From Suchman A, Sluyter D, Williamson P. *Leading Change in Healthcare: transforming organizations using complexity, positive psychology and relationship-centred care.* Oxford and New York: Radcliffe Publishing; 2011.

**Chapter 9**

**A community of influence: clinician researchers join to make a difference to people affected by consequences of cancer treatment**

**by Alison Donaldson with reflections by Jane Maher and Patricia Shaw**

An organization is a conversation before it is anything else: it begins with people talking together about something they would like to do that is beyond their capacity to do as individuals. At some point, their shared idea gains sufficient coherence—there is sufficient similarity in what each of the individuals is understanding—that they can begin to coordinate their actions effectively. That’s when the organization begins to function.

It is exactly this process—a shared idea gaining sufficient coherence—that we are privileged to observe in this case study. What emerges here are a shared identity and common purpose that are vital prerequisites if this group (this new organization) is to function. Notice how this happens and how the conveners manage a skillful balance between providing facilitative structure while also leaving plenty of space for serendipity and emergence and for the participants to be co-creators of their enterprise. (Editor)

## Synopsis: a community of influence

This story is about a group of 12 clinician researchers, formed to improve the patient experience by influencing research, education, services, practice and policy in an increasingly topical field: adverse consequences of cancer treatment. The story, which includes three episodes from the group’s early life, gives a flavour of its face-to-face meetings, the benefits (and drawbacks) of informal email exchanges, and the part played by narrative writing in tracking and making visible what the group achieves. Although this particular community of influence is still young, a number of themes and outcomes are beginning to emerge: in the first few months, members have pooled resources, identified numerous issues worth pursuing jointly, and made some first collaborative moves.

## What led up to the current story?

The group of professionals whose story is told here is made up of clinician researchers with nursing or allied health professional backgrounds. We have come to think of these people as “hybrid creatures,” because of their multiple identities. These place them well to influence research, education and policy as well as services and practices on the ground.

But to explain how this group came into being, we first have to talk briefly about doctors. The roots of the story go back at least two decades, to debates in the UK around cancer and palliative care in the 1980s, when many still viewed cancer as the preserve of specialists administering radiotherapy, chemotherapy, surgery and other treatments in hospital. Others, however, were starting to argue that General Practitioners (GPs) could make a valuable contribution to caring for cancer patients “in the community”, i.e. outside hospital.

One particular organization that recognized the role of GPs in supportive care was Macmillan Cancer Support—a major charity and household name in the UK. Known especially for its “Macmillan nurses,” the organization provides practical support for people living with cancer. In the early 1990s, Macmillan started to invest in its relationship with selected GPs by paying them for “protected time” (typically one day a week), which they could use to educate and influence their peers. There is now a community of some 300 “Macmillan GPs,” influencing practice and policy both locally and nationally. The collective voice of Macmillan GPs has been influential on many levels. For example, it helped to establish new processes in primary care (in order to improve the quality of care given to dying cancer patients) and to persuade the UK government to include supportive care among the services for which it rewards GPs. Apart from these highly visible achievements, myriad initiatives have emerged on the ground and been shared whenever the GPs meet.

After a decade of working with the GP community, the team at Macmillan decided in 2004 to form a slightly different kind of group. This time, the intention was to encourage collaboration between researchers and “service developers,” clinicians who have a track record not just in caring for patients but also in improving healthcare more widely). Its core members were clinically active academics, mostly doctors, with a track record in researching end-of-life care. The group, which came to be known as the “Macmillan Palliative and Cancer Care research collaborative” (MacPaCC for short), represented six UK universities. By 2009, its members had produced more than 60 peer-reviewed publications (often as principal authors), and it had succeeded in both advancing knowledge and achieving recognition in the field of end-of-life care.

Meanwhile, the number of people surviving cancer in the UK had been steadily growing and a whole new set of issues was beginning to emerge around adverse consequences of cancer treatment.

### Consequences of cancer treatment: time to act

In 2008, a National Cancer Survivorship Initiative (NCSI) was launched as a partnership between Macmillan Cancer Support and the UK’s Department of Health,[[1]](#endnote-1) with a major stream of work focused on the adverse consequences of cancer treatment. Planned activities included: articulating a vision for cancer survivors, developing a model of care, testing the model in the specific area of “pelvic cancer,” reviewing data collection, producing guidelines, and pursuing research and development.

The team at Macmillan responsible for the consequences of treatment work stream (which included Jane Maher, Macmillan’s Chief Medical Officer) spotted an opportunity to take the learning from the academic GP group mentioned earlier and to create a second clinician–researcher group. The story of this group, which has since adopted the name “Consequences of Cancer Treatment collaborative group” (CCaT for short), is told in the rest of this chapter (*see* Table 9.1 for a list of members).

Table 9.1: Members of Consequences of Cancer Treatment Collaborative Group (CCaT)

|  |
| --- |
| *Clinician researchers:* |
| Jo Armes | Research Fellow,King’s College London |
| Natalie Doyle | Nurse Consultant, Royal Marsden NHS Foundation Trust |
| Mary Wells | Senior Lecturer in Cancer Nursing, University of Dundee |
| Karen Robb | Consultant Physiotherapist, Barts Hospital, & King’s College London |
| Diana Greenfield | Nurse Consultant, Sheffield Teaching Hospitals |
| Claire Taylor | Lecturer in Gastrointestinal Nursing, St Marks Hospital, Harrow |
| Isabella White | Remedi / Macmillan Clinical Research Fellow in Cancer Rehabilitation, King’s College London |
| Karen Roberts | Nurse Consultant/Visiting Fellow, Northumbria University |
| Sara Faithfull | Professor of Cancer Nursing Practice, University of Surrey |
| Deborah Fenlon | Senior Research Fellow, Macmillan Research Unit, University of Southampton |
| Gillian Knowles | Nurse Consultant, Edinburgh Cancer Centre |
| Theresa Wiseman | Joint appointment: Senior Lecturer, Guy’s and St Thomas’ NHS Foundation Trust, and King’s College London |
|  |
| *Supporting team:* |
| Jane Maher | Chief Medical Officer, Macmillan Cancer Support |
| Janice Koistinen  | Macmillan Projects Support Manager |
| Alison Donaldson | Writer / consultant |
| Patricia Shaw | Consultant / facilitator |
| Chris Steele | Project manager |

How many people suffer negative consequences of cancer treatment?

Among people living with a diagnosis of cancer today, about a quarter are also living with consequences of treatment. This means about half a million people in the UK are suffering reduced quality of life. Many visit doctors or have tests for symptoms they do not understand, costing the UK’s National Health Service tens of millions a year. The risks differ according to type of cancer, form of treatment and the individual’s constitution, but evidence (some of which was published by members of the group described in this chapter) shows that different problems appear at different stages:

* nearly all patients will have moderate or severe treatment-related effects, either physical or psychological, during the first few months after treatment,
* the proportion falls to around a quarter of patients after six months,
* for others, e.g. those with pelvic malignancies, troublesome bowel, urinary or sexual problems may not develop until months or years later,
* in 5–10% of all people who have had cancer treatment, these problems will become complex or life-threatening over a 10-year period,
* for still others, consequences may result in chronic illnesses decades after treatment, e.g. heart disease, second malignancy or osteoporosis after breast or prostate treatment.[[2]](#endnote-2)

During 2009, Jane Maher and her colleagues invested considerable time seeking support in order to be able to fund the new group. The initiative sparked strong interest and by the time of the first community meeting (in November 2009), there was sufficient funding (more than £½ million) to create and sustain a new group of research-active senior health professionals, with the intention of improving the experience of people living with the consequences of treatment.

Jane Maher writes:

We needed buy-in from a whole range of stakeholders—the Department of Health, Macmillan senior management, and the Macmillan regional teams (all of whom provide funding and support for this work). In particular, we wanted the Macmillan regions to recognize the value of having clinician researchers. So we invested a lot of effort early on in engaging our regional colleagues in the work. For example, we invited them to suggest people who might be interested in joining a new community focused on consequences of treatment, and we made sure we had people from the regions on the selection panel. In seeking financial support, there was no fixed amount on offer. Rather, as the year went by and people saw the quality of the group, offers of funding grew.

There was a striking experience quite early on in the process, in which we used pictures to describe the “communities of influence” work to senior managers and Department of Health officials. A series of images—sculptures set in rural landscapes—enabled people to “get it,” to grasp the concepts that had been difficult to explain just in words, such as “hybrid creatures” (referring to the kind of clinician researchers whom we hoped to attract to the new group) and “working across boundaries” (see Figure 9.1).

**Figure 9.1:** Photo credit: Andy Goldsworthy, CASS Sculpture Foundation

The power of the pictures first became clear after some teleconferences with Macmillan regional heads of service, the National Cancer Director Mike Richards, and Department of Health representatives. After these calls, we followed up by sending round the slides containing the photos, and it was then that people really started to show an interest in what we were doing. We had tried meetings, words and papers. Pictures influenced people in a different way.

### Helpful concepts emerge

As we (the authors of this chapter) continued to refine the way we were talking about our experience of cultivating influential communities of health professionals, we found ourselves coining the phrase “communities of influence.” We had long been conscious of Etienne Wenger’s notion of “communities of practice.” Wenger first became associated with this term in the 1990s in the context of learning theory, positing that learning is a fundamentally social phenomenon.[[3]](#endnote-3) We all belong to and participate in informal communities of practice, he argued, in which we refine our practice, negotiate meaning and develop a sense of identity. The groups Macmillan had been cultivating seemed to fit this notion of a “community of practice” quite well. However, it struck us that the term didn’t quite capture the essence of the groups we were studying, whose main *raison d’être* was to *have an influence on practice and policy*. In general, people join them and stick with them mainly because they want to make a difference to the patient’s experience, hence our term “community of influence.”

It may be helpful to add a few words here about the terms “community” and “network.” In everyday language, network sounds perhaps looser than community. For our purposes, however, the difference is unimportant. What matters, whether one is talking about communities or networks, is *relationships and conversations*. Relationships make a community, but they also emerge and grow from community conversations.

With time, we have become increasingly convinced that cultivating communities of influence offers a fresh approach to service quality improvement, organizational change and policy development*.* This may be welcomed by those who are frustrated by top-down bureaucratic control, especially in the public sector.[[4]](#endnote-4)

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During the months running up to the creation of the Consequences of Cancer Treatment group, other concepts emerged in our conversations, including “hybrid creatures” and “no man’s land,” which helped us to explain that clinician researchers have the potential to cross boundaries, influence a range of colleagues and make a difference to patient care.

Jane Maher writes:

I began to realize that between the clinical world and academic research there was this zone, a “no man’s land” that was full of “corpses,” including broken down research projects, and researchers ready to give up their search for funding. This was true for both GP and nurse researchers, but the nurses faced additional difficulties. There was a common view among clinicians that “we don’t need nurses with PhDs.” So my wish was to create bridges across no man’s land, to help people develop from “alien visitors” into recognizably different but valued colleagues.

Patricia Shaw adds:

In organizations, people can only recognize activity that they can draw one another’s attention to in their speaking together and so sustain its life. So as we began to talk about hybrid creatures (we even had an image of a man/beast sculpture—a minotaur), people started to recognize themselves and be recognized. They also started noticing how hybrid creatures work and thus eventually bring new terrains of professional activity into active recognition. We speak of this as “populating no man’s land.” We are helping people take more seriously activity which is neither within one professional discipline nor in another, and so does not “count”; it is literally not measured or officially reported as a substantive contribution. This imaginative language provides a way of speaking on the way to the eventual emergence of new practices and roles which will have new names. Listening for and using imaginative language which resonates with what is happening allows otherwise “invisible” activity to be “caught” in conversations and slowly become more formally named and organized.

### Getting started

As soon as funding was in place (in September 2009), Jane Maher and Macmillan colleagues invited suitable candidates to bid for membership of the new hybrid group. They all had a track record in the field, e.g. they were already involved in developing services, educating clinicians or doing research into consequences of treatment.[[5]](#endnote-5)

The selection panel chose 12 individuals from across the UK, with either nursing or physiotherapy backgrounds.[[6]](#endnote-6) Some were based in academic institutions (e.g. King’s College London, University of Surrey, University of Southampton, Northumbria University, University of Dundee), others in hospitals or cancer centers (e.g. the Royal Marsden NHS Foundation Trust, St Marks Hospital, Sheffield Teaching Hospitals, Edinburgh Cancer Centre).

Early exchanges with the 12 chosen to make up the new group confirmed the challenges faced by hybrid creatures. They may get caught in academia, unable to get back into clinical work to implement their findings, or they may get trapped in clinical or management roles, unable to get the funding they need to do research.

### Assembling a supporting team

From experience we knew that certain kinds of support are vital if communities of influence are to enjoy fruitful collaboration. The supporting team set up therefore included:

* an experienced manager to negotiate and manage funding arrangements (Chris Steele),
* a project support manager to organize document sharing and other important administrative tasks (Janice Koistinen),
* a writer/facilitator to track the evolution and achievements of the group (Alison Donaldson), and
* a facilitator to make the meetings and conversations among group members as productive as possible (Patricia Shaw).

As a team, we spoke and corresponded regularly, meeting to prepare community meetings and later to reflect on them after the event, as well as participating in ad hoc teleconferences as need arose. We also encouraged progress and connections among group members between community meetings.

## Stories along the way

The early stages of any new community are significant—they set the tone and start to form a “direction of travel” for the group. To shed light on how a community of influence develops, therefore, we have chosen three stories from this particular group’s early life:

* an early “conversational” email exchange among members,
* the first meeting of the group, and
* the first episode of narrative writing.

In the accounts below, we deliberately include more detail than is normally found in a managerial report. In our experience, it is often seemingly small moves that create a collaborative atmosphere, shift thinking, and move people to act. The stories are written in the present tense to make them more immediate.

### Story 1: An email exchange among members

in which members of the group start to become visible to each other, preparing the ground for a productive first meeting.

Often in organizations, when a new group is about to meet for the first time, the kind of paperwork circulated includes agendas, objectives and the like. Rather than follow these managerial habits, as we anticipate this group’s first meeting we want to prepare the ground, so that when they finally meet they can quickly get down to real and fruitful exchanges. We therefore jointly formulate an email to all 12 members, which goes out in early November 2009 from Jane Maher as convener. The style is deliberately informal, inviting people to join a “conversation.” It begins like this:

“Now that you and others have agreed to become part of a community focused on consequences of cancer treatment, I wanted to start reflecting together in the run up to our first meeting. By sharing some early thoughts and starting to make connections with each other, we will be better prepared to make the most of our time together. So I hope you will read this and send any responses by using “reply to all” so that we can start a conversation which we will continue when we meet.”

An initial email reiterates the issue that brings this particular group together (to help people suffering consequences of treatment). Then it tells the story of how the idea of creating a new community emerged from a conversation . . .

The email goes on to reiterate the issue that brings this particular group together (to help people suffering consequences of treatment). Then it tells the story of how the idea of creating a new community emerged from a conversation a year ago with three members of the future group about the particular challenges faced by “hybrid creatures.” Patricia Shaw adds:

Following on from my last comment, we encouraged Jane to acknowledge the early beginnings of the forming of the community, the real story so far, including risking allowing the uneven processes of involvement to be revealed. Yes, some people may seem more central, others more peripheral, some feel well established, others feel like new joiners, some feel confident of welcome and regard, others wonder if they need to prove themselves. . . . The official version begins supposedly with a fair and rational process of selection in which everyone starts at ground zero, but instead we actively acknowledge the history, the different experiences of inclusion and simultaneous worries about exclusion. We want to work with this explicitly all along the way so that the difficult processes of power and influence, leading, following, risk taking will be available for reflection and learning amongst us all.

We actively acknowledge the history, the different experiences of inclusion and simultaneous worries about exclusion. We want to work with this explicitly all along the way so that the difficult processes of power and influence, leading, following, risk taking will be available for reflection and learning amongst us all.

Next, Jane’s email introduces each member of the new community, with a few words about their background and field of research. To give a flavour, here are just two of these introductions:

*Sara first encapsulated the concept of the "hybrid creature" for me: she has experience of education, research and clinical work. As well having written a definitive book on long-term problems after radiation therapy and served as president of the European Oncology Nursing Society, she is also a professor with experience in establishing commissionable education for nurses; and she has a Dimbleby-funded project whose aim is to improve rehabilitation of prostate cancer patients, especially in relation to urinary symptoms. Despite all this, she has had difficulty returning to a clinical role, so she is looking for help in buying some of her research time to enable her to work clinically in a Primary Care Trust, giving her a chance to implement her research. She has a particular interest in how to develop and implement commissionable services.*

*Mary has a long interest in the consequences of cancer treatment and is a particular expert in head and neck cancer. She also epitomizes the challenges of being a clinician researcher. She has written guidelines on the effects of radiotherapy on the skin and, like many of you, knows the challenges of implementing evidence-based guidelines. She has also tested an assessment tool that identifies patients’ priorities, so that services can be designed around them. Yet, like Sara, having got into research, she has found it difficult to find a foothold in clinical work again. She knows that to really make a difference you need “to get out there in the field and warm people up" before you attempt to implement research or new ideas.*

After introducing all members of the group, including the supporting team, the email concludes:

*I know this email is longer than most! I hope if you have read to this point it means you will reflect on your experiences so far in the very early stages of this project and write in response in any way that will start to flesh out who we all are, the connections you are beginning to see between us and to say more about what you hope we can achieve by coming together rather than each ploughing a lone furrow.*

It ends by again urging people to use “reply to all” so that everyone will see any written responses, since experience suggests that otherwise people often reply just to the sender. Over the next few days, we wait with curiosity to see how people respond. After a week has gone by, only one person writes back—to ask if she has missed something: has an agenda for the first community meeting been circulated? Then, one evening, about a fortnight after the original email, I send a short note to the group, starting like this:

*I am very much looking forward to seeing you all on November 30. I haven’t noticed any other responses to Jane’s email of November 2, so I am curious to know if you all read it! I gather a lot of you know each other already, so perhaps there are lots of bilateral conversations and exchanges happening anyway.*

The very next day, there is a burst of responses from group members, starting with the following:

*I think your assessment of the potential explanation for the lack of response to Jane’s introductory email is astute and certainly not because we haven’t read the email, rest assured. Most of us do already know each other if not closely, then by reputation, and there have indeed been a number of parallel conversations about this initiative when we have met in other contexts. (Clinical Research Fellow, based at a UK university)*

Another member makes a suggestion:

*Since Jane’s email, I have been thinking about the short summaries she provided of each of us (this can’t have been easy, and it is interesting to reflect on how someone else perceives you!). I wondered whether it would be useful if we all attempted to do our own (very short) summaries too—not to give everyone loads of work to do but just perhaps to jot down a few key issues related to the consequences of treatment that we feel most passionately about, ideas we are bringing to the table (even if very early or obvious ideas) and maybe a summary of one or two pieces of work or a couple of publications that we care most about and that have some relevance to the work of the community. (Senior Lecturer in Cancer Nursing, based at a UK university)*

Over the next few days, a steady flow of emails appears, responding to this invitation. Below is one example, which further illustrates some of the difficulties faced by clinician researchers.

*I have been a nurse working with cancer patients (mostly breast cancer) for over 20 years. . . . Seeing how women suffer menopausal problems without the prospect of being able to relieve them through HRT launched me into my PhD. I am also a "hybrid creature" having spent three years as a full-time lecturer and now working as a full-time researcher. However, funding streams mean that I have to be contained within a discrete "box" and so I now have little direct clinical contact with patients. It frustrates me that medics have specific posts that allow and even expect them to work both clinically and in research, yet in nursing you can only do one or the other. I am also very concerned about the divide that we are forced into, because of funding streams that keep "practice development" and "research" as separate entities. My clinical colleagues may want to develop a new service and ask my advice on getting some research evidence out of the change in practice. However, they can’t wait until we have put together a proposal, got it funded and gone through ethics [equivalent of the US institutional review board]. Unless we do that we can’t get our work published in high-quality journals and no one will fund us. If we in this group can find ways round this then we will have the potential to make a huge difference. It has always been my passion to get nursing underpinned by research evidence and I know the AHPs feel the same way. (Macmillan Senior Research Fellow, based at a UK university)*

By introducing themselves, often in quite a personal way, members are becoming more visible to one another. The benefit, we hope, is that, when they meet for the first time face-to-face at the end of the month, they will already be aware of many common interests and experiences.

There is a small catch to the story, however. After a subsequent exchange of emails, some of which include attached documents, someone sounds a protest:

*Dear all, I am finding the scale of email and messages coming from the group difficult to keep up with especially as I have a full-time job where I am not sitting at my desk most days but also have European responsibilities. We keep being asked to respond but in reality I am reacting rather than developing considered pieces of work. Could we at the meeting next week take stock, talk about this approach, and have a more considered communication strategy and action plan. I would find this very helpful. Despite feeling a little overloaded I am looking forward to seeing everyone next week. Best wishes . . .*

This seems an important moment. Somebody has been honest enough to express their frustration. It provokes two kinds of response: 1) some group members write to echo the concern about the volume of email, and 2) the supporting team offers to investigate creating a web space to accommodate some of the communications and documents circulating between meetings. At time of writing, an online “learn zone” has been created, though people are making relatively little use of it, and email traffic continues to flow.

This whole episode highlights the constant challenge faced by groups who want to stay in touch but all have busy lives. The technologies now available for this can be helpful. Email has the advantage that it is generally easy to access—most people know how to use it, and no web link or special password is needed. A web space, if people get used to it, can offer a tidy way of collecting shared documents, even if few individuals actually post comments in the discussion areas. But these electronic forms of communication can also start to feel like a burden. The pragmatic approach emerging for this group is to: 1) continue using email for quick exchanges, and 2) use the web space to store documents and useful information about the group, such as contact details, profiles, lists of publications, and so on.

### Story 2: Gathering for the first time

in which an “iterative conversation” enables members to become more and more fluent in expressing their interests and hopes for the group

Shortly after the first email exchange mentioned above, the first community meeting takes place. Nine out of the 12 group members (three are unable to make this first meeting) travel to a venue on the University of Warwick’s campus outside Coventry to gather as a group for the first time.

<INSERT Fig 9.2>

The supporting team, which is also present, has given considerable thought to this first community gathering. We see it as much as an opportunity for the group to bond as a chance for its members to explore the topics they would like to take on together in coming months. We know from past experience that seemingly small things can do much to develop relationships, e.g. the opportunity to arrive the evening before the community meeting, and time within the agenda to share experiences and tell stories.

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Our suggested agenda for this meeting also leaves plenty of room for improvisation, as we want the flexibility to “work emergently.” We break the day loosely into 90-minute intervals, with topics phrased as simple but important questions, such as: “Who knows whom, what are the opportunities and challenges in forming this community, and what is our experience of influencing in a complex world?” Improvising is not just a question of making it up as we go along. Rather, we take seriously what is arising in the group so that, for example, when people become excited about a particular issue, they can explore it together in depth without somebody cutting in to say “and now we are going to move on to the next item on the agenda.” This can test the patience of those who feel more comfortable with a firmer “structure” or who are anxious to achieve clear and quick results. However, in our experience, this way of working does lead to many of the “results” desired, such as coherence, learning, trust and desire to act. This is where it starts to be paradoxical: we develop an imaginative sense of what kind of outcome is required, yet at the same time we work with the energy in the room, staying alert to what is emerging.

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On the day, we begin at about six o’clock in the evening. As the sponsor for this work, Jane Maher starts by clearly stating her goals for the group in its first year: 1) to make it more visible; 2) to start thinking about a program of work that, by the end of the year, could become a platform to attract further funding in this field. She particularly emphasizes an insight from working with MacPaCC (the other hybrid group mentioned earlier): the importance of sharing resources—papers, reference lists, proposals, tools, etc.—from the beginning. To this end, we hang large sheets of paper on the walls and during the next day and a half an impressive list grows, making visible the extensive pool of resources available to the group. These include good research papers that could be revived to influence practice or policy, literature reviews on various aspects of cancer survivorship, promising grant applications that were turned down but could be resurrected, and knowledge and skills that could be used to create new services for patients.

Jane Maher comments:

There may be a tension between getting papers written versus spreading the message. Once a researcher has a good paper, rather than rushing on to the next, it may be worth putting effort into “giving it a social life.” That way, good research is less likely to “get lost in translation.”

In the meeting, the natural thing to do next is for people to explore who already knows whom and what common interests exist. It becomes strikingly clear that most know more than half the other members already. They have met through a range of circumstances—working on projects, studying or training together, supervising another member’s PhD, working on papers or books together, being in the same post-doctoral forum, taking part in key committees and collaborative bodies (including the National Cancer Survivorship Initiative), or just sharing special interests.

People are invited next to talk about what kinds of topics they want to pursue as members of this group. Again, we hang large sheets of paper on the walls so that, if they wish, they can put up their topics for us all to see, though we do not expect these formulations to be the final word.

Over the next 24 hours, we intend to give people a number of chances to articulate and re-articulate their interests and aspirations. In practice, the process began two months ago with the bid presentations. However, today people are not simply repeating what they have already said. As they address their peers in the new group, they may express themselves differently compared to what they said in their bids. Over the next 24 hours, they will have several chances to practice describing what they care about and want to take on together in coming months. We think this is useful, since one of the key skills for people who want to influence is the ability to speak engagingly about issues that matter to them.

Thus, next morning, after an opening discussion of the challenges faced by “hybrid creatures,” people are invited to return once more to exploring their common interests. This time, anyone who wants to can stand up, walk to a spot in the room and declare a topic they care about and would like to take on as a member of this group. Next, we urge anyone else who feels a connection to that topic or who wants to offer another one, to stand up and add their voice. More than once, Patricia invites people to give examples of relevant experiences. After three individuals are already standing, she explains why this matters:

What we’re looking for is exactly what three of you have already done: you put the high-level topic very articulately and at the same time you give a clear picture—which is often omitted—of the concrete experience that this relates to. If we can get that mixture over time that’s the best kind of material to do stuff with.

Patricia Shaw

Below are two examples of how people describe a personal experience before going on to suggest what needs to change:

I had a patient in the supportive care needs survey who filled out the questionnaire, then wrote to me and then rang me to talk about her supportive care needs that she felt hadn’t been met. She had been going round the houses [futile or inefficient action] speaking to different people who she perceived to not be helping her. She was obviously in a black hole and the clinicians around her seemed unaware or unwilling to help her.

Research Fellow, based in a UK university

The insight that this group member draws from this experience is that nurses, at the end of treatment, should be able to conduct a systematic assessment of patients’ supportive care needs. And nurses should also be skilled up to provide patients who are suffering fatigue with active lifestyle management (not just supplying patients with information). Another member of the group tells another story:

In our original study we skilled up a nurse and she blooming well got run over! And then we were really stuck. She had a broken leg doing consultations because we had nobody else with the skill sets. And really what we know is you have to skill up a team and everybody has to take responsibility for changing the system. It taught me a lot about how to look at designing systems.

Professor of Cancer Nursing Practice

The individual uses this example to stress the importance of working out how to maintain supportive care skills. It’s not just skilling up one individual (which is what tends to happen), she says, but skilling up a team, making sure that everybody takes responsibility—or as she puts it, “designing systems for sustainability.”

Eventually, every member of the group is standing, having indicated what matters to them and whose interests feel close to their own. As people literally stand up for their interests in this way, a kind of “map of connections” emerges in the room over the next 45 minutes.

< Fig 9.3 >

From here, people are invited to move into clearer groupings of threes and fours, and to continue exploring an issue that connects them, this time using large sheets of paper. After about 20 minutes, three distinctive areas of interest emerge:

* shifting the context from illness to wellness after treatment,
* developing assessment skills for follow-up care among Clinical Nurse Specialists,
* making interventions sustainable/understanding barriers and systems.

Patricia Shaw adds:

This process of taking up positions in relation to each other in the room was another step in creating a working community. It is not easy for people to show the affiliations, disquiets, differences they may be experiencing amongst themselves. As facilitator I was trying to find ways to begin this process: questions such as “shall I start?”, “shall I go next?”, and “shall I wait for x or y to declare themselves first” all acquire a sudden life and urgency and everyone learns a little more about themselves, each other and the relationships which are forming. It was noticeable how people tended to cluster close together, a bit reluctant to open up spaces between them. One person who found herself “in the middle” rapidly moved back out from this “exposed” position.

This process of taking up positions in relation to each other in the room was another step in creating a working community. It is not easy for people to show the affiliations, disquiets, differences they may be experiencing amongst themselves. As facilitator I was trying to find ways to begin this process: questions such as “shall I start?”, “shall I go next?”, and “shall I wait for x or y to declare themselves first” all acquire a sudden life and urgency and everyone learns a little more about themselves, each other and the relationships which are forming.

Later, we go through yet another iteration of the same process (of members exploring what they want to do together—what a joint program of work might look like). So far during this meeting, people have been addressing each other—the members of the new group. Now, Jane Maher spontaneously and unexpectedly urges everybody to try speaking to a different audience—a future potential funder. She invites them to talk about a project or idea they would like to bring to the group, addressing their words this time to an imaginary “Mr Moneybags”:

Let’s pretend we’re making a story up about a program of work that we’re doing. I am Mr Moneybags or Mr Very Important Person and everybody has been invited to describe the work that they’re doing and how it fits together into a kind of program—or not.

Jane Maher

Again, people are “iterating,” not just repeating themselves. With each round of conversation, the emphasis shifts as they further develop the way they are talking about what the group might do in coming months. They are constantly finding new ways of expressing what matters to them, and through this process we start to get a glimpse of the ingredients that might go into a program of work as the year progresses.

### Story 3: Making the invisible visible

in which a narrative account gives shape to the group’s first steps together

In our experience, written narrative accounts help to track a community’s evolution and influence over time. This can enable interested parties to understand the work of the group and, perhaps most importantly, it can help to satisfy funders/sponsors that money is being well spent. It can also stimulate people to reflect on and learn from what has happened. And finally, it provides a shared story of the group that can be re-consulted and re-used as much or as little as people want.

Written narrative accounts help to track a community’s evolution and influence over time.

As narrative writer, I (Alison Donaldson) take an active part in the meetings and email exchanges, recording people’s words and stories by taking notes and/or audio-recording. In other words, I do not just observe silently.

In this case, my official involvement begins when I am invited to sit in on the day of bid presentations in September 2009, where candidates talk about why they want to join the new group and what they would contribute. I listen, noting phrases that particularly strike or move me. Later, when we are formulating the introductory email to the group (*see* Story 1), I use a few of the striking phrases to add colour to Jane’s descriptions of individual group members. For example, one said “At the moment the whole nursing agenda is around chemotherapy . . . I want people to know what is available so they don’t get on their knees before they get support.” I find these spoken words honest and moving, refreshingly free of medical jargon. I imagine that somebody might use less-engaging language if they were asked to write down their own thoughts.

My first real challenge as writer, however, comes when I sit down to capture the first community meeting in writing. At the meeting itself, after several hours of listening, everything seemed frustratingly complicated and amorphous to me. And now, four weeks later (Christmas holidays have intervened), the memory has faded. I start by re-reading my handwritten notes from the meeting, immersing myself in the detail. This makes it possible for me to sketch out a contents page and, as I do so, a story starts to take shape. Next, as I begin describing in detail what happened, I feel a need to re-listen to parts of the meeting, which I audio-recorded. I transcribe some passages in full and my draft grows into a lengthy collection of raw material. When Patricia and I meet up a few days later, we take time to go through the material, reflecting on how we might use it, e.g. to stimulate further conversations at a future community meeting. For example, the discussion about the nature of influence (fully transcribed) may provide a useful starting point for further exploration of this topic at a future date.

We also explore the form of the narrative writing in some detail. For example, does it work best to leave people’s comments (e.g. on the challenges they face) in chronological order (as spoken), or is it better to reorganize them under theme headings? The latter version is more common in business writing—the headings do part of the work for the reader. The “unstructured” version leaves readers to notice what themes and connections emerge in their minds as they read. I notice that my initial tendency is to create headings, because I imagine the reader getting impatient reading a lengthy, unedited transcript. However, on this occasion I choose to maintain the chronological order, without introducing any subheadings, because our intention with the narrative account is to stimulate group members into reflecting on experience. By playing their own comments back to them, without imposing my own structure, I hope to give them a chance to judge the meaning for themselves. At the end of the chronological account, I simply offer one possible way of summarizing people’s comments (*see* box).

Challenges faced by “hybrid creatures”

A number of possible themes seem to emerge, e.g.

* managing time and coping with the reality of the NHS
* getting connected/being known
* finding good mentors/senior allies
* developing/maintaining relationships with clinicians
* finding appropriate research methodologies
* getting what you want can be scary.

(From the first draft narrative account about the group)

Next, I send the draft narrative account to the supporting team, which is meeting in a few days to reflect on what has been happening and to plan the next community meeting. In my covering email, I insert a “health warning” by explaining that the account should be viewed as “raw material” that can later be reworked and adapted for other purposes.

Despite my warning, I discover (when the supporting team meets) that my revised, still lengthy draft has left at least one individual bewildered. My “health warning” about the unfinished nature of the writing has not been taken up quite in the way I expected. This experience reminds me that no amount of precise instructions to readers can determine how they will respond—nothing can shortcut the important process of learning from others’ responses to a draft. I go home and revise the account again, this time including some orienting material near the beginning, e.g. a proposed “direction of travel” for the group in its first year—which has emerged from today’s conversation among the supporting team, who think it will reassure group members.

The draft that eventually goes to the whole group has come a long way. It still has no executive summary—a conscious choice, as we want to use the writing to stimulate further thinking, and the time for executive summaries and peer-reviewed articles will come later. There is, however, a new Foreword to guide readers—my second attempt at a health warning!

Much of what you see in this paper is "raw material.” It aims to make visible some of the early events and conversations in the life of the new community of influence. It is not designed as a summary nor is it meant for publication in its current form.

There are different ways of reading documents. When reading this one, I would like to invite you as group members to notice what strikes you, what seems important to you, what you find yourself reflecting on, what you want to take up in future conversations.

Finally, the draft now also has an Afterword containing some provocative questions, which have arisen during a spontaneous phone call between me and Jane Maher. For example:

If one way of making yourself more visible is to "be useful” to others, is there a risk of becoming taken for granted? Could you become a useful colleague rather than "top-table material” [a leader]?

The draft narrative account now goes to the whole group with a covering email, including the following words:

Dear all,

I am attaching a draft narrative account of the group’s early life (“episode one”). I’d like to give you some context and suggestions for how to read it.

First, it is quite long (28 pages plus appendices), as I wanted to get down the story of the group’s formation and include enough detail and verbatim material to help you recall the first meeting and what emerged from it. For those unable to be there, it should give you a flavour of the conversations.

Patricia and I have given it a lot of thought and we came to the conclusion that you would all be very good judges of what is significant in the account, which bits interest you, what themes and insights arise as you read, and what you would like to take up in our live discussions in February. So, it is not meant to be a streamlined account or executive summary of “objectives” and “outcomes.”

We see the writing process as iterative. So the account will evolve and change as time goes by and I get a chance to weave in your responses. The writing is meant as much to stimulate sensemaking as to establish a visible record of the group’s life and achievements . . .

Best wishes,

Alison

The only response to this email is one of those automated “Out of Office” replies! Meanwhile, having sent off the draft narrative, I now have time to start writing the present chapter, a task made much easier by having the “raw material” at my finger tips. (We are light-heartedly referring to this raw material as a “kitchen sink document” as it contains “everything but the kitchen sink.”) I am therefore quickly in a position to send round a first draft of the present chapter. This time we do receive some interesting email responses. First, the mention of giving documents a “social life” seems to have stimulated some members into thinking about where the group might publish to make it more visible; and second, one particular individual sends me the following comment on the chapter: “For me, it definitely captured the flavour and unfolding of the community so far and it also drew me back in to feeling part of a group.”

Next, I also send the draft chapter to two guests whom we have invited to join the second community meeting. When the day of the meeting arrives, one of these guests confesses that, as described in the chapter, the group seemed rather “intimidating.” A week later, Jane Maher and I bump into this individual again and she remarks that the group she met seemed much less “intimidating” than the one in the chapter. They seemed uncertain, she adds, about what they wanted to focus on. This encounter serves as a helpful reminder that there is never just one narrative about any group or event.

Reflecting back on the whole process of drafting the first narrative account, including people’s comments along the way, I am reminded how writing enables us to “give form” to conversations and processes that may otherwise feel amorphous or ephemeral. It may be harder for critics to say it was all “just talk” when they see a crafted, detailed written account. Yet a narrative account is always just one possible story about what has happened. As the writer, I hope that the group described in it will recognize something of itself and that the account will help to make it more visible, as well as stimulating thinking about its future direction.

For those interested, below are some of the writing methods that have emerged for us over the years when working with communities of influence:

* creating both an evolving group story and some individual written portraits of selected community members; this provides two complementary ways of making the life of the group more visible
* trying to reflect complex causality in the writing; this involves: avoiding oversimplified “a led to b” accounts, always striving to describe what happened, rather than giving an idealized picture, and including different perspectives where appropriate
* keeping an eye and an ear open for “serious anecdotes,” specific experiences, and stories, as these stimulate a particular quality of reflection; real examples are also helpful in “evaluating” the work of a community
* writing “iteratively,” using successive drafts to stimulate further reflection and sensemaking, so that the account that emerges is to some degree inter-subjective, even though my voice as author may prevail
* looking for ways of giving the writing a “social life”—using it to stimulate further reflection and action, making sure it does not disappear into a “black hole” like so many reports.

Some of these insights have been enriched by studying relevant literature, e.g. in fields such as historiography, ethnography, storytelling in organizations, complexity and emergence.

Jane Maher adds:

I am confident that this community is beginning to become more visible and influential. I am also keen for the group to make some short video clips. For example, a researcher might show some statistics, describe a problem and give a patient example. I have seen the effect this can have on the people whom we need to influence—a short video often allows people to “get it” instantly, where words and writing have failed. Nevertheless, writing plays an important part because it provides a way of securing what is otherwise ephemeral.

## Outcomes so far

At time of writing, the community has met just twice, so it is rather early to give a definitive list of “outcomes.” Nevertheless, we feel confident from our experience of working with other communities of influence that this one will make a difference. Indeed, by forming a group that meets and communicates regularly, much has already been achieved—as one group member put it, “nobody has ever asked us to get together before.” And we know from our experience with the Macmillan GP community that a collective voice tends to be more influential than just one practitioner pressing for improvements in her local area. In the case of the group described in this chapter, some early progress is evident, as we shall see next.

### A pool of knowledge and resources

As mentioned earlier, at the group’s first meeting people were encouraged to make a start with identifying resources they could share with one another. After the first meeting, the list already included:

Fig 9.4

* 6 literature reviews on various aspects of cancer survivorship (e.g. interventions related to fatigue, self-management in prostate cancer, female sexual problems)
* 8 research papers that could be revived to influence practice (e.g. on quality of life in patients with skin reactions to radiation, quality-of-life priorities in patients with bowel cancer)
* 9 grant applications that could be resurrected (e.g. randomized controlled trials on nurse-led service delivery, and on different exercise regimes for postoperative breast cancer patients)
* 21 examples of knowledge or skills (e.g. related to risk stratification, exercise for cancer patients, rehabilitation services, psychosexual therapy, and cognitive behavioral therapy). These could be the seeds of new services for patients.

### Preliminary statement of the group’s goals

In the first narrative paper we decided to include a section near the front called “proposed direction of travel for the group,” as we felt that a preliminary statement of the group’s purpose, even if it would be modified over time, might ease people’s anxiety at this early, uncertain stage. Table 9.2 shows the text as it appeared.

Table 9.2

Proposed “direction of travel” for the group

*Main intentions:*

* Develop the capacity of its members to influence research, service development and education
* Help ensure that the shared vision (see box below) of the Department of Health and Macmillan Cancer Support is taken forward
* Demonstrate the benefits of working as a “community of influence.”

*Aspirations for the first year:*

* Make the group more visible and influential, in order to make the issue more visible (how to care for those living with consequences of cancer treatment), e.g.
	+ Identify, tell, retell stories/experiences that move and influence;
	+ Become expert at presenting your “gems” (e.g. projects, products, stories) to influence practice and policy;
	+ Publish (e.g. good papers that proved hard to publish in the past);
	+ Demonstrate changes in practice, including examples of collaboration across primary and secondary care;
	+ Use video clips to convey a patient problem, evidence for it, research under way, how that research should be translated/implemented, and the challenges involved in doing so.
* Identify skills and services that you can market or get commissioned
* Secure funding for and start relevant projects
* Spread knowledge/skills
* Show evidence of collaboration
* Secure promotion/new roles where appropriate
* Achieve new qualifications where appropriate.

A vision for cancer survivors

Our vision is that consequences of cancer treatment are acknowledged and therefore described, measured, coded, enumerated and reported routinely by the NHS. Preventable consequences are avoided through universal access to the safest and most effective treatments for cancer. Where adverse consequences cannot be prevented, effective and accessible services are available for all patients in order to reduce functional impairment and to alleviate distress, whether physical or psychological. The nature and content of the services provided is matched to need using stratified assessment tools. There is a continuing research and development program to improve our understanding of the consequences of cancer and its treatment, and this research program is seamlessly integrated into mainstream research into the treatment of cancer.

From the National Cancer Survivorship Initiative Vision

published jointly by the UK Department of Health and

Macmillan Cancer Support in January 2010

### Opportunities emerging from conversations

Email exchanges among members between the first and second meeting highlighted a range of opportunities that could be followed up. A few examples give a flavour:

*Rehabilitation pathways.* The UK’s National Cancer Action Team launched these pathways in January 2010, and one group member prompted a discussion about them, suggesting that the group pursue this further.

*Health and well-being clinics.* Stimulated by this email exchange on rehabilitation, one member mentioned that she and her colleagues were bidding to provide a Macmillan-funded health and well-being clinic. This prompted another member to say that she and her colleagues had just secured funding to run such a clinic for gynecological patients. These two emails sparked a debate about the merits of different forms of follow-up, e.g. hospital-based, community-based, and telephone.

*Sexual problems.* Two members shared views with the group on managing patients’ sexual problems after treatment, sparking useful debate about the pros and cons of guidelines, and about the ability of clinicians to talk to male and female patients.

*Hybrid careers.* Two members reported increased interest from their universities in sustaining the “hybrid creature.” This may help towards one of the goals suggested to the group: that at least half the group secures both nurse consultant and senior lecturer posts within three years.

Meanwhile, informal phone calls brought to light further stories of collaboration and influencing activity. For example, after the second community meeting, two members worked together to revamp a proposal for a trial of telephone follow-up for women finishing treatment for ovarian cancer. One, a professor of cancer nursing, had failed with this so many times that she had become disheartened. The other, a nurse consultant who was able to contribute a clinical perspective, responded with enthusiasm. A subsequent teleconference between their two teams enabled them to use unpublished research to strengthen the bid document. They also modified the language to emphasize the practical relevance of the trial in terms of “service development.” Meanwhile, the nurse consultant got the professor invited to speak at a key meeting in Glasgow. This was at the other end of the country, so it took some encouragement for her to go, but afterwards she was delighted she had gone, as several people came to speak to her after her talk. As a result, she was able to include three extra collaborators in the new bid, which also came to involve six centers instead of three. Both women were optimistic about its prospects.

### Moving towards a collective sense of purpose

At the second community meeting, in February 2010, there was a distinct shift towards the group finding its own words to articulate its purpose. From our experience with such groups, we know that they tend to develop new ways of speaking that become useful for the purpose of influencing. This “common language” cannot be created by individuals on their own. Only a community can develop a language.

Despite the pleasure of seeing each other again, people also expressed a degree of frustration at this second meeting. One put it like this:

I feel we are stepping into the Tardis [the “time and relative dimensions in space machine” from the TV series, Dr Who]. We are trying to get a feel for where we are going. We could do almost anything.

Professor of Cancer Nursing, group member

Some way into the conversation, however, something of a breakthrough occurred. The group agreed to sketch out a map of the cancer patient’s journey, from diagnosis right through to possible consequences of treatment several years down the line, using large sheets of paper fixed on the wall.

The drawing (see photos below) helped us all get a much clearer sense of where the work of individual group members was located in relation to different stages in the patient’s experience. In particular, it became apparent that the group’s research interests were clustered around the time of treatment, with few of them looking at the period some years later when negative consequences of that treatment may first come to light for patients.

Figs 9.5 and 9.6

In a post-meeting email exchange, several members pointed to this sketch as having been helpful. For example, one wrote:

I am most excited about how from the process map we were able to see where best to place ourselves and how there is a huge gap in the market that is just waiting to be filled by us . . .

Nurse Consultant

Towards the end of the meeting, after people had done further sketches and explored ways of articulating a collective purpose, four members agreed to draft a one-page “introduction” to the group. A couple of weeks later, they circulated their first attempt. There is not enough space to include the whole text here, but to give a flavor, below is the first paragraph, summarizing the purpose of the group in members’ own words:

To improve the experience, outcomes and care of people who are living with the consequences of cancer treatment, by:

* 1. conducting meaningful and rigorous research
	2. developing sustainable services/systems of care
	3. raising awareness and delivering education
	4. influencing policy and strategy
	5. changing the culture of care.

At the second meeting, the group also began to explore what it might call itself. A few weeks later, a vote among members pointed to “Consequences of Cancer Treatment Collaborative group” as the preferred name, with the short form “CCaT” (we suggested using the short form with care, given the sea of acronyms health professionals often find themselves swimming in.) It is worth noting that settling on a name only became possible after people had met twice and had an opportunity to explore aims and activities in their own words.

## Epilogue: Getting ready for further collaboration

As this account draws to a close, the third community gathering is approaching, and a number of between-meeting activities have come to our attention.

For example, towards the end of the second gathering, members agreed to pair up and write short profiles of one another in the coming weeks. We urged them to “talk up” the skills, knowledge and achievements of the other person, since this is something that many find hard to do when writing about themselves. Many chose to pair up with somebody they didn’t yet know well. Thus, as well as generating profiles, this exercise is creating new pairings within the group that may facilitate future collaboration and influence.

Another example is the phone conversations we (Alison and Patricia) have had with each member to gauge their feelings about the group and their wishes and concerns about the future. (We sometimes refer to these informal connections and calls between meetings as “weaving”—it is a vital part of cultivating communities of practice.) This group has seemed unusually cohesive from the start, yet we have learned from these informal conversations that the usual hard-to-talk-about feelings are present, at least for some. For example, one person gently raised the question “who owns the work?”—she wondered if this might be a worry for those pursuing academic careers. Her own view, however, was “as long as it gets to a patient, it doesn’t matter who owns it.” Another expressed her concerns about how we were going to use the recordings of the meetings and the narrative accounts. She had missed the first community gathering, where we had spoken about these methods, so the phone call provided an opportunity to explain our way of working to her more fully.

The calls have also drawn our attention to influencing activities going on between meetings. For example, one member related how she had offered to speak about her research to a group linked to UK charity *Beating Bowel Cancer*, stressing that she might not have made this offer if she hadn’t been part of the consequences of treatment group.

Finally, we were able to use the calls to encourage and accelerate collaborative activities. For example, there had been some email exchanges about whether the group might approach the editor of a relevant new publication, the Journal of Cancer Survivorship, but this suggestion seemed at risk of remaining “just a good idea,” so in one of our informal calls we encouraged a member of the group to take the lead on it. She swiftly took up this suggestion, and in no time a teleconference was set up for members interested in getting the group a place on the editorial board. As a result, instead of one individual singly approaching the editor, five members of the group agreed to offer their services collectively to the journal, and the email sent to the editor received a positive response.

In this chapter, we have told the story—just one possible account—of the early months of a new community of influence. With other groups, it might be more customary to wait until two or three years have passed and then write a report of their work, with conclusions and recommendations. We hope, nevertheless, that this story proves useful to anyone who is wondering how they might create and sustain a similar group with a view to influencing an important issue, whether in the health sector or elsewhere. It is during the early stages of such a community’s life that there is the greatest opportunity to build trust, develop a collective sense of purpose and identity, and demonstrate some early achievements.

# Editors’ commentary: Macmillan Cancer Support

The story of the Macmillan Consequences of Cancer Treatment Collaborative Group shows the “micro moments” of a team forming and, through conversation, developing a collective identity and common purpose. While our other case studies don’t describe the communication processes in this depth of detail, we can be certain that such dynamics (inclusion/exclusion, emerging and evolving understandings of purpose and direction, etc.) were taking place in every moment of every story; it's happening all the time in human interaction. We just don't usually notice it. We tend to get so absorbed in the content of the work that we don’t attend to the process. Yet we can see in this story how exquisite mindfulness of the conversational process and very small interventions can make a big difference.

For example, the conveners explicitly attended to diversity and responsiveness in order to foster creativity and innovation. As they assembled the group, they were thoughtful about the diverse perspectives that would be needed to seed the emergence of novel patterns (creativity). And they actively encouraged the group members to bring that diversity forward (i.e. to be authentically present). For example, at the very outset (in Story 1) they invited members to share self-introductions. Later, in Story 2, we see them invite people to spontaneously propose discussion topics, rather than specifying the topics themselves. Not only does this invite expression of diversity, but it also is a gesture of partnership, sharing control of the discussion agenda with the entire group—a clear example of a relationship-centered meeting practice (*see* Appendix 2).

To enhance responsiveness, the conveners share observations back to the group about its process and offer empathic reflections about discomfort that the group members might be experiencing (Story 2). They also use sequential rounds of narrative writing to foster reflection on both the themes and the process of the group’s conversation (Story 3). Curiously, this chapter itself was a part of that process! This technique of narrative writing is an interesting variation on the method of “reflective time outs” described in Appendix 2.

The conveners used various methods to provoke small disturbances in how people were thinking (patterns of meaning) that subsequently grew into transformational changes. For instance, they offered a variety of images as visual metaphors for the group members and their work. One of these pictures, of a minotaur, helped introduce and reinforce the theme of “hybrid creature.” The clinician researchers recognized themselves in this image, and gained a new way to make new sense of their previously enigmatic and under-appreciated position. It offered them a valuable new identity as boundary spanners, laying out an effective new direction that they were uniquely qualified to undertake. Hence we see a small disturbance in a conversation—a new phrase—amplify and spread, resulting in a transformative new way of thinking about roles.

There was more going on here than people just meeting each other. Most of these people already knew each other, but they were not taking any sort of action. Over the course of the story, we see the group develop a sense of coherence—shared purpose, an understanding of how to work together, even a shared vocabulary—that allowed them to truly become a community of influence. And by the end of the chapter, after three months of elapsed time, they began to take effective action. The conveners skillfully stewarded the entire process by fostering dialog, and being attentive and responsive to what was emerging. And so we have witnessed the ephemeral change in the organizational conversation that is the heart and precursor of every kind of organizational change.

1. *See* [www.ncsi.org.uk](http://www.ncsi.org.uk) (accessed November 11, 2010): The NCSI aims to “improve the ongoing services and support for those living with, and beyond, cancer—currently two million across the UK. This number is likely to grow by over 3% per annum, reflecting the increasing incidence of cancer and better survival rates. The aim of the NCSI is, by 2012, to have taken the necessary steps to ensure that survivors get the care and support they need to lead as healthy and active a life as possible, for as long as possible. The initiative is a partnership between the Department of Health and Macmillan Cancer Support and is co-chaired by the National Cancer Director, Professor Mike Richards, and the Chief Executive of Macmillan, Ciaran Devane. [↑](#endnote-ref-1)
2. Based on: Armes J, Crowe, M, Colbourne L, *et al*.Patients’ supportive care needs beyond the end of cancer treatment: a prospective, longitudinal survey. *J Clin Oncol.* 2009; **27**: 6172–9. [↑](#endnote-ref-2)
3. Wenger E. *Communities of practice: learning, meaning and identity.* Cambridge: Cambridge University Press; 1998. [↑](#endnote-ref-3)
4. A book on this subject, entitled *Communities of Influence,* by Alison Donaldson, Elizabeth Lank and Jane Maher, is shortly due for publication by Radcliffe Publishing. [↑](#endnote-ref-4)
5. For example, a seminal article previously published by a member of CCaT was: Armes J, Crowe, M, Colbourne L, *et al.*,op. cit. [↑](#endnote-ref-5)
6. The selection panel included Jane Maher, Stephen Hindle (Macmillan Survivorship Program Manager), Chris Steele (Workstream Support—Late Consequences of Treatment), Donal Gallaher (Macmillan Development Manager) and Jacqui Graves (Macmillan Clinical Program Manager). [↑](#endnote-ref-6)