whereby there is movement toward a future that is perpetually under construction by the movement itself, by paradoxically expressing identity and difference, continuity and transformation, the known and unknown., at the same time (Stacey et al, 2000).

View of time

Traditionally time is viewed as having a linear structure of past, present and future, with the present being a point dividing past from future. However, Stacey suggests

"The theory of complex responsive processes takes a particular perspective on time, thought of as the living present. The time structure of the living present is paradoxical in that the interaction takes place in a present which reproduces the past in expectation of the future, and that expectation changes the reproduction of the past. In other words, this is a perspective of continuous iteration in the present in which the past is reproduced, always with the potential for transformation" Stacey 2003

Appendix 2

The Tale of the Fortress

Once upon a time there was an old man who lived in a small wooden hut, in the middle of a small village, surrounded by lush countryside. He was a kindly old man who used to sit making potions with herbs, which he took to ease his aches and pains. Soon people began to tell one another about the man and his potions. They talked of a magician who cast magic spells and could heal people. News got around and people began to come from the village and further afield to see the magician and take advantage of his magical powers. They would wait to see him every morning, sometimes queuing for miles down the bumpy lane. While they waited they told one another of his magical powers and who had been healed by his potions. Not only did the people come to see the magician, but other would- be magicians came too, to join him in his wooden hut. One of them wanted to be able to help people as it made him feel important. Another wanted to teach others so that he could become wealthy, and another to have many people under his control to make him feel powerful. And so their popularity grew.

At first the magicians were proud of their success. There were proud of the numbers of people there were able to see and worked long and hard so that they wouldn't have to turn people away. But soon they realised that they would have to do something to stop people coming. They built walls around their hut; then they built a bigger place to live with high walls and gates, to stop people coming in. They locked their doors and invited a wicked witch to live there, to help to deter people from coming in. They tied wolves up at the door to frighten people away and a Miser to keep hold of the money they made. But still the people kept coming. Wizened old people and laggards visited, hobbling up to the doors, trying to get in to see the magicians; and the wolves

howled outside and snapped their teeth when anyone came near. But this made people want to come even more. If it was so difficult to see the magicians, their powers must indeed be very great and very special.

Soon the people began to name the magician's home "The Fortress". For many years the Wicked Witch and the wolves tried to keep people away but without success. People talked about the wickedness of the Witch and the greediness of the Miser but they still wanted to see the magicians, even if they had to pay a price or wait a long time to see them.

As time passed the Fortress grew in size and importance and the magicians decided they needed even more helpers, to sweep and clean, to look after the needs of the magicians and the miser, to feed the wolves and the sick laggards and wizened old people. What they didn't realise was that among the new helpers were a young princess and her elves. The elves chattered away about the wickedness of their masters and how they were deceiving the magicians, taking their money for themselves and not feeding the wolves. Secretly they began to tell the wolves about a better place to live and how if they cast a magic spell on the Wicked Witch they might be able to live happily every after. All the people of the town would become well and only come to see the magician once in a while. They began to work on their potion and told one of the magicians about it too. They put some of the potion in the drinks of the magicians, the Wicked Witch and the Miser and slowly things began to change.

Soon the wolves began to stop snapping, they had full stomachs and the elves used to stroke them and talk to them. The Wicked Witch couldn't persuade them to be nasty any more. The Wicked Witch became miserable and didn't like the elves being nice to her.....so she packed up her broomstick and flew away one bitter night. The elves began to talk to the magicians who slowly

began to come out of their rooms where they had sat in mysterious darkness and safety. The magicians began to talk to the wolves and the princess and her elves. They began to light candles and open the windows of the Fortress, just a little at first, and then they opened the ramp to the iron gates and let the laggards and the wizened old people in. They were so surprised to be greeted so well and to be able to see the magicians that they came and went quickly realising that they didn't have to struggle to get in. Sometimes the magician could make a spell work but sometimes they couldn't. The magicians took off their robes and shaved their beards and they began to look like the other people of the town. The people asked "but where is the magician?"....the wolves and the elves said "but you have just seen him". The people were disappointed at first. They had looked up to the magicians for so long, to solve all their problems and to tell them what to do. But the elves and the princess told them how they could heal themselves. There was no mystery power - they had the power within themselves all along. At first the magicians felt afraid. They were supposed to be able to make people better. They were supposed to have magic powers, but they had hidden a dark secret. They were only ordinary people after all.

And so this is the story of how the Fortress became a happier place, where the magicians, elves, princess, wolves and the people lived happily together, telling the stories of how things used to be and stories of how things really are today.

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