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PLURALISTIC DIALOGUE: A GROUNDED THEORY OF INTERDISCIPLINARY PRACTICE

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Learning through Life

After a while you learn the subtle difference between
holding a hand and sharing a life
and you learn that love doesn't mean possession
and company doesn't mean security
and loneliness is universal.
And you learn that kisses aren't contracts
and presents aren't promises.
And you begin to accept your defeats
with your head up and your eyes open
with the grace of an adult
not the grief of a child.
And you learn to build your hope on today
as the future has a way of falling apart in mid flight
because tomorrow's ground can be too uncertain for plans.
Yet each step taken in a new direction creates a path towards
the promise of a brighter dawn.
And you learn that even sunshine burns if you get too much.
So you plant your own garden and nourish your own soul
Instead of waiting for someone to bring you flowers.
And you learn that love, true love,
always has joys and sorrows,
seems ever present, yet is never quite the same,
becoming more than love and less than love, so difficult to define.
And you learn through it all you really can endure
that you really are strong, that you do have value,
and you learn and grow.
With every goodbye you learn. (Anon)

Abstract

This grounded theory study explains how health professionals work in interdisciplinary teams in health services where the call for new collaborations is intensifying. Forty-four participants from four teams in two major acute-care hospitals participated in the study. In total there were eighty hours of interviewing and eighty hours of participant observation. All data were constantly compared and analysed using Glaser's emergent approach to grounded theory. Underpinning the study are the premises of symbolic interactionism that are assumed to shape the focus of this study, team interactions, and collective action within an acute care setting.

It is argued that interdisciplinary team members express a concern for meeting service needs, and continually resolve that concern through the process of **pluralistic dialogue**. This is a means for discussing differences, that supports team members who are thinking through and constructing new ways of working together. It emerges as various health professionals integrate multiple perspectives, which contribute to the clinical and organisational management of the client service. **Pluralistic dialogue** has two complementary phases. These are *rethinking professional responsibilities* and *reframing team responsibilities*. Rethinking and reframing are theoretical processes that are underpinned by team learning, and, by new ways of managing changing service structures. Therefore, it is suggested that, in an interdisciplinary team, health professionals must *break stereotypical images* in order to meet service needs in a context where teams are constantly *grappling with different mind-sets*. Team members continually resolve their concern for meeting service needs by *negotiating service provision*. As a result, the health professionals are free to *engage in the dialogic culture*.

The process of **pluralistic dialogue** has the potential to challenge, to empower, to transform; or it can perpetuate mediocrity. The decision to dialogue mindfully with others is essentially individual. Any variation in an individual's commitment is covered by disciplinary associates but seldom challenged by colleagues from a different professional group. A person may

choose a non-involved response at any time, although someone must fulfil functional responsibilities in the team. Any variation in an individual's commitment is covered by disciplinary associates but seldom challenged by colleagues from a different professional group.

This study also highlighted several significant categories impacting on effective interdisciplinary practice. Competency, alternative world views, information exchange, accountability, personality differences, and leadership, all affected team processes and **pluralistic dialogue.** But, it was quite clear from the data that, interdisciplinary team members *can*, and *do* form synergistic relationships that benefit both clients and colleagues. Team success is dependent on the individual's courage to challenge the self and the humility to cooperate in collective learning experiences.

This substantive theory presents just a glimpse of the practical life of interprofessional people working in two busy city hospitals. The teams studied were unusual in that they each offered specialist care to a select group of clients. Perhaps they were unique and are non-representative of the average person who is a health professional today. So many of the health professionals were highly educated, well-respected specialist practitioners who stand out for their individual investment and dedication to improving the client's pathway through acute care. The study participants' patterns of behaviour would suggest that, when interdisciplinary practice is well established, an attitude of cooperative inquiry pervades joint actions and interactions that focus on meeting service needs.

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CHAPTER ONE
Introduction

This research began in 1995 with a general interest in examining nursing practice within a changing health care context. Informal discussions with registered nurses had revealed much reservation about service provision in acute care organisations that were being restructured. Nursing practice was strongly influenced by organisational change that, in turn, was shaped by health reform on a scale that was perhaps unprecedented in the history of health service delivery in New Zealand.

In order to understand better some of the contextual issues the researcher perused the national and international literature about recent health reforms. Some clarification of the common trends was sought. It quickly became obvious that the magnitude of health policy changes has been such that any structural reorganisation was by no means confined to nurses. Changing roles have influenced everyone working in the health sector. Therefore, it seemed unreasonable to isolate nursing practice from professional practice in general in such a volatile environment. The researcher became distinctly uneasy about scrutinising just one professional group. So, how could the research topic be refined to permit an exploration of professional practice in the changing health sector?

Bishop and Scudder's (1985) suggestion that "only minimal consideration has been given to the moral issues involved in the day-to-day health care and to the ongoing relationships of physicians, nurses, and patients" (p. 2) struck a chord with the researcher and helped her to clarify thinking. Their views were consistent with the public debate on health reform in which consumers, and health professionals, questioned current health restructuring. Englehardt's (1985) ideas were useful:

> [There are] no essential or conceptually significant differences between the professions of nursing and medicine in their caring for patients. One discovers, at best, differences in accent and emphasis. Central to understanding the triad of physicians, nurses, and patients are the conflicts and tensions engendered by the various restraints on power and authority that stem from the prevailing hierarchies in health care institutions. (p. 63)

The researcher began to question whether her long-term study within the discipline of nursing had de-sensitised her to the wider issues common to all health professionals working in the health reform environment. Even though nursing practice was the general area of interest maybe it was unwise to view nursing as a separate entity when practice responsibilities and professional boundaries were blurring across the health professions? But, what exactly was the problem?

Refining the Research Topic

Glaser's (1992) style of grounded theory was selected for the project because of its ability to support the emergence of problems that are identified by the selected participant group. Glaser (1998) states that grounded theory is a general research method that works well when a qualitative perspective is required. Grounded theory is based on the belief that, as individuals within groups comprehend events from a personal perspective, common patterns of behaviour can be discovered (Glaser, 1998). This perspective was supported by Hutchinson's (1993) idea that people make sense of their environment despite apparent chaos.

One of the strengths of grounded theory is that it explains what is actually happening in practical life, rather than describing what should be going on. The premise was useful at the beginning of this project because there were so many different perspectives in the literature on nursing practice and the health reforms that it was difficult to define the problem area. The grounded theory method was ideal, as it created a scientifically legitimate space whereby the researcher was permitted to encourage participants to explain their main concern and how they continuously resolved that. Concepts did not have to be identified as predetermined variables, but would emerge from

observation and discussion with participants. The goal was to be an "integrated set of hypotheses [that accounted] for much of the behaviour seen in a substantive area" (Glaser, 1998, p. 3).

To avoid distraction from preexisting concepts so that emerging themes can be clarified, Glaser (1992) advises grounded theory researchers "not to review any of the literature in the substantive area under study" (p. 31). Glaser (1978) suggests though, that reading need not be abandoned completely:

> It is vital to read, *but in a substantive field different from the research.* This maximises the avoidance or pre-empting, preconceived concepts which may easily detract from the input. ... It is hard enough to generate one's own ideas without the "rich" derailment provided by the literature in the same field. (p. 31)

In grounded theory the aim of general reading in other fields is to extend theoretical sensitivity (Glaser, 1998). The researcher accepted that advice literally and began reading literature about the professions (Abbott, 1988; Dingwell & Lewis, 1983; Ehrenreich, 1978; Ehrenreich & English, 1973; Johnson, 1972). As the researcher considered nursing practice amidst structural reform she began to argue that most nurses worked alongside, if not in active cooperation with, health professionals from other disciplines. Therefore, she assumed that nursing practice did not stand alone, but had to be integrated with a cohort of health professionals who worked together in an interprofessional work-group. It is argued that the reading did not force the area of interest, as data was used as a baseline to describe what was happening at the macroanalytical level in society. In other words, the literature perused was eventually turned into data collection and constantly compared to incoming data, in order to avoid issues associated with the preemption of the research problem (Glaser, 1998).

Initially, the identification of interprofessional practice as the general research area was daunting, as the researcher certainly felt as if she was entering the field "knowing nothing" (Glaser, 1998, p. 54). However, the willingness to accept the challenge to study a completely different area was also influenced by the researcher's life cycle interests that were taking new directions in the workplace. The researcher was facing new professional challenges. Although work as an acute-care nurse in the distant past had

been complemented by study within the discipline of nursing, she had taken on a new position teaching in an interdisciplinary program in the health sciences. Interdisciplinary practice assumed a greater significance in the researcher's professional development as she slowly appreciated the issues faced by other health professionals (psychotherapists, physiotherapists, occupational therapists, and radiographers) working in the acute care environment. Changing interests were consistent with Glaser's (1998) belief that the study of life cycle problems has the potential to motivate and sustain researchers.

Reading therefore was extended into the area of interprofessional practice. According to Glaser (1978) that move was not strictly in accordance with the emerging grounded theory method, as the researcher runs the risk of preconceiving the problem area. However, this researcher had no idea of current writing, so, in order to satisfy university authorities and ethics committees that she entered the research project with some sense of direction, she decided to scan the interprofessional literature. Again, the position taken was that any literature is data, and it can be neutralised as long as it is constantly compared with data that emerges later in the study (Glaser, 1998). Fortunately, the literature revealed that there was little published research on the concept of interprofessional practice (Bishop & Scudder, 1985; Casto & Julia, 1994; Gabe, Kelleher & Williams, 1994; Leathard, 1994; Ovretveit, 1993; Petersen, 1994; Soothill, Mackay, & Webb, 1995). Although some research was available, most readings proved to be anecdotal accounts of interprofessional teamwork. The huge literature on teams was not reviewed since this was emerging as a significant concept. However, selected general management literature was perused for a sense of organisational issues associated with change and restructuring (Drucker, 1994, 1995; Handy, 1990, 1994; Morgan, 1986; Senge, 1990).

The medical sociology literature was also scanned (Freidson, 1986, 1988, 1994; Nettleton, 1995; Turner, 1987). This was thought to be important to further understanding of the sociocultural influences on professional practice, and to gain some insights into the historical influences that had shaped the health professions. Familiarity with the nursing literature alone was increasingly inadequate for the study that had moved beyond the

boundaries of nursing, so a baseline understanding of the medical profession, the dominant disciplinary group among the health professionals, was sought. Substantial controversies and contradictions surrounding power relationships in the health professions were revealed (Ashley, 1976; Bishop & Scudder, 1985; Daniel, 1990; Davies, 1995; Fox, 1992; Hugman, 1991; Willis, 1989; Witz, 1992). In fact, this heightened sensitivity about interprofessional tensions made the researcher wary about predetermining problems that supported unsubstantiated myths and assumptions.

Nonetheless, most researchers enter a new study with prior knowledge and some assumptions, which should be stated openly. This research is based on the assumption that some health professionals do find different ways of working together despite the uncertainties and reorganisation of health services. They are ideally placed to discuss the nature of interdisciplinary practice. It is also assumed that constitutional, social, and political reforms inevitably influence professional work. However, the researcher was conscious that she would have to put any normative expectations to one side if she genuinely endorsed Glaser's (1992) call for not forcing the data and if she was to "allow the emergence of what is going on" (Glaser, 1998, p. 41).

In summary, the reading about interprofessional work revealed a new emphasis on the development of teamwork amongst health professionals. As a result, the researcher concluded that the interdisciplinary team was the prevailing research area even though the actual problems of practice remained ill defined at that point in time.

Aim of the Research

The aim of this research is to use the grounded theory approach to discover the main concerns of health professionals working within interdisciplinary teams, and to explain the processes that members of the teams use to continually resolve practice problems in a restructuring workplace.

Purpose of the Research

The purpose of this research is to develop a substantive theory of interdisciplinary teamwork in the acute care hospital. The term interdisciplinary refers to people with different training and preparation (e.g. management, medicine, nursing, occupational therapy, physiotherapy, dietetics, and social work) who share common objectives but make differing, complementary contributions to patient care (Leathard, 1994). Glaser (1998) argues that "grounded theory is well-suited to discovering the participants' problem and then generating a theory accounting for the processing of the problem" (p. 11). When the public health service is being restructured, the demands for new ways of working together are intensifying, so understanding how team members process their concerns seems appropriate.

Significance of the Study

It is difficult to predict the precise significance of a grounded theory study. Initially, the researcher was aware that the givens were teams that practised in a changing health care environment, which was influenced by sociopolitical and economic agendas. Although it is tempting to argue that radical restructuring must affect collegial interactions and increase interdisciplinary conflict when professional roles and boundaries are being re-drawn, in an emerging grounded theory study normative expectations are not automatically accepted (Glaser, 1998). Conjecture and preconceptions need to be suspended if the problem is not to be forced in a direction that misrepresents the participants' reality. This study is likely to be significant because little is understood about the processes of interaction as teams manage interprofessional work in the acute care hospital. A better understanding of interdisciplinary teamwork has the potential to improve the quality, efficiency, and effectiveness of service delivery.

The Key Argument of the Thesis

The outcome of this thesis is a grounded theory, which suggests that interdisciplinary team members express a concern for meeting service needs, and continually resolve that concern through the process of **pluralistic dialogue**. This is a means for discussing differences that supports team members who are thinking through and constructing new ways of working together. It emerges as various health professionals integrate multiple perspectives, which contribute to the clinical and organisational management of the client service. **Pluralistic dialogue** has two complementary phases. These are *rethinking professional responsibilities* and *reframing team responsibilities.* Rethinking and reframing are theoretical processes that are underpinned by team learning, and, by new ways of managing changing service structures. Therefore, it is suggested that, in an interdisciplinary team, health professionals must *break stereotypical images* in order to meet service needs in a context where teams are constantly *grappling with different mind-sets.* Team members continually resolve their concern for meeting service needs by *negotiating service provision.* As a result, the health professionals are free to *engage in the dialogic culture.*

Pluralistic dialogue is about largely apolitical professional people practising in an increasingly political context that is shaped by a cooperative-competitive spirit[1]. As interdisciplinary team members they manage the tensions and contradictions of their practical life by drawing on formal-informal connections[2].

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[1] The term "cooperative-competitive spirit" is coined from the work of Tjosvold & Tjosvold (1994). These authors suggested that teams have a positive impact on organisational success and quality when they share cooperative goals but also impede workplace effectiveness when competitiveness dominates communications and actions. In reality cooperation and competition coexist. Antonyms are used deliberately in this study to convey the paradoxical nature of the environment that is seldom static but more likely chaotic, complex, and changeable.

[2] The idea of "formal-informal connections" is derived from the data and is discussed in detail in Chapter Six. The term refers to changing communication styles that emerge especially when colleagues are negotiating service provision with each other in the clinical setting. Health professionals use various channels of communication depending on the situated context. Although they communicate formally in meetings, more and more, they communicate casually in the clinical areas, as they move around and about. Informal communication occurs freely and

As a result, the teams are liberated to engage in both-and thinking[3]. All told, the process of **pluralistic dialogue** has the potential to challenge, to empower, to transform. Or, it can perpetuate mediocrity and anonymity. The decision to dialogue mindfully with others is essentially individual. Any variation in an individual's commitment is covered by disciplinary associates but seldom challenged by colleagues from a different professional group. A person may choose a non-involved response at any time, although someone must fulfil functional responsibilities in the team. Any variation in an individual's commitment is covered by disciplinary associates but seldom challenged by colleagues from a different professional group.

The study highlights several significant categories impacting on the success of interdisciplinary practice. These are competency, world views, information exchange, personality differences, and pluralistic leadership[4]. Team agency[5], and the responsibility-based organisation[6] also affected team

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naturally as people work together, with colleagues and patients.

[3] The concept of "both-and thinking" refers to a way of thinking that is based on ideas articulated by Zohar & Marshall (1994). These authors argued that "the old vision of one truth, one expression of reality, one best way of doing things, the either/or of absolute, unambiguous choice, must give way to a more pluralistic vision that can accommodate the multiplicities and the diversities of our new experience. Learning to live with many points of view, many different ways of experiencing reality, is perhaps the greatest challenge of the new, complex society in which we find ourselves. Either/or must give way to both/and. 'My way' must yield to a shared way that respects many possibilities as valid and many truths as steps along some further evolutionary way" (p. 30).

[4] McWhinney (1997) discussed the concept of pluralistic leadership. In this study it is evident that leadership was shared as it changed according to contextual determinants. McWhinney believed leadership alters in the pluralistic environment, as it becomes a way of recognising and valuing individual contributions. He argued that pluralistic leadership is integrative, participative, or consultative, depending on the circumstances of the time. This author interprets plural to mean multiple or many. In other words there are many different forms of leadership.

[5] Team agency is a term coined by the author who uses it to explain how the clinician integrates individual interests and actions within the collective process of teamwork. It is used to depict the melding of individual and collective interests in teamwork. May (1996), Fine (1992) and Williams (1994) all discussed the concept of agency in greater depth. This author's idea was shaped by their arguments.

[6] Drucker (1994, 1995) analysed the responsibility-based organisation that accepts social responsibility for organisational function and competence, which meets broader sociopolitical needs in a pluralistic era. In the post-capitalist society new pluralisms evolve because "the society of organisations, the knowledge society, demands a responsibility-based organisation" (Drucker, 1994, p. 97). The

processes and **pluralistic dialogue.** But, it was quite clear from the data that, interdisciplinary team members *can*, and *do* form synergistic relationships that benefit both clients and colleagues. Team success is dependent on the individual's courage to challenge the self and the humility to cooperate in collective learning experiences.

This substantive theory presents just a glimpse of the practical life of interprofessional people working in two busy city hospitals. The teams studied were unusual in that they each offered specialist care to a select group of clients. Perhaps they were unique and are non-representative of the average person who is a health professional today. So many of the health professionals were highly educated, well respected specialist practitioners who stand out for their individual investment and dedication to improving the client's pathway through acute care. The study participants' patterns of behaviour would suggest that, when interdisciplinary practice is well established, an attitude of cooperative inquiry pervades joint actions and interactions, which focus on meeting service needs.

Structure of the Thesis

So far an overview of the research process has been outlined. In Chapter Two pragmatism, the philosophy that inspires symbolic interactionism, is introduced, followed by an analysis of symbolic interactionism. The chapter closes with a synopsis of the grounded theory method used in this project.

Chapters Three through to Five present three perspectives of the macro context to the study. This sets the scene for the microanalytical approach to the data.

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responsibility-based organisation is complex. A critical tension exists between the sociocultural need for stability and the organisational need to destabilise structures and processes amidst change. Drucker (1995) believes that social transformation changes the mutual responsibilities between individuals and the organisation. The responsibility-based organisation is tense with the demands of coordinating specialist clinicians into effective, socially responsible teams.

Chapter Three begins with the historical influences on present-day values, knowledge, attitudes and beliefs of health professionals. The rise of professionalism, the concept of profession, and the discourse of professionalism are explored, together with issues of power and social control in the professions.

In Chapter Four the political context of health reform is summarised. The changing social demands in health care, the political impact of the health reforms, and the management challenge to health care in the post-industrialist society are examined.

Next, in Chapter Five the literature about teams and teamwork in restructuring health care organisations, is reviewed. Terminology is clarified and the concepts of work redesign and the differences between teams and teamwork are analysed.

The research process is examined in Chapter Six. Access to the field, participant selection, ethical concerns, and data collection and analysis are explicated.

The actual grounded theory is presented in Chapters Seven through to Twelve.

In Chapter Seven the basic core category **pluralistic dialogue** is analysed in order to provide a general understanding for the discussion and the components of the theory that follow.

In Chapter Eight the two theoretical codes, *rethinking professional responsibility*, and *reframing team responsibility*, and the associated findings that emerged in the study overall are presented.

In Chapter Nine the conceptual category, *breaking stereotypical images* is illustrated together with its component properties of blurred boundaries, pioneering new structures, confirming competence, and the collegial attitude.

In Chapter Ten the second conceptual category of *grappling with different mind-sets*, is introduced. There, the properties of pluralistic world views, differentiated commitment, practising a team philosophy, and collective practice are discussed.

Negotiating service provision, the third conceptual category, is considered in Chapter Eleven. The explanation of the properties includes analysis of continuous information exchange, business-humanitarian clashes, deciding together, and collective accountability.

Then, in Chapter Twelve, the fourth conceptual category, *engaging in the dialogic culture,* is discussed. The properties covered in this section of the theory include interprofessional safety, pluralistic leadership, tolerating personality differences, and a sense of community.

In Chapter Thirteen a summary of the grounded theory of pluralistic dialogue is presented. The findings are discussed and the implications of the research for practice, education and further research are considered. The limitations of the research are reviewed, and the chapter closes with a personal reflection on the research experience.

Finally, in Chapter Fourteen the author discusses the research findings and locates them in the professional literature. Significant issues that emerged in the research process are synthesised under three themes: leadership in the pluralistic era, team agency, and the responsibility-based organisation. The thesis is closed with a concluding statement.

CHAPTER TWO

Meaning and Method

Philosophy of science without history of science is empty; history of science without philosophy of science is blind. (Lakatos, 1981, p. 107)

Introduction

Just as widespread social and cultural change altered the face of society and impacted on the philosophy of science during the Renaissance, so science is challenged to respond in new ways, again, when we approach the new millennium. In the past, disputes over the best or the right scientific method were heated, controversial, and unsettling. As the world moved towards a post-industrial society in the later half of the twentieth century the Newtonian world view was found to be limited in solving the systemic sociocultural crises occurring the world over (Capra, 1982). This chapter provides a brief outline of modern ways of thinking. Pragmatism is explored as a prelude to an analysis of symbolic interactionism, which is identified as the basis of grounded theory. This is followed by a synopsis of grounded theory, the method used in this study.

Modern Ways of Thinking

Science and philosophy are closely intertwined. The scientific study of knowledge, epistemology, furthers a common understanding about the origins of knowledge, the nature and construction of knowledge, and agreement on the questions that are most likely to generate knowledge (Denzin & Lincoln, 1994; Guba, 1990; Maykut & Morehouse, 1994). Ontology, the science of being, adds another dimension to knowledge development. Logic is critical too because it directs methodology, the scientific strategies and practices used to collect and analyse data during the research process.

Modern thinking is rooted in the sociohistorical understandings of knowledge development that explained changing conceptions of reality and how they influenced thinking. Lakatos (1981) argued aptly that the history

and the philosophy of science complemented each other when competing methodologies were examined against common historical interpretations and cultural tradition. The two major shifts in thinking about the world - deduction and induction – were identified epistemologically as rationalism and empiricism.

Empiricism assumes that all knowledge starts with the senses, while rationalism presumes that all knowledge originates in the mind. The essential argument is whether knowledge about the world develops through the senses or through the mind. Are the senses fallible and is the mind the only way to be certain about anything? Equally well, perhaps the mind is questionable and the senses reliable? Alternate world views have changed dramatically the perceived connections between philosophy and science (Thompson, 1995), and influenced analysis of the surrounding world.

The differences between rationalism and empiricism can be traced across the centuries in narrative history. Philosophers have challenged the certainty of reason as reason, against reason as confirmation through experience. Arguments clarifying the sources of genuine knowledge were reduced to the origins of innate ideas and how they were to be justified. Thompson (1995) argued that the rise of modern Newtonian science was impossible without a renewed interest in the value of human reasoning and the ability to challenge existing ideas. Uncertainty about any certainty underpins the debate that has dominated the recent rise of postmodern thinking.

New ways of thinking are congruent with the changing sociocultural context that recognises knowledge as an historical progression that is simultaneously dynamic, complex and fluid. Dialogue reveals a perpetual dialectic struggle that uncovers tensions, confusions, and contradictions within knowledge. Anomalies and competing ideas signal a paradigm shift, as scientists explore different ways of generating knowledge that challenge existing ways of knowing (Kuhn, 1962). A new world view emerges. Tarnas (1991) noted the diversity of thinking that is typical of the new postmodernism:

> The postmodern mind may be viewed as an open-ended, indeterminate set of attitudes that has been shaped by a great diversity of intellectual and cultural currents; these range from pragmatism, existentialism, Marxism, and psychoanalysis to feminism, hermeneutics, de-construction, and post-empiricist philosophy of science. (p. 395)

On the other hand, Thompson (1995) observed that postmodernist philosophy has been vague. If truth does not exist there is no fixed point of reference from which knowledge can be judged as authentic. Knowledge is always provisional and situated in a constantly changing reality. Reality is inconstant, shaped by the individual engaged in the world, created by actions in response to the demands of an unpredictable, paradoxical context. Because individual orientation and motivation are unable to be understood completely, the perceived legitimacy of knowledge can often be reduced to utilitarian understandings. At the same time hypothetical ideals are criticised when they do not explain a fluid, unfolding reality – the modern world - that is in a regular state of revision (Tarnas, 1991).

Postmodern thinking emerged in a milieu of cultural upheaval and uncertainty. Social values and beliefs were constantly revised as political and social change altered the face of society. Although verificational science and logical rigor have dominated knowledge development for some time, the exclusion of all non-sense, ethics, values, emotions, and the meaning of human experience certainly stimulated the rise of interpretive inquiry in the nineteenth century. Pragmatism was one perspective that focused on common sense thinking and practical consequences as a measure of truth (Thompson, 1995).

Pragmatists object to the static, predetermined, mechanistic view of a universe that is a dynamic, unpredictable, historically situated world in the midst of creation (Collins, 1989; Shalin, 1986). While rationalists struggle to explain the irregularities and constant changes of the natural world, pragmatists grapple with social order and process in a freely developing reality pervaded by vague abstractions. The pragmatists' most significant contribution to postmodern thinking was their overt recognition of the social conditions that affect human existence (Shalin, 1986).

The Rise of Pragmatism

Pragmatism is a humanistic philosophy. Solomon and Higgins (1996) suggested that the pragmatist doctrine was essentially American in that the philosophical style reflected the "practical, hard-headed thinking" (p. 240) typical of the pioneers colonising a new country:

> Accordingly, American pragmatism is inspired by the conviction that the ultimate test of a theory's worth is its practical *usefulness*. With pragmatism, unlike so much of traditional metaphysics, one could actually set out and *do something,* even change the world. (p. 240)

The practical application of knowledge is critical in the pragmatic perspective. White (1996) argued that the single most important criterion of the pragmatic approach is "what works?" (p. 86) Pragmatism also embraces pluralism, "the legitimacy of different ways of experiencing and living in the world" (Solomon & Higgins, 1996, p. 260).

The founder of pragmatism was Charles Peirce (1839-1914) who influenced William James, John Dewey, and George Herbert Mead. William James (1842-1910) was prominent as the founder of a school at Harvard University. James argued that truth rested with usefulness to either predict experience or promote helpful behaviour. Today, James is known for his study of the mind function, the role of introspection, and the dynamic nature of consciousness - the stream of consciousness (Cottingham, 1996).

Dewey (1859-1952) and Mead (1863-1931) were recognised scholars at the University of Chicago that was very different from the Harvard School, possibly because of the local context. Chicago's history as a pioneering town where fortunes grew alongside immigrants' struggle for survival (Kallen, 1973), gave rise to a form of pragmatism that studied people adjusting practically to new surroundings (Hewitt, 1997). In such a reality truth was dependent on how people responded to an evolving world that was being created in action. Beliefs were tested in action, used or discarded depending on their practicality.

In this sense, mind, self, and society were interconnected. According to Mead (1967), all behaviour is social because all individual activity is located in "natural social situations" (p. 8) and gives rise to social processes:

> ... the behaviour of an individual can be understood only in terms of the behaviour of the whole social group of which he is a member, since his individual acts are involved in larger, social acts which go beyond himself and which implicate the other members of that group. (p. 6-7)

Mead (1967) was quite clear about how behaviour was to be understood. It was important "to explain the conduct of the individual in terms of the organised conduct of the social group, rather than to account for the organised conduct of the separate individuals belonging to it" (p. 7). This approach was fundamental to Mead's sociological theory of the mind.

Mead's theory evolved from the basic premises of pragmatic philosophy. Despite its rudimentary development, Mead (1967) believed that knowing and acting are integrated because all living things respond practically to environmental demands. Truth is relative to the needs of the person who changes responses through active involvement and interaction with others. Social processes such as communication help individuals respond to each other as they create meaning, new actions and experiences, together. Mind, body, and conduct are not reducible to separate entities, for each emerges within society that is forever changing. Charon (1998) concluded that Mead's theory assumed that "humans define and do not respond; they believe what is useful to them; they see and define objects according to their use; and they can understand primarily by focusing on what they do" (p. 30-31).

Mead (1967) was influenced by Darwin who perceived thinking as an integration of behaviour, in which the mind, body and conduct are inseparable aspects of a naturally evolving process. Darwin's notion that the environment is fluid and changeable shaped Mead's thinking about the person who he perceived as being in a constant state of becoming. Even though Mead (1967) recognised that experience is dynamic he was not

convinced that a preexisting consciousness influences behaviour. Rather, he perceived consciousness as emergent from behaviour in which 'the social act is the precondition of [consciousness]" (p. 18). Mead (1967) described the concept of consciousness as being highly ambiguous, conditional, and attention-dependent. "Awareness or consciousness is not necessary to the presence of meaning in the process of social experience" (Mead, 1967, p. 77). It is also affected by language that, in turn, stimulates communication, reasoning, understanding, and action.

Mead (1967) was affected by behaviourism as well although he criticised the separation of mind-body activity. Even though Mead studied with John Watson (Collins, 1989), he did not believe that all behaviour is observable. He believed that behaviour depends on the sensitivity of the person and how individuals define a situation. "It is the sensitivity of the organism that determines what its environment shall be, and in that sense we can speak of a form as determining its environment" (Mead, 1967, p. 328). Common attitudes and universal experiences guide behaviour, providing indicators for acceptable responses, and guidelines for the control of mutual actions. Self-control emphasises self-consciousness, which underpins understanding, definition, interpretation, and meaning. Mead (1967) assumes that the mind and consciousness exist in some form or other that is inseparable. Denying the existence of the mind altogether was untenable:

> This attempt, of course, is misguided and unsuccessful, for the existence as such of mind or consciousness, in some sense or other, must be admitted – the denial of it leads inevitably to obvious absurdities. But though it is possible to *reduce* mind or consciousness to purely behaviouristic terms – in the sense of thus explaining it away, or denying its existence as such entirely – yet it is not impossible to *explain* it in these terms, and to do so without explaining it away, or denying its existence as such, in the least. (Mead, 1967, p. 10)

Collins (1989) criticised Mead's perspective as anti-intellectual because the mind was presented as a means to an end, as a "mechanistic materialism" (p. 9) that is typical of reductionism. Likewise, Hinkle (1992) scrutinised Mead's work and suggested that he did not explain automatic, fixed, habitual, or unconscious conduct. Neither did he rationalise consciousness

or discuss how mutual understanding evolved. However, his focus on the mind and language moved sociological exploration into the realms of thinking about subjective life experiences that are now integrated philosophically (Collins, 1989). Rationalist thinking was challenged by the position that group life is central to all human behaviour (Stone & Farberman, 1970).

Symbolic Interactionism

Mead's pragmatic philosophy inspired symbolic interactionism in sociology. Symbolic interactionism provides an approach for the analysis of human group activity and conduct. It focuses on how people interpret and define situations influencing social action (Blumer, 1969). Mead, though, published so little that his students resorted to the distribution of his lecture notes (Charon, 1998; Collins, 1989). The lack of publication was not particularly unusual for a scholar living in the era of the "oral tradition" where theoretical ideas were transmitted verbally, according to the academic traditions. The emphasis was on repetition, ritual and "getting it right" (Kuhn, 1964, p. 61). Mead's few writings have formed the basis for symbolic interactionism (Blumer, 1969), but

> ... for many, Herbert Blumer was symbolic interactionism... Although never providing a systematic statement of interactionist belief, Blumer served as an arbiter for what symbolic interactionism "really" meant. Even if not all accepted his interpretation, to reject it was to reject "Blumerian" symbolic interactionism. (Fine, 1993, p. 63, 64)

Blumer's (1969) publication stimulated analysis of ambiguities and contradictions about a social perspective that had hitherto passed unquestioned by many. Symbolic interactionism was criticised as an apolitical, astructural, and ahistorical position because it fails to include conceptions of power, inequality, structure, institutions, or ideology in the study of social life (Meltzer, Petras & Reynolds, 1975; Musolf, 1992). While Mead clearly made every effort to respond to the social issues of the day, the interactionists who followed did not update his theoretical ideas for a more modern context. The place of human emotions and social structure,

or their impact on social interactions and behaviour were not fully appreciated (Fine, 1993; Meltzer et al. 1975). Hinkle (1992) argued:

> Admittedly the utopian image of a homogenous, equilibrated society, free from social tension and conflict with freedom of choice and equality for all, was congenial and suitable with earlier theoretical efforts, but it is impotent and out of touch with the needs and issues of a global social order. (p. 316)

Debate about the meaning of Meadian interactionism provoked fractionation into some very different schools of thought (Meltzer et al. 1975). The better-known groups included the Chicago School, the Iowa School, the dramaturgical approach of Goffman, and Garfinkel's ethnomethodology. Common to all were Herbert Blumer's (1969) basic premises of symbolic interactionism. Everyone agreed in principle that people act towards things according to the meaning those things have for them; meaning evolves from social interaction with others; and meaning changes as interpretation alters once people are actively engaged within the world. In other words people construct realities through interaction with others (Meltzer et al. 1975).

However, the two main academic perspectives differed methodologically (Meltzer et al. 1975). The Chicago School was known as the key supporter of the classical Meadian tradition, and was popular because it defended the "microsociological, non-statistical, robustly relativistic, and proudly anti-positivistic" approach (Fine, 1993, p. 64). Led by Herbert Blumer (1900-1987) until he joined the University of California (Berkeley) in 1952, the Chicago School followed humanism, endorsing an involved role for the social researcher within the interpretive paradigm. Qualitative methods were developed and included participant observation, interview, life histories, case studies, diaries, and letters that were integrated into data collection to discover how people shape and reshape their environment (Meltzer et al. 1975).

In contrast, the new Iowa School – new because it opposed humanistic traditions with the positivistic – focused on the structuredness of human interaction in which social reality and social process are jointly

constructed. The dyadic nature of interactions and interrelationships and the interconnectedness between people were explicit (Adler & Adler, 1994). Led by Manford Kuhn, the school took an eclectic approach to the scientific study of interactionism (Meltzer et al. 1975). The Iowa School defended post-positivistic explanation, emphasising systematic control, objectivity, hypothesis testing, and the quantification of all variables.

Meltzer et al. (1975) observed that while Kuhn attempted universal predictions about social conduct, Blumer sought to understand contemporary society better. Disagreements between the schools included the relative value of phenomenology or positivism, the techniques of participant observation, and the concepts best suited for the study of human behaviour. Agreement centred on the belief that, despite social constraint, hierarchy or culture, the meaning of interaction arises from shared action and definitions of the situation (Musolf, 1992).

Symbolic interactionism was extensively critiqued (Denzin, 1992; Fine, 1993; Hinkle, 1992; Meltzer et al. 1975; Musolf, 1992). Both schools of thought were scrutinised as social consciousness increased in a society where "power is embedded in the social structure of race, sex, occupations, and everyday interaction and communication" (Musolf, 1992, p. 172). Critics motivated the interactionists to reconsider optimistic, microsociological, astructural biases, and to examine macrosociological structures in a way that preserved the theoretical traditions but also integrated indeterminism with the social construction of meaning (Denzin, 1992; Musolf, 1992). By the 1980s, the themes of constraint and human agency emerged (Musolf, 1992). New leaders in the field - people like Denzin, Strauss, Stryker, Fine, Shibutani, Becker, Goffman, and Lofland – guided ongoing development (Charon, 1998).

Symbolic interactionism in the 1990s has a diversity that fosters intellectual ferment (Fine, 1993). As a perspective, it has not gone away. Today, it incorporates the macrosociological structures that encompass the pragmatic perspective, phenomenology, existential sociology, feminism, political viewpoints, dramaturgy, discourse, structural role identity

theories, reality constructionism, interpretive and contextual interactionism (Denzin, 1992; Fine, 1992). Fine believes that the agency-structure debate stimulated a synthetic interactionism, a seamless approach that subsumes "divisions, divides and chasms" (p. 104), connecting action sociology to structural sociology.

Similarly, Denzin's (1992) demand for new directions in symbolic interactionism challenged interactionists to move beyond unsophisticated, idyllic interpretations that represent a conservative social perspective. Certainly, traditional interactionism may be an appropriate theoretical view, but Hinkle (1992) believed it to be inadequate when the complex, ambiguous problems of social order in the post-industrialist society are considered. Denzin's call to locate critical interactionism within the postmodern reality was provoked by the deconstructionist bent to envisage a world without constraint or structure, while preserving the privileges of agency (Fine, 1993). That view is quite different to the classical Mead-Blumerian symbolic interactionism that informed Glaser and Strauss' (1967) grounded theory method.

General Ideas of Blumerian Symbolic Interactionism

Symbolic interactionism is based on the study of social process and how people understand the world through meaning that is created and changed continuously by self-interaction and social interactions with others; meaning is assumed to be interactional and interpretive. It is founded on the idea that "people transform themselves and their worlds as they engage in social dialogue" (Stone & Farberman, 1970, p. v). Interpretation is accepted as being the core process of interaction. Indeed, interpretation clarifies meaning (Denzin, 1989).

Symbolic interactionists reject the notion that the person is a passive, pre-determined being simply responding to environmental stimuli. Instead, they view the person as a reflective, self-directing, dynamic, individual who is influenced by mutual interpersonal interactions (Charon, 1998). Symbolic interactionism differs from positivistic perspectives of social science that

value linear causality, objectivity, measurability, and determinism. Instead, it regards a person as capable of thinking and defining what is happening in the world. The past is integrated and considered with the future. Individual deliberations focus on environmental objects according to personal and practical use.

Blumer (1969) outlined three basic premises of symbolic interactionism. Firstly, people act towards something according to the meaning those things have for them. Interactionists assume that meaning is always emergent as people define things and act towards them in various situations. Meaning is always dynamic and purposeful. Meaning is central and cannot be separated from the interpretation of behaviour. If meaning is taken for granted, reduced to non-existence, or, causes attributed incorrectly to behaviour, understanding is weak.

Secondly, Blumer (1969) suggested that symbolic interactionists emphasise the source of meaning. People constantly change personal interpretations about the world once they communicate with others and consider the actions of others towards something. People are not reacting to stimuli as such, but are responding to personal definitions of a situation. Meaning does not evolve from the intrinsic understanding of something, or from the psychological constituents of the person. Instead, meaning develops from the way in which people act towards each other as they communicate together.

Finally, Blumer (1969) argued that meaning is constantly changed in interpretive processes as people are engaged within the world. This begins with personal awareness of the significance of a situation that develops according to the way meanings are applied and readjusted during an ongoing process of self-interaction. Personal definitions of the situation change in social interaction with both the self and others who shape understanding, interpretation, and social action. These three premises emphasise how people create meaning together within a particular context (Fine, 1992).

The Self

The basic concepts are the self, the act, social interaction, objects, joint action, and society. People are active, thinking beings simply because they possess a self. Blumer (1969) suggested that, because a person can be objective about the self, self-perception directs behaviour towards others. The human ability to imagine "the world from the perspective of another", to take on the roles of others, is critical for the emergence of selfhood (Charon, 1998, p. 110). Role taking influences how we make roles, how we define situations and construct our roles and integrate them with the activities of others (Hewitt, 1997).

This notion is derived from Mead's (1967) belief that the self is a social object, an integration of objective and subjective thinking, a product of symbolic interaction with others and social interaction with the self. In this sense the self is a process, not a structure (Blumer, 1969). The self is also reflective. Self-reflection co-constitutes the self. Similarly, self-objectivity is a prerequisite to rationality. It represents the "I" or the personal response to the attitudes of others (Mead, 1967, p. 174). Indeed, Mead argued:

> Reason cannot become impersonal unless it takes an objective, non-affective attitude towards itself; otherwise we have just consciousness, not self-consciousness. And it is necessary to rational conduct that the individual should thus take an objective, impersonal attitude toward [the self], that he should become an object to [the self]. (p. 137)

That self-objective attitude shapes intelligent, rational action. But, self-consciousness is incomplete if removed from the field of experience that also affects how we act towards ourselves – the me. In this sense, consciousness is an experience of, an experience with, the self (Mead, 1967). Self-consciousness is not separate from the self, but develops with others, as we understand ourselves through reflections in the eyes of others.

The Act

Human action is both individual and collective. Because every individual is self-interpreting and self-directing, person-environment interaction must be interpreted to enable action. Defining and redefining situations is the basis of interpretive action as the person assesses possibilities for action. Blumer (1969) stated that interpretation involves noting wants and wishes, potential for realisation, answers and anticipated actions of others, self-image, and the likely outcome of actions. Lines of action are flexible, changeable, and can be altered individually or collectively. Individual actions seldom occur in isolation, and are more usually integrated within groups.

Acts are social objects because the social act must be taken as part of the dynamic whole. "No part can be understood by itself" (Mead, 1967, p. 7). People engage in a continuous stream of action, both overt and covert. Action is influenced by ongoing decisions that are affected simultaneously by definitions of a situation, social interaction and self-interaction. Action is directional as well because definitions and decisions influence potential behaviours (Charon, 1998). The person absorbs the attitudes of others towards the self. In turn these influence social interaction in a context that shapes experience and behaviour.

Social Interaction

Social interaction is a unique formative process. Group life infers that individuals interact with each other in an all-inclusive process. Group behaviour emerges when people communicate and respond to each other as thinking, intentional beings, actively exchanging ideas. Blumer (1969) emphasised that "social interaction is an interaction between actors and not between factors imputed to them" (p. 8). Social interaction is more than a means of expression. It shapes behaviour as people direct, bend, and transform individual lines of action depending on perspectives encountered in others. Distinctions are taken into account so that the person may "abandon an intention or purpose, revise it, check or suspend it, intensify

it, or replace it" (Blumer, 1969, p. 8). Individual actions emerge from collective action.

Blumer (1969) drew on Mead to explain the two levels of social interaction in society. The first is non-verbal communication, non-symbolic interaction, which arises from the conversation of gestures that is not voiced (Mead, 1967). Direct responses to others usually occur immediately, automatically, or without thought. By contrast, symbolic interaction involves the interpretation of shared significant symbols like gestures that invite responses using commonly accepted sociocultural meanings. Gestures indicate a general intention of impending behaviour, which is shaped by accepted rules, rituals and courtesies ingrained within people. For example, a person wanting to talk to another might wave to indicate the need for connection with another. Symbolic gestures signal individual intent, expectation of the other, and joint expectation. Strauss (1969) observed that they help people define situations and organise mutual activities. Understanding depends on each person taking the role of the other, to grasp the intention and approaching action of the other.

Symbolic interaction is central to group life as people clarify expectations of others and interpret reciprocal hopes in social processes. People adjust ideas and fit behaviour to others, while defining personal positions en route. "Both such joint activity and individual conduct are formed in and through this ongoing process; they are not mere expressions or products of what people bring to their interaction or of conditions that that are antecedent to their interaction" (Blumer, 1969, p. 10). Redefinition conveys the formative nature of social interaction that frames new objects, new conceptions, new relations, and new types of behaviour.

Interpretation and definition of other people's acts mean that symbolic interaction embraces the full range of human behaviour. It explains the extensive dimensions of interpersonal interactions including "cooperation, conflict, domination, exploitation, consensus, disagreement, closely knit identification, and indifferent concern for others" (Blumer, 1969, p. 67). Regardless of the nature of the social act, participants do construct

individual actions by interpreting and defining the acts of each other. Social interaction enables people to look broadly at any interaction, rather than focusing on some narrow aspect of interrelationships that represent a more limited picture of exactly what is happening in a particular situation.

Objects

Blumer (1969) argued that meaningful worlds are made up of objects defined in symbolic interaction. Objects may be physical, such as houses, or trees; social, such as brother, sister; or abstract, such as moral ideals, philosophical beliefs, or ideas like equality, the self, the past or the future. Any person involved with the object assigns meaning to it. Charon (1998) noted that objects are "pointed out, isolated, catalogued, interpreted, and given meaning through social interaction" (p. 44). For example, a book has different meanings for the author, student, publisher, or retailer.

In turn, the environment is defined by objects that the person recognises and understands (Blumer, 1969). Irrelevancies are not noticed at all. The meaning of objects is cocreated in a collective interactive process whereby the person defines and redefines situations with others. Although objects may not actually change, understanding alters continuously as the person inspects objects, thinks about them, works out a plan of action towards them, and decides whether or not to act at all (Blumer, 1969). Meaning is forged and forwarded via social processes, unfolding through change and communication.

Joint Action

"Joint action of the collectivity is an interlinkage of the separate acts of the participants" (Blumer, 1969, p. 17). Blumer notes that "joint action is Mead's social act" (p. 70). It emerges as participants interpret and define situations, aligning respective actions with each other once meaning is clarified. Understanding the actions of others is fundamental in society (Mead, 1967). Communicating what we are doing, what we believe, and what we are about to do is crucial for social co-operation in society because socialisation depends on recurrent patterns of behaviour continuing over

time. Common behaviour is the basis of cultural understanding that establishes a collective social order.

Meaning within interaction is more important than joint action itself (Blumer, 1969). Although joint action melds groups together, organisations do not function automatically because of inherent dynamics or system requirements. Rather, organisations exist because people carry out roles and responsibilities according to how they define the situation in which they act. Meaning guiding behaviour is localised, focusing on how understanding is "formed, sustained, weakened, strengthened, or transformed, as the case may be, through a socially defining process" (Blumer, 1969, p. 20). Organisational function depends on interpretive interactions across many different groups that are located in a sociohistorical context.

Society

Society develops as people interact. Blumer (1969) stated that groups are comprised of people interacting in all sorts of daily activities. Selfhood is influential because individuals can act independently, as part of a group, or on behalf of another, or organisations. According to Blumer, activities, or behaviour, always relate to an individual engaged in a situation in a society that can only be understood as it "exists in action" (p. 6). All social action must be located in society that is in the ongoing process of cocreation as people fit activities with one another. Charon (1998) concluded that interpersonal interaction requires people to draw on cooperative symbolic interaction for engagement in collective action that incorporates ongoing communication, mutual role taking, defining others as social objects, defining social objects together, and developing mutual goals.

The Methodological and Philosophical Position of this Project

This research study is based on grounded theory as explained by Glaser (1978, 1992, 1996, 1998), Glaser and Strauss (1967), and Strauss (1987). Grounded theory is a general research method that has been shaped by pragmatism and informed by symbolic interactionism. Glaser (1996, 1998) stated that Everett Hughes and Herbert Blumer trained Strauss in symbolic interactionism and qualitative analysis at the University of Chicago. Strauss (1987) noted that the grounded theory approach to qualitative analysis evolved from the general philosophical ideas of American Pragmatism and the specific writings of Dewey, Mead, and Peirce. By contrast Glaser (1996, 1998) was trained at Columbia University. There, he was influenced by Paul Lazarfeld's techniques of quantitative analysis, and Robert Merton's courses in theory development, as well as his structural-functional analysis of sociological problems and social conditions that effect conformity and deviance in society. In the grounded theory method qualitative and quantitative research traditions are integrated within symbolic interactionism (Glaser, 1996; Glaser & Strauss, 1965).

Grounded Theory as a Research Method

Grounded theory is an inductive research method that generates theory from data which is gathered, organised, and examined systematically in an ongoing interplay between analysis and data collection (Glaser & Strauss, 1967; Strauss, 1987). The aim is to explain and to predict behaviour, and to discover the underlying social processes shaping interaction and human behaviour. As an approach it is guided by the notion that to know about a person is not enough. Even though the person learns to understand the self through social interactions with others, the purpose of grounded theory is to "type behaviour not people" (Glaser, 1992, p. 69). Therefore, the emphasis is on patterns of action and interaction. Behavioural patterns of the wider group are the focus, not personal patterns.

Grounded theory is a useful approach to direct theory development (Glaser, 1978). It is also an effective style for the qualitative analysis of data and conceptualisation (Strauss, 1987; Strauss & Corbin, 1994). Grounded theory research is based on the assumption that the social world is discoverable via naturalistic inquiry into the social conditions shaping interaction and behaviour. Glaser and Strauss (1967) drew the method from the quantitative tradition developing an interpretive method that embraces the systematic collection and analysis of data in the everyday world in a way that ensures reliable and rigorous results. They extended conventional quantitative techniques, introducing field observation, semi-structured interviews, and the examination of varied documents as a valid means of understanding how people define and interpret situations and meld their behaviour and expectations with others.

Constant comparative analysis, theoretical coding, and theoretical sampling, all processes contributing to the systematic generation of theory, are features of grounded theory (Glaser, 1978, 1998; Glaser & Strauss, 1967; Strauss, 1987). *Constant comparative analysis* is an ongoing process whereby the researcher jointly codes and analyses data into concepts and categories. Tentative hypotheses about the main concern are checked against incoming data and emerging theoretical ideas (Glaser & Strauss, 1967). Systematic generation of theory progresses as the researcher identifies categories and searches the data to identify wide dimensions. The goal is not to cover the field in its entirety. Rather, theory that accounts for a broad range of interaction and behaviour is developed. The disciplined process permits "some of the vagueness and flexibility that aid the creative generation of theory" (Glaser & Strauss, 1967, p. 103).

Constant comparative analysis facilitates theory reduction by delimiting and saturating the categories (Glaser & Strauss, 1967). The researcher compares similarities and differences between incidents common to a category. Incidents are contrasted with incidents in the same category and across categories. Next, the analyst integrates categories with properties that are all-inclusive of causal conditions, the context, interactions among

the people, strategies and tactics, and consequences (Glaser, 1978; Strauss, 1987). Although incidents and categories are both concepts they differ in the level of conceptual abstraction. Thick description is reduced by conceptualisation, by selecting and focusing on conceptual and theoretical categories that control development of the emerging theory. The content behind the categories, is explained in *memos* that diary the developing meaning in the theory.

Theoretical coding is used to fracture the data (Glaser, 1978). Coding helps the analyst sort out, summarise and synthesise incoming information so that it is developed effectively. Glaser identifies two types of codes: substantive and theoretical. Substantive codes identify ideas emerging from the data while "theoretical codes conceptualise how the substantive codes may relate to each other as hypotheses to be integrated into the theory" (p. 55). Substantive coding is open while theoretical coding is selective in that it is focused on checking out tentative hypotheses and relationships between concepts. At this point coding is directed towards the development and explication of the basic core variable or a core category that draws the theory together (Strauss, 1987). The two types of coding occur concurrently and are integrated with theoretical sampling.

Theoretical sampling is another hallmark of grounded theory. As the researcher collects, codes, and analyses data she decides where to move next to clarify the dimensions of emerging categories (Glaser, 1978). Glaser (1992) believed that the participants are chosen, as they are needed, to further the theoretical purpose and relevance of the evolving theory. Different participants help the researcher to clarify the patterns of action and interaction between and among people, and develop a theoretical conceptualisation within the area of study. Data are collected in various ways. For example, focused interviews, observations, and documents may broaden the slices of data, providing different perspectives and issues of concern within the emergent theory (Glaser & Strauss, 1967).

Theoretical sampling assists the analyst to identify the similarities and differences within and between the discovered categories. Categories are

clarified as their meaning is developed in relation to various dimensions, social conditions, and consequences until they are theoretically saturated and no new ideas appear (Glaser & Strauss, 1966). As a process, theoretical sampling is ongoing, logical, highly organised, and rigorous. This process is enhanced by the researcher's theoretical sensitivity, ability to conceptualise and to abstract a total theory systematically, and capacity for theoretical insight into the domain of study (Glaser & Strauss, 1967).

Theoretical development in grounded theory is generally consistent with middle range theories that are either formal or substantive (Glaser & Strauss, 1967). Substantive theory focuses specifically on areas where the researcher seeks to understand the actions and interactions of people in a particular place. Formal theory though, develops disciplinary knowledge in relation to existing abstracted concepts such as human science and human care (Watson, 1988). Usually, it follows substantive theory development by building knowledge about preexisting concepts to a more abstract level.

The Credibility of Grounded Theory

Conveying credibility is a two-way process between the researcher and the participants. Glaser and Strauss (1967) argued that it commences once the researcher feels ready to convince others of theoretical plausibility while acknowledging that theory development is evolutionary. Closure seems reasonable when the researcher is confident that the field is represented accurately. Although the interpretation is but one, the researcher uses theoretical explanation to illustrate the social world so vividly that others can easily connect the theoretical framework with reality.

Glaser and Strauss (1967) stated that the notions of fit, workability, relevance, and modifiability, confirm theoretical credibility. A study has fit when theoretical categories match the data. Fit is consistent with the research validity (Glaser, 1998). Categories are not preconceived or forced to fit the preexisting assumptions. Explanations are congruent with the emerging patterns and account for the participants' construction of reality.

A well-developed grounded theory captivates readers who are convinced by the lifelike presentation of a familiar reality (Glaser, 1978).

Similarly, a grounded theory is workable when it explains what is happening in the place of study (Glaser, 1978). The theory is verified in the field as hypotheses are checked and confirmed by participants. Integrated hypotheses explain many of the patterns of behaviour seen in a substantive area (Glaser, 1998). A well-developed grounded theory is much more than description, as it informs expert practitioners of the implicit dimensions of practice that are understood but seldom shared explicitly with others. Strong theoretical explanations provide participants with "a new way of seeing what we all know that's very useful – even an eye-opener" (Strauss, 1987, p. 20).

A workable theory is also relevant to the substantive area of study. The main concern and the core process for handling concerns are explicit within the theoretical framework. People in the field recognise the variations in action, once the interactions and behaviours are presented.

A credible grounded theory is modifiable because theoretical development is always ongoing. That is consistent with the symbolic interactionist approach which assumes that as social conditions change, so does theory, if it is to remain relevant. Ongoing modification makes findings transferable across various settings. Overall, a credible grounded theory is conceptually dense, parsimonious and has broad scope in that the conceptual findings are tentatively applicable to many people in similar situations.

The Grounded Theory Style Used in this Study

Initially, the particular style of grounded theory used in this study was that of Glaser and Strauss (1967), Strauss (1987), and especially Glaser's (1978, 1992, 1996, 1998) method that supported the emergence of problems of the group being studied. Glaser (1992) stated clearly that grounded theorists ask two formal – not preconceived – questions. These are "What is the chief concern or problem of the people in the substantive area, and what accounts for most of the variation in processing the

problem? And secondly, what category or property of what category does this incident indicate?" (p. 4). The grounded theory analyst is looking for the principal theme that integrates behavioural patterns explaining the main concern or problem for the people in the setting. Through systematic, detailed examination of data, the analyst aims "to bring out the amazing complexity of what lies in, behind, and beyond those data" (p. 10).

This method was chosen because it was, and still is, congruent with the researcher's philosophical perspective. Glaser's (1978) guidelines provided an approach that supported researcher flexibility, creativity, and systematic structured analysis. However, analysis using Glaser's (1978) coding family of "causes, contexts, contingencies, consequences, covariances, and conditions" (p. 74) was eventually constraining in the latter stages of theoretical development. Although the Glaser model was followed carefully for two and a half years, in the final period of analysis, the overlaps between causes and conditions became especially frustrating because specific breakdown of that set of data perpetuated a data fragmentation that interfered with the participants' impressions. When the researcher took interpretations back to the participants, confirmation of findings according to discrete causes and conditions was not forthcoming. Discussion with many participants revealed that causes and conditions overlapped in their everyday world. Although difficulties may be accounted for by a researcher-in-training, it may also be possible that the pace of change is such that some slight modification to the general theoretical guidelines may now be required.

Early in the project, Strauss and Corbin's (1990) version of grounded theory was originally perceived to be confining. After further study of the paradigm model the researcher decided to use a particular section in which causes and conditions were merged together. The data was successfully reorganised so that it was consistent with the participants' explanations. As a result a tighter, more coherent, substantive theory was generated.

Conclusion

This chapter has briefly outlined how modern ways of thinking have shaped postmodern knowledge generation. On the one hand, because all knowledge is linguistically linked to cultural tradition, meaning is never fixed and everything is doubted. On the other hand, a rare flexibility of thought creates shared conversations and understandings. Such a context supports diverse approaches to knowledge development. Therefore, the need to develop divergent ways of knowing is critical if there is to be a better understanding of health professionals working amidst the health reforms. Grounded theory will further understanding somewhat, although the method makes no claim to pronounce any absolute truth. Clearly, the method is one among many. It offers one way to systematically study wide-ranging experiences and to uncover the subtle meanings behind everyday practical life. In the next chapter analysis begins at the macro level with an illustration of the historical backdrop against which interdisciplinary teamwork is situated.

CHAPTER THREE

The Historical Backdrop of Teamwork

Introduction

Undoubtedly, the way interdisciplinary teams work together in the 1990s is affected by historical and societal factors that continue to influence modern-day understandings. Professional work is complex, interwoven with historical circumstances and social structures that have had a long-lasting impact on current meanings. The place of the professions in society is a tangled web of social, political, and economic relationships. If there is to be any understanding of current teamwork involving health professionals, it must encompass the context.

In the previous chapter some philosophical debates were outlined, and in particular, symbolic interactionism was examined. Shalin (1986) observed that symbolic interactionism requires the analyst to forward understanding by considering the historically situated world of culture and meaning as part of an evolving universe, continuously shaped by the actions and social interactions of people. In this chapter the historical backdrop of teamwork is examined. The rise of professionalism is explored, the concept of profession is discussed, the discourse of professionalism is analysed, and issues of power and social control are considered.

The Rise of Professionalism

Within the health service medicine and nursing are closely involved in service provision. Over time, allied health professionals - physiotherapists, occupational therapists, dieticians, social workers, speech therapists, pharmacists, and psychologists - joined clinical teams as specialisation increased. However, medicine and nursing remain the mainstays of most clinical teams. These professions have worked together, surviving times of

However, by the 1800s, formally trained doctors followed European tradition that favoured middle-class white males. Class differentiated doctors from lay healers. To secure a powerful place in society, medicine required legal authority to control membership and regulate practice. Medicine competed with the folk healers, the osteopaths, and the homeopaths "who espoused, among other novel ideas, the practice of not killing patients" (Abbott, 1988, p. 20). Medical monopoly thrived once the medical profession gained enough support to outlaw lay practitioners. Although medical practitioners gained ground by claiming technical expertise superior to that of the lay healers, medical knowledge was as weak as, and not dissimilar to, the group it was trying to oust. Freidson (1986) reasoned that the only way medicine could procure complete control of illness and health was by activating patronage from the upper classes, who believed doctors offered something special.

Medical control gained momentum in America in the early 1900s (Ehrenreich & English, 1973). Educational reform was the catalyst. Philanthropists, keen to establish a creditable medical profession, backed medical education reform that emulated existing European models. Upper-class support for the medical profession was secured financially when considerable funds were donated to develop medical schools in accord with the standards set by the highly respected Johns Hopkins University. Abraham Flexner, an employee of the philanthropic Carnegie Corporation, was appointed to inspect medical schools throughout the country and to decide which were suitable to receive funding for development. Consequently, many smaller, less influential schools were closed. The 1910 Flexner Report established criteria for professionalism that benchmarked professional ideology for years ahead.

Flexner (as cited in Bernhard & Walsh, 1995) identified formal knowledge, skill, and altruism as the very qualities that were missing from the medical groups seeking professional status. Flexner's criteria suggested that the activities of the work group were intellectual, knowledge-based, and learnable. Professionals would be distinguishable because their work was

expected to be practical, not theoretical; skills and techniques were to be teachable and learned in formal education; work had to have a strong internal organisation; and practitioners were expected to show a commitment to work for the good of society. Although the well-established professional groups accepted Flexner's work, occupational groups seeking professional status critiqued it vigorously. Nursing was especially challenged later in the century.

Historically, nursing has been perceived as a subordinate occupation to medicine. Developments in medicine and the establishment of Nightingale apprenticeship training systems in the late nineteenth century resulted in a situation whereby nursing practice has been largely prescribed by medicine. Medical influence on nursing practice has been far-reaching:

> The knowledge and skills passed down from doctors was mediated by them in such a way that nurses learnt how but not why they undertook certain practices. This meant that they learnt how and what to do in certain situations but did not acquire the knowledge necessary to make independent nursing decisions, decisions about why and when to implement such practices. Consequently, nurses were dependent on doctors' orders to be able to implement the technical aspects of practice. (Sutton & Smith, 1995, p. 1039)

For almost a century, hierarchical training perpetuated nurses' dependence on doctors. Witz (1994) believed that nurses accepted the routines and medical procedures of junior doctors without realising that they were reducing workloads and costs for a medical profession facing shortages. However, by the mid-twentieth century a core group of nurses, the nurse theorists, sought to explicate nursing's professional independence and advance nursing knowledge development, as they articulated the nature of nursing knowledge within the discipline of nursing (Meleis, 1991). That knowledge development was significant, as it affected professional progress and status in nursing. However, whilst some nurses recognised colleagues as professional practitioners, others continued to perceive nursing as an occupation when it was compared to medicine that had a clear social mandate to practise as a profession (Parkin, 1995; Salvage, 1988).

The Concept of Profession

From the 1960s onwards the concepts of profession, professionalism, and professionalisation were used freely in the literature. With the word profession "there is a semantic history of contradictory connotations and denotations" (Freidson, 1986, p. 20). Differences in meaning are subtle, mirroring the complexity of interprofessional interactions. Horobin (1983) argued that many definitions overlapped so that any agreement was impossible when the words were used descriptively and analytically. Profession was used idealistically and often defined the attributes of being a professional person (Becker, 1970; Greenwood, 1957; Vollmer & Mills, 1966). The term profession often described occupations such as nursing and occupational therapy that were not necessary accorded professional status throughout society (Roth, 1974).

Johnson (1972) struggled with the concept of *professionalisation* that also held multiple meanings. Professionalisation referred to broad alterations in occupational structure; the increased numbers of occupational associations regulating recruitment and control in practice; the core attributes of a group striving to become a profession; or the processual passage of an occupational group seeking the end-point of professionalism. About that time Freidson (1977) argued that understanding lacked clarity because the concept of profession described an historical occupation, or an ideal type, while there was little evaluation of the inherent relationships between the variables. Freidson (1986) eventually concluded:

> First, the terms of analysis are often used so vaguely that it is almost impossible to determine precisely what people and activities they refer to. Key words are often undefined, or they are defined so loosely that one can never be sure what they mean. In much of the literature they are used as part of a colourful rhetoric that exercises the imagination by its connotations but that does not allow actual connection with concrete human events and experiences in the real world. Second, even when denotations are specified, key terms are usually not grounded in human activities. (p. ix-x)

In due time, Freidson (1994) summarised the issues according to semantic specificity:

> Professionalisation might be defined as a process by which an organised occupation, usually but not always by virtue of making a claim to special esoteric competence and to concern for the quality of its work and its benefits to society, obtains the exclusive right to perform a particular kind of work, control training for and access to it, and control the right of determining and evaluating the way the work is performed. It represents a basis for organising jobs and work in a division of labour, which is entirely different from the administrative principle. (p. 62)

When Friedson reviewed the development and progression of the professions in the 1990s he suggested that when language was ill defined, questions could not even be raised, let alone answered. In other words, if you do not know what you are talking about, how can you ask the question? He clarified the concepts:

> I use the word "profession" to refer to an occupation that controls its own work, organised by a special set of institutions sustained in part by a particular ideology of expertise and service. I use the word "professionalism" to refer to that ideology and special set of institutions. (Freidson, 1994, p. 10)

In fact the inconsistencies in definition are complex. Interpretations are either historical or ideal and have undoubtedly affected the discourse of professionalism.

The Discourse of Professionalism

The discourse of professionalism refers to "the set of ideas, beliefs and practices in respect of being a professional" (Petersen, 1994, p. 150). The way professional groups are perceived today is changing, as the concept is located in cultural understandings that are historically embedded. Clearly, Flexner's (as cited in Bernhard & Walsh, 1995) original emphasis on expert knowledge, specialist skills and the control of technology had advanced medicine's privileged position in the first half of the twentieth century

(Ehrenreich & English, 1973). During this period specialist knowledge was dispensed rationally and benevolently to a society ready to support medicine as a major means of social control (Zola, 1978). Abbott and Wallace (1990) claimed that, although physicians linked physical disease to moral decay, medical involvement in health and social problems was preferable to legal and religious scrutiny that sustained moral judgments and punitive condemnation. Society was inspired to champion any physician who embodied the professional spirit of unselfish devotion and a commitment to improving the world (Becker, 1970).

That professional spirit affected health service delivery until the 1960s. Practising within the medical model of health, physicians removed personal responsibility for illness from people so that they were not blamable for illness or recovery. Zola (1978) argued that physicians medicalised many aspects of daily living. Society was prepared to let doctors treat physical ills, judge right and wrong behaviour, and provide advice about living a good life (Zola, 1972). Medical judgement was professional judgement and was preferable to religious scrutiny of living patterns. Therefore, society freely sanctioned the medical labelling of disease despite the fact that effective health services to treat disease were limited (Freidson, 1970a). In retrospect, in the first half of the twentieth century, the profile of medicine and its professional influence increased effortlessly in an industrialising society that *was* a professionalising society (Goode, 1960). As social change impacted on professional development the industrialisation of society gradually altered work organisation and health care delivery (Kelleher, Gabe & Williams, 1994).

The power of the medical profession in industrial society continued until the 1960s when sweeping social and cultural instability undermined the status quo. This period was notable for the shifting attitudes towards the professions. McWhinney (1997) labelled the period from 1962-1974 as the turning point and the beginning of the end of the Industrial Age. The Cuban missile crisis, the Kennedy assassination, international peace action, the women's movement, increased ecological consciousness, and South East

Asian wars marked this period. General cultural confusion signalled the end of an era that became an opportunity for change on a scale that had never been seen before. Historical conditions that had supported professional ascent were fading (Johnson, 1972).

The world was ready to accept liberal world views that were moving politically towards the social democratic left (Cheek, Shoebridge, Willis, & Zadoroznyj, 1996). An emphasis on communication and humanistic values heightened public awareness of freedom of choice and the meaning of informed consent. Society was increasingly appreciative of other occupations that offered professional services supporting partnership and alternative viewpoints. Medicine with its controlled approach was interpreted as a dehumanising institution that treated people as machines who needed repair. That perspective was increasingly tenuous.

By the 1970s society was less inclined to simply accept professional knowledge without question. Freidson (1970b) documented the medical dominance and monopolisation of the health services. Scepticism about the progression of knowledge and technology increased as new contextual concerns emerged and destructive possibilities were re-appraised (Capra, 1982; Rueschemeyer, 1983). People who had accepted the professions positively until then exercised the right to critically analyse medical knowledge, technology, and practice (Kelleher et al. 1994).

The sociological analysis of the professions began (Johnson, 1972). Medicine was the primary target. Two major themes emerged. The first concerned the professions as a unique division of labour in society. The second theme examined the functions of the professions in industrial society. Did the professions have a special role in society? If so, was it economic, political, or social? According to Johnson, the second question faded once sociologists narrowed problems to manageable issues and operationalised the theme out of existence. Johnson described that sociological retreat as "a nervous withdrawal from a value-laden controversy" (p. 12). Researchers were reluctant to be drawn into the social

and political arguments. On one hand, the professions were perceived as having a positive influence on social development. On the other hand, the professions were responsible for the economic monopolisation of technological services and practice. Rueschemeyer (1983) deduced that medicine exerted substantial power and control in society that scholars, who shared a similar professional outlook and ethos, were reluctant to disturb.

Analysis of the professions settled on two broad areas. Issues were classified under either *trait theory* or the *functionalist approach* (Johnson, 1972). However, both approaches proved to be problematic once analysts questioned which groups deserved the coveted label of professional status. Numerous lists were produced, scores given, traits, functions and definitions identified, but no one common attribute was found (Millerson, 1964). Roth (1974) noted that many characteristics upheld professionals' own definitions of themselves and supported unexamined claims for professional autonomy. According to Roth, attribute identification was most helpful for those occupational groups trying to separate specialists from laymen, and improve their scores in relation to other upwardly mobile occupations.

Meanwhile, the call to broaden access to the professions took another turn when Etzioni (1969) identified a semi-professional practitioner who had some of the traits of the professional person. Etzioni was quite clear that nursing, social work and the remedial therapies (occupational therapy and physiotherapy) were semi-professions as their work was skill, rather than knowledge based. Those groups lacked disciplinary knowledge; members did not operate as autonomous practitioners. This criticism was justified to some extent when disciplinary knowledge development was so slow. However, definitions of rational knowledge were narrow and did not embrace broader conceptions of knowledge intrinsic to practice-based situations (Chinn & Kramer, 1994). Thus, the labelling of the semi-professions legitimised lower status groups that assumed subordinate positions in society (Hugman, 1991, 1995). Longstanding patriarchal

relationships of women serving men were replicated, and these clashed with emergent gender issues in society. Clearly, definitions of professionalism were male dominated.

Meanwhile, efforts were made to clarify the functional components of professionalism applicable to professional-client relationships and society as a whole. Parsons (1951) set the scene soon after the Second World War when he discussed the changing social order and social structure, and the potential for discrepancies between altruistic behaviour, self-interest, and motivation in a business economy. Dingwell and Lewis (1983) thought Parson's work about personal values, as a regulator of work standards, was vague if not naive. Many authors have argued since that, more often than not, professionals support self-interests at the expense of client interests (Dent, 1993; Harrison & Pollitt, 1994; Hugman, 1991; Hunter, 1994; Mechanic, 1991; Roth, 1974; Willis, 1989). Paradoxically, professional groups were seen to be powerful collectives, while their practitioners were accused of intense individualism.

Parsons (1951) also classified doctors as agents of social control who monitored patients, making sure they did not avoid their social obligations, become deviant, or remain in the sick role. Johnson (1972) though, believed that Parsons over-emphasised the rational aspects of the client-professional relationship. Turner (1987) extended the argument further suggesting that, physicians focused on technicality at the expense of personal understandings, emotions, and cultural and social values, which influenced states of health and illness too. Overall, Parson's position raised many questions that stimulated the dichotomisation of objective and subjective understandings and caused misunderstanding as contradictions in a rapidly changing society surfaced.

By contrast, Hughes (1971) studied the professions as occupational groups engrossed with the delivery of goods, services, and the division of labour. Hughes concentrated on articulating what the professions did in order to retain their unique place in society. Although Hughes recognised the

importance of resources and task allocation in professional work, he thought that occupational status differed in the organisation because specialised groups had the power "to delegate dirty work" (p. 345). Understanding occupational distinctions and 'negotiative interaction' (Friedson, 1994, p. 57) was crucial as it influenced organisation and control and, inevitably, the legal authority for the training, licensing, and reviewing of practitioners (Hughes, 1958). Sociological analysis moved from roles, values, and socialisation, to focus on situated learning and workers' control of disciplinary knowledge and progress (Atkinson, 1983).

Johnson (1972) argued that Parsons and Hughes failed to promote a better understanding of the professions because each adopted professionalisation as a core concept, which was central to disciplinary development. Too many questions remained unanswered. The questions highlighted the semantic problems and the reluctance to distinguish differences in the occupational activities of various work groups. In reality, both traditions failed to recognise the professions as organisations of power and social control in society. The market place, the economy, and the relationship between the business sector and the professions were ignored. The professions' wider contract with society and the influence of power and politics were disregarded.

The Professions – Power and Social Control

In the latter half of the twentieth century many authors have analysed the professions, and power and conflict from the critical perspective (Freidson, 1970a, 1970b, 1984; Harrison & Pollitt, 1994; Hugman, 1991; Johnson, 1972; Larson, 1977; Petersen, 1994; Roth, 1974; Willis, 1989). There have been many debates on the social division of labour and social power in the caring professions. More recent dialogue has been clearly pluralistic as society recognised multiple points of view in the postmodern society.

Johnson (1972) argued that specialisation promotes professional autonomy and client dependence simultaneously. The development of specialised occupational skills was thought to perpetuate social and economic dependency relationships. Dependence on the skills of others, albeit specialised skills, was seen as a strategy to reduce partnerships, to control knowledge, thereby increasing social distance. According to Johnson, the professions were not occupations, but rather they were a means for controlling an occupation.

Many writers criticised the drive by professions towards an enhanced economic position and prestige, gained through control of the lower classes or through gender hierarchy in the division of labour (Davies, 1995; Freidson, 1977, 1984; Gamarnikow, 1978; Larson, 1977; Roth, 1974; Witz, 1990, 1992, 1994). The theme of medical dominance pervaded the literature (Abbott, 1988; Freidson, 1970a, 1970b). Freidson (1970a, 1970b) challenged Parson's respectful approach to the professions by examining medical superiority. The ideological nature of professional claims, the unmerited attitudes underpinning monopolistic privilege, and the organised professional endorsement of authority over clients and occupational workgroups, were disputed. The professional labelling of deviant, undesirable behaviour was debated. Economic and institutional dominance was criticised. Freidson (1970a) identified the paradoxical awe and anger that marked the social need to examine differences and expose contradictions. Analysis proceeded amidst a certain public ambivalence towards medicine for "both the technical wizardry and the arrogant insensitivity of a seemingly impregnable profession" (Light, 1991, p. 499).

Willis (1989) argued that professions were perceived to be invincible because the importance of medical knowledge and technology were over-exaggerated. According to Willis, the medical profession developed specialties and expert roles to ensure functional, fragmented control. Role specialisation enhanced professional skill and knowledge so practitioners became unique experts. Controversy focused on the task domain, expert knowledge, and competence rather than occupational role descriptions.

While that approach may have perpetuated protectionism and the regulation of self-interests, it is unsustainable in the 1990s where practice demands require an integration of individual and collective interests.

Light (1991) observed that individual medical dominance was replaced by a strong, collective medical control of clinical work that is challenged, yet again, by reformatory change in the health sector. Light linked medical dominance to deprofessionalisation, deskilling, and corporatisation, connecting ideas through the concept of countervailing power. Hugman (1991) suggested that countervailing power emerges when one party increases its power base over time so that another party is forced to launch a takeover. Once market forces shape state policies the professions are pressed into a mediative role because consumers control the power balance. Countervailing power explains more recent debates in the reform environment where the government challenges control of health expenditure and medical dominance.

At the end of the twentieth century medical dominance is clearly influenced by managerialism (Fincham, 1996; Hunter, 1994). Politicians have shifted the balance of power from medicine towards the hospital managers, but medical dominance has not disappeared. Neither has medicine's collective autonomy declined because the health system is being restructured (Hunter, 1994). Medicine has survived much greater turmoils in the past eight hundred years. Despite the winds of change, doctors retain influence in determining health priorities and resourcing. Mechanic (1991) questioned whether there has actually been any decline in clinical freedom. Likewise, Dent (1993) argued that while medical influence has lessened, its authoritative position remains. Claims that medical power was subjugated by managerialism should be treated cautiously.

Although medical authority is under political scrutiny in the 1990s, medicine generally retains a high social status and respect in society. Hunter (1994) believes that doctors have a collusive relationship with a public that willingly accepts the medical model of health. The alleged

deprofessionalisation of medicine arising from the argument that professions are losing their prestige and trust (Freidson, 1984), has not eventuated (Kelleher et al. 1994). Mechanic (1991) stated that, despite much rhetoric, "there is little evidence that the social dominance of medicine or its intellectual dominance has eroded" (p. 495). Both Mechanic and Freidson have little faith that the public is now better able to evaluate either medical knowledge or technical competence. Freidson (1994) noted that "there is no noticeable trend toward a shrinking jurisdiction. ... if anything, continual medical advances in technique make even more medical work possible" (p. 7).

In recent years, radical proletarianism has provided another challenge for professional groups in relation to occupational work roles (Hugman, 1991). The proletarian perspective warns skilled workers to defend themselves against deskilling and the introduction of unlicensed health care assistants. Nurses may be especially vulnerable here as some nursing tasks are being taken over by unqualified personnel. While deskilling has the potential to sustain oppression and the long-standing paternalistic relationships typical within the health services, nurses are also well-positioned to share significant tasks with medicine as roles and responsibilities and the boundaries of practice alter during restructuring.

There is a substantial literature connecting professionalisation to the male assumption of control over female tasks (Abbott & Wallace, 1990; Ashley, 1976; Davies, 1995; Gamarnikow, 1978; Hugman, 1991; Gabe, Kelleher, & Williams, 1994; Johnson, 1972; Stacey, 1988; Witz, 1990, 1992). Many authors believed that professionalisation was a patriarchal process that helped men secure control across social and domestic life. Hugman (1991) suggested that divisions within the caring professions disadvantaged women and benefited men by replicating the gender relations of the wider society.

Inequality has had widespread implications for the caring professions that, historically, were seen as women's work. Many nurses value caring as

essential to personal-professional practice (Benner & Wrubel, 1989; Boykin & Schoenhofer, 1993; Gaut, 1992; Leininger, 1978, 1984; Watson, 1979, 1988). Although caring has been analysed scientifically (Chinn & Watson, 1994), it is misunderstood. It is perceived as an extended female role, naturally aligned with women's work in the family (Reverby, 1987). Similarly nursing has been negatively stereotyped as a woman's vocation with low status. Cultural labels promote ascribed role responsibilities. This has had serious implications for semi-professionals seeking professional recognition. Despite changing educational systems for all health professionals, medical dominance hampers nurses' workplace satisfaction where conventional divisions of labour maintain structural barriers in collegial relationships (Adamson & Kenny, 1993; Adamson, Kenny & Wilson-Barnett, 1995).

Barriers to collegial relationships are reinforced by technological bureaucracies (Petersen, 1994). Bureaucratic structures have limited, and continue to limit, the control nurses have over their work. Nursing philosophy is difficult to support in organisations where the focus on technical rationality devalues experiential, intuitive knowledge. Davies (1995) insisted that nursing issues are gender issues. Nurses' discontent represents the wider societal devaluation of women and their work. Discrepancies between knowing and doing have been highlighted:

> As nurses we are particularly vulnerable to an unrelenting sense of disparity between what we know and what we do. We know we would be stronger as a profession if we were unified with each other and with other health care providers, but we are not unified. We know we would be able to provide a high quality of care if we were free to practice nursing as we envision it to be, but we do not and cannot practice in these ways. We know we would better serve society if we focused our practice on health and developed greater knowledge about health, but we practice in an illness care system, and not a health care system. (Chinn, 1988, p. vii)

In the current economic climate the nursing emphasis on caring may have emerged as a reaction to the increasingly technological environment, which devalues the metaphysical aspects of nursing practice. Nyberg (1991) observed that the tension between caring and economics has intensified to

the point where it is impossible to think about the terms simultaneously. When concepts are dichotomised, societal perceptions tend to value the masculine side more positively over the feminine side, which is more likely to be seen in a negative light:

> Work settings have the power to enhance or inhibit practitioner functioning. Dysfunctional settings resist improvement and sap morale. ... In many settings, technological, bureaucratic, and financial pressures can blur and devalue aspects of caring practice ... caring practices become invisible, or just something extra after the "important stuff" is done. How does one care when the setting devalues it? (Karl, 1992, p. 7)

The issues of gender and professional status have pervaded most occupational work groups. Gender issues represent power struggles between men and women that are located in broader patriarchal social structures. Hugman (1991) concluded that, "caring professions are sexist as they are a part of sexist society" (p. 201). Yet, gender hierarchy is not the central focus of health reform. There are complex parallel issues. An increasing number of contemporary teams are working collectively, sharing knowledge and expertise across disciplines to benefit the client. A new way of looking at the world is being enacted:

> And this restructuring can't be accomplished in terms of women versus men, black versus white, old versus young, conservative versus liberal. We need a new political movement. ... that puts the lives and interests of people first. It can't be done by separate, single issue movements now, and it has to be political, to protect and translate our empowerment with a new vision of community, with new structures of community that open the doors again to reveal equality of opportunity ... (Friedan, 1997, p. 116)

Equal opportunity is affected by politics, social forces, and technological change that occur beyond the professional world (Abbott, 1988). Freidson (1994) decided that the study of professions, monopolistic interests and power, is in decline. Emphasis has moved to the role of the state and public control over professional affairs. On balance, professionalism is preferable to alternative ways of organising professional work. However, Freidson also reminded researchers that inadequate theoretical roots and definitional problems hamper the study of professions. Future research must be

grounded sociologically in a theory of occupations. Professions are occupations that are distinct from each other because of "the specialised knowledge and skills required to perform different tasks in a division of labour" (p. 7).

Conclusion

Professions have been shaped by wider sociohistorical influences that have existed for many centuries. Professional groups have always dominated occupational work. As the social milieu changes, so will the nature and demand for professional services. The need for research is clear. Much of the literature presented is based on ill-defined concepts that have tainted the salient issues. Anecdotal evidence is useful to raise awareness of the historical-contextual conditions that have shaped modern day practice. But, historical contributions are more effective when they are analysed and learning is located to the present so that the mistakes of the past are not repeated. Debate and confrontation between and within professions has been well documented. Collaborative dialogue between health professionals has been weak. However, professional groups can no longer survive in isolation. Professional practice is interconnected with social, political, and cultural change that pervades society. That is evident today when health professionals are challenged to respond to social change effectively and efficiently. The widespread nature of that social change will be examined in the next chapter where the political context of health reform is analysed.

CHAPTER FOUR

The Political Context of Health Reform

We trained hard – it seemed that every time we were beginning to form up into teams we would be reorganised. I was beginning to learn later in life that we tend to meet any new situation by reorganising; and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralisation. (Petronius Arbiter, 210BC, as cited in Welborn, Matters & Buzzard, 1990, p. 53)

Introduction

The discussion in this chapter shows how a variety of political forces, some introduced by the health professions, some initiated externally, and some constituted by the system itself, have underpinned the upheavals and change in professional work. Changing social demands in health care, the political impact of the health reforms, and the management challenge to health care in the post-industrial society are covered. Issues are examined separately for ease of discussion even though they are always interconnected. Separation facilitates initial analysis as consideration of one thing leads to another in a world that is a mixed milieu of multiple realities.

Changing Social Demands in Health Care

In recent years the state's role in health care has been debated vigorously. In New Zealand, the economic downturn in the 1980s, changing demographic patterns, and advances in technology undermined the sustainability of delivery systems that provided largely universal access to free health care (Bowie & Shirley, 1994). In a political-economic critique of the New Zealand health service, Scott, Fougere and Marwick (1986) revealed a system dominated by the medical profession, bureaucratic organisation, poor management practice, unnecessary fragmentation, and the inequitable distribution of services.

New Zealand was not particularly unique. Global trends indicated that health services did not met the needs of people or local communities (Hunter, 1994). Hunter observed that organisations were "run rather more for the benefit of those who worked there, especially doctors, and rather less for those who used [them]" (p. 6). Kelleher et al. (1994) noted that many consumers demanded a decentralisation of power and a greater promotion of consumer interests. The increasing public awareness of social responsibilities in health care has continually challenged health professionals and impacted on the nature of professional practice. Politically, successive governments have also pressured health professionals to recognise changing social demands and consumer expectations for more information and active participation (Shipley, 1995).

Since then, anyone working in health care has been faced with seemingly never-ending change. For many people, change is automatically assumed to be negative (Shipley, 1996). Despite uncertainty though, many health professionals have learned to find innovative ways of responding to new practice situations. Certainly, society expects health practitioners, secure in a time-honoured professional status, to respond actively to sociopolitical change. Responding is about the recognition of obligations, accepting collective accountability, and seizing opportunities for professional development. Ignoring change means remaining with the status quo, carrying out delegated tasks determined by others, or being right-sized or downsized out of existence.

Most professional positions are influenced by health service redesign, as health care organisations are scrutinised for cost effectiveness when political and economic ideologies dominate service distribution (Dowling & West, 1995; Mackay, Soothill & Webb, 1995). Shortell and Kaluzny (1994) suggested that "economic, political, and social forces have moved the health services system beyond the largely reactive acute care paradigm to a more holistic paradigm emphasising population-based wellness" (p. 6). However, the increased emphasis on economic management is criticised,

especially by clinicians who believe that the strong economic focus is inadequate if the long-term benefits of effective service provision and health promotion programs are considered (Petersen, 1994). Indeed, Drucker (1994) questions the sensibility of subordinating and sacrificing all considerations in favour of one goal such as economics in any publicly owned enterprise.

Nevertheless, the emphasis on economic objectives in a climate of economic scarcity has forced clinicians to reevaluate their professional performance in relation to clinical costs and quality care. Because key economic objectives are considered to be synonymous with efficiency and equity (Donaldson & Gerard, 1993), many health professionals have found themselves reviewing role responsibilities. Clinicians have sought new ways of working together so they can balance consumer expectations in health care organisations where health management is paramount (Hunter, 1994; Lorbiecki, 1995). Somehow, many health professionals have learned to adapt to consumers, colleagues and organisational requirements.

Others, though, have been less resilient. Some resisted change and have been slow to accept professional responsibility to keep abreast of the current sociopolitical context (Beattie, 1995; Hugman, 1995). These people struggle to integrate organisational objectives and wider political interests into clinical work (Hunter, 1994; Petersen, 1994). Ovretveit (1993) observed that, although problems of cooperation are often reduced to personality issues, structural conditions affect professional behaviour significantly, making cooperation difficult. In this context, professional actions and interactions are interconnected with social transformational change. Petersen (1994) points out the intrinsically political nature of health work:

> Professional people are especially likely to fear being labelled "political". Many professionals see political activity as antithetical to the scientific, "value-free" ideal of their primary disciplines and to the emphasis of their practice on not being directive or judgmental. However, it is important to recognise that every activity is political in some sense. It is political not to be involved, and it is political both to support and to resist change. (p. 143)

New ways of thinking are required so that every clinician is involved with rethinking professional responsibilities and reframing team responsibilities to improve client care.

The Political Impact of the Health Reforms

The political impact of health reform has been problematic. Indeed, professional people working in the public services are expected to embrace the wider social responsibilities in society. Moreover, misunderstanding of the interconnections between social responsibility, professional practice, and health reform create barriers to change. Mostly, health care reform has been reduced to debate about cost reduction, increased access to services, improving quality of care, or more or less government or community involvement and regulation (McDermott, 1994). Political interpretations of health reform are all encompassing:

> The principal aim of reform was not to save money, but to ensure that the money we were spending was buying as much high quality health care for our New Zealand people. (Shipley, 1996, p. 4)

Somehow, many health professionals have failed to understand that health reform is linked to global socio-economic change (Abel-Smith, 1991). For instance, the economic downturn and concurrent population decline in the 1980s coincided with substantial debt servicing for balance of payment deficits, and caused a devaluation of local currencies. Government budgets tightened while social sector spending declined. Health service budgets were reduced substantially although many governments were politically committed to increasing training for health workers. The main concerns were how to manage costly hospital maintenance, and pay the specialised staff. Covering everything was impossible. Hospital buildings were not maintained; equipment was not replaced or repaired; and staff pay rates were kept to the minimum. Reform impacted everywhere; it was not simply fine-tuning of one isolated sector in society. Rather, it represented the

social transformation of society, as governments and consumers questioned responsibilities, resources, and who would pay for what (Creese, 1994).

Generally, people did not welcome any debate over the sociocultural implications of responsibility. Bowie and Shirley (1994) noted that, in New Zealand, the welfare state approach, with its emphasis on state protection and the social and economic well-being of the population, resulted in health care that has been funded and provided by the government since 1937. Acceptance of state responsibility for health care was based on the philosophy that, if medical treatments were spread evenly across the population, economic barriers between the users and providers of care would be reduced. The system worked very well for many years until increased unemployment, a decline in social stability, and the population redistribution towards the north, skewed the balance.

By the 1970s serious political reform of current health policy was called for. The economic recession and the 1974 oil crisis had stimulated the Labour Government to formulate a radical health policy detailing political reform of the existing system. Labour's White Paper on Health (Department of Health, 1975) highlighted the need for cost shifting and rationalisation (Blank, 1997). According to Blank, although health service spending had increased between 1970 and 1980, hospital spending, waiting lists and fragmentation had increased, while accountability and access to primary care services had worsened.

To move the reform process forward, the government suggested the introduction two national policy levers, population based funding and service planning using nationally identified guidelines (Malcolm & Barnett, 1994). Population-based funding was to have a major impact on New Zealand health policy as it heralded capitation-based funding. At the same time, new approaches to service management were discussed in efforts to move social and professional change forward (Heyssel, Gainter, Kues, Jones & Lipstein, 1984). But, the proposals for decentralised specialist service management posed a genuine threat to medicine's traditional

clinical freedom even though new management systems had the potential to enhance that freedom. Eventually, service management would be rejected by the 1989 Labour government on the grounds of insufficient financial information (Malcolm, 1991). In the meantime, the 1983 Area Health Boards Act introduced the decentralisation of services from the Department of Health to the regions, and from 1983 onwards health policy was pervaded by "instability and a series of often disruptive changes" (Blank, 1997, p. 268).

Policy changes were supported by the first of two reviews, the Health Benefits Review (Scott at al. 1986) that recommended the introduction of the tendering process. Scott et al. suggested that health services be contracted out according to quality and price (Blank, 1997). This move was designed to improve health service provision because consumer services were dwindling, and the health status of certain social classes and ethnic groups was deteriorating (Blank, 1994).

The second review of public hospitals in 1987 revealed organisations that were over-administered and under-managed (Gibbs, Fraser, & Scott, 1988). Seeking to establish managerialism, in order to force competition and accountability, Gibbs et al. recommended that hospitals be reorganised along market lines. Those conclusions were criticised for their bias towards acute hospital care and their neglect of the wider needs of long-term care and the community (Malcolm, 1989). The Gibbs Report advised the funder-provider separation. Regional Health Authorities were to be established and expected to purchase services from providers and act on behalf of all the people in their region (Blank, 1997). The Labour Government rejected the recommendations.

However, 1988-1989 was an important period in health reform as general management replaced the traditional hospital administration systems, and the restructuring of the Area Health Boards was completed (Blank, 1997). Area Health Boards replaced Hospital Boards in 1989. Capitation-based funding forced the Boards to deal with local health issues as well as the

treatment of disease. Boards assumed regional responsibility for organising long-term care services, health promotion and prevention programs, and coordinating services across non-government and public sector agencies (Malcolm, 1989). The Area Health Boards were expected to organise their spending priorities according to a set of health goals and targets that supported the New Zealand Health Charter (Ashton, 1992a). Although the moves were designed to reduce hospital-related expenditure, many backfired when some Area Health Boards simply could not cope with so much change (Malcolm & Barnett, 1994). Members did not have the skilled commercial expertise to manage care. Boards went into debt and ran down assets to manage deficits (Shipley, 1996). Although the Labour Government had tried to make Area Health Boards more accountable, the public and health professionals opposed changes to the status quo, and the Labour Government was replaced by a National Government.

The National Government demonstrated their commitment to building a competitive, market-driven health service by initiating "sweeping changes in the structure, delivery and financing of health care" (Blank, 1997, p. 271). Although the comprehensive changes were due, "partly because of demographic and economic pressures and partly because of the failure of existing policies to provide efficient delivery of health services" (Blank, 1994, p. 67), the consequences for the general public were to be significant. As economists debated governmental failure to provide an efficient, effective social service (Ashton, 1992a; 1993; 1994; Boston & Dalziel, 1992), politicians stressed the need for a business-like approach to the health services. In the Green and White Paper (Upton, 1991) the user pays policy was introduced, moving more costs from the government to the individual. Despite intense public and professional resistance to the changes, in an effort to totally restructure the health service administration, purchasers and providers were separated when Area Health Boards were abolished overnight in 1991.

These changes were vital (Malcolm & Barnett, 1994) because they marked the onset of major restructuring and service management across all health

services in New Zealand (Ashton, 1993). Four Regional Health Authorities (RHAs) were appointed to purchase primary care and hospital health services for all people in their region. These authorities did not own services but were to operate as businesses that negotiated contracts with providers from the public, private, and voluntary sectors (Upton, 1991). Hospital and community services were renamed Crown Health Enterprises (CHEs) and reorganised as independent businesses set up to compete to sell services to the RHAs (Ashton, 1993). The strategy was designed to stimulate market competition, to integrate services, and to make efficiency gains that would make up for funding deficits. The commercialisation of health care had begun (Bowie & Shirley, 1994).

The competitive approach to health reform opened a lively public debate among doctors, nurses, and administrators, who criticised a health system that was not responding to the demands of either health professionals or consumers. Blank (1997) believes that health workers were demoralised by the successive restructurings by both governments, and the public was confused by the rapidity of changes. The strong political emphasis on abolishing the dependency culture and passivity characteristic of modern medical care, and establishing commercial principles in the state services overall, was questioned (Kelleher et al. 1994). Moral arguments uncovered fundamental values related to individualism and collectivism, competition and cooperation. Should health care be organised for the benefit of the individual or recognise the needs of society as a whole? Fears that economic efficiencies would dominate health care delivery were expressed as the established humanitarian approach to health care clashed with economic rationalism. Moral issues were linked to quality care, consumer choice, professional ethics, and always, rising health costs, declining resources and cost containment. Ashton (1993) concluded:

> Supporters of the health reforms believed the changes would make services more transparent, improve efficiency, reduce waiting lists and increase consumer choice. Opponents argue that the system will be costly, as well as uncertain and unproven. (p. 57)

Any public demand for proof of intention and consequence was quite unrealistic in a period of radical political reform. Yet providers and consumers argued over society's social obligations to ensure every citizen had ready access to health care. Consumers, more knowledgeable and aware of human rights, challenged the consequences of reform. They put pressure on politicians and professionals. The latter were seen to be less effective at maintaining standards and social service in a changing context.

Professional practice that was based on a positivistic philosophy was no longer seen as the only way of meeting client needs (Petersen, 1994). The medical profession was particularly vulnerable to any public scrutiny of its role. Prior to the reforms, doctors had enjoyed institutional power, status, and privilege. As the predominant leaders of health care in society, they exerted significant control and autonomy over the nature and quality of medical care (Dent, 1993). While many consumers accepted medical knowledge as the indubitable truth, others questioned medicine's right to medicalise complex social problems as health problems (Petersen, 1994). The reductionist approach to medical problem solving was inadequate when so many patient problems were likely to be caused by more complex social, environmental, and economic factors (Capra, 1982). Professional practice was under threat.

The arguments were heated, often controversial, but seldom addressed the struggle for power and control of health policy and financial resources taking place between the medical profession and the incoming hospital business managers (Hunter, 1994; Lorbiecki, 1995). Hunter (1994) claimed that "getting a grip on the freedom enjoyed by clinicians and holding them to account for the expenditure they incur is seen as the last unmanaged frontier in health" (p. 6). Non-medical managers challenged the long-established expectation that hospital administrators would be medical people. Clinicians also argued for a non-involvement in health management "because of the conflict of interests between the allocation of resources and the needs of their own patients" (Malcolm, 1990a, p. 272). Debate was intense. Many doctors were slow to consider the costs of care. Smith,

Graham and Chantler (1989) reminded colleagues to control resources or they would be reduced and clinical freedom would decline.

Differences between professional and organisational management were clear. The call for economic efficiency created conflict over expenditure and the need for expensive new technology. Professional judgements were debated publicly once doctors were given financial accountability for their decision making (Malcolm, 1990b). Clinicians were responsible for the analysis of care processes, clinical costing, and for identifying opportunities for improvement. While administrators provided the tools for data collection clinicians were accountable for the quality of professional care and outcome analysis (Strassner, 1997). Efficiency, effectiveness, quality, choice, and satisfying consumer needs dominated discussion.

The traditional values of equity, comprehensiveness, equality of access, and free health care contrasted sharply with the new organisational values guiding health consumerism, managerialism, and the free market culture (Cole & Perides, 1995; Wells, 1995). Although the government saw the changes in disease patterns, demographics, resources, consumer expectations, technology, and clinical practice as opportunities to deliver services in a new way (Shipley, 1995), health professionals struggled with change that was interpreted as a political threat to professional autonomy. Professional practice was no longer separate from organisational management and change.

In all the arguments there was a peculiar absence of locating the issues within the social structures of society itself. Analysing what was right or wrong for health service delivery per se was simplistic. Arguments were disjointed when they were removed from a wider society that was also in the throes of significant social transformation. Society was rearranging its world view, history, and indeed, civilisation. Values, social and political structures, the arts and the key institutions as well as the political, economic, social, and moral landscape, were crystallising into a new post-industrial society (Drucker, 1989; McWhinney, 1997).

The Management Challenge to Health Care in the Post-Industrial Society

World wide chaotic change has characterised the post-industrial society that emerged in the 1970s. Drucker (1989) has suggested that management was the new social function. The concept of the "post-industrial society" explains the transformational changes occurring in industrial countries and restructuring economies (Bell, 1973; Drucker, 1994). "New" societies were identifiable by "the shift from manufacturing to service, high rates of technological development, a turbulent and changing environment, increasingly complex organisational and interorganisational structures, and the declining importance of national boundaries as economic life became internationalised" (Gummer, 1988, p. 117). In this milieu organisations redesigned traditional hierarchical controls, tasks, and the division of labour.

Bell (1973) explained post-industrialism as a society divided into three parts. Firstly, social structures include the economy, technology, and the occupational system. Economising and the principles of moderation control the allocation of resources by optimisation, maximisation, substitution, and identification of the least cost. Secondly, the polity regulates the distribution of power in society. Formal political organisation determines the merits of pluralistic claims made by individuals and groups in a participative political organisation. Thirdly, culture shapes changing social values, attitudes and behaviour. The principle of culture is perpetuated by personal motivation to fulfil and enhance the self. Post-industrialism cannot but help influence the health reforms, even though the general social appreciation of the impact seems to have passed unnoticed by the majority.

Overall, so many of the arguments about health reform focused exclusively on economic issues. But, obviously, reform was much more than a strategy

to rebalance economic scarcity. Health reform was affected by political and cultural change as well. Economics, politics, and culture were interconnected in a momentous social transformation that suggested a paradigm shift in action (Capra, 1982; Shortell & Kaluzny, 1994). These changes altered service management and the very essence of professionalism.

The application of general management principles into health service management was influential. The new wave of organisational managers understood professional autonomy in a very different way. They preferred to claim a commitment to "responsible" autonomy, which took a broad view of health management. Patient services and the delivery of care had to be balanced across the responsibility-based organisation (Drucker, 1994). Unconditional professional autonomy was insufficient in the restructuring environment, as it created competition and conflict in organisations which had to manage many complicated aspects of health care delivery (Dent, 1993).

Thus, general management challenged medical dominance through organisational control that supported the rules and regulations imposed by a state bureaucracy aiming to limit professional autonomy in the workplace (Dent, 1993). This was quite different from the traditional institutional control model that had maintained independent control over practice for members of the well-organised medical profession. The incompatibility between professional ideology and bureaucratic management systems that emerged undermined the occupational status of medicine and other health professionals, including nursing.

The managerial challenge to medical dominance of the health service in New Zealand has been facilitated through managed care, a strategy for service delivery. Managed care was part of the government agenda for health reform, although the concept was somewhat vague. It was used generally "to describe a range of models for organising better co-ordinated service delivery" (Shipley 1995, p. 24). The Government challenged the

health sector to manage public expectations and meet health needs within available resources (Shipley, 1996). Regional Health Authorities experimented with various models of managed care but the key issues overall were to improve the quality of care, decrease costs and maintain control over clinical practice and resources.

Any sort of managed competition for health care providers had the potential to change the relationships between funders, providers, consumers, and the communities. This has had, and will continue to have, major implications for those health professionals who were trained to practise autonomously and demonstrate accountability to professional colleagues rather than to be budget holders. Too many seemed unable to look at the bigger picture of organisational life and consider how practice fitted in with organisational strategies and health goals as a whole. Professional practice was seldom viewed as political work that should encompass the wider social changes in society.

Nonetheless, Petersen (1994) suggested that the health workers were a political force to be reckoned with. Potential was more likely to be realised once capable managers and competent professionals learned how to activate political processes more effectively. This is difficult as so many are used to working in bureaucratic organisations that have traditionally supported fixed ways of thinking. In contrast, service management focuses on breaking down the barriers surrounding hierarchy and role responsibilities. The management of services claims to facilitate interdisciplinary negotiation, teamwork, and the development of collective accountability for clinical and organisational services (Malcolm, 1990a).

The new organisational managers have taken a broad-brush approach to service delivery, which now incorporates overt priority setting and rationing. No matter what the level of government funding, the need for services will always outstrip the available resources (National Advisory Committee on Health and Disability, 1997). The government is encouraging "efficiency, flexibility and innovation in delivering health care" (Shipley,

1996, p. 15). Now it is addressing needs, not demand. During this era of tumultuous change few of the economic and social structures remain the same as they were prior to the reforms. As costs are cut and organisational redesign gains momentum, leaders are rethinking strategies for service delivery in the pluralistic organisation.

Conclusion

In the past decade, New Zealand has passed through some of the most dramatic social reforms in its history. The health reforms have been so extensive, and happened so quickly that it is questioned how much the public and professional community understood, or, if change was understood at all. Debate has been fiery and furious, acrimonious and antagonistic. Arguments have indicated that many people involved in the public debate took a particular position in relation to the health reforms. Society seemed to simply react to problems. This resulted in confusion about what has happened, what should happen, and blocked the exploration of options. Few people looked at the whole; few saw health reforms as part of a wider picture representative of the social transformation in a post-industrial society. All in all, there was little literature to justify the master plan, if there was one at all, and the many governments were slow to provide better explanations of the overall strategy. In hindsight, successive governments have stalled many changes, despite the fact that some of the suggestions were sound, in keeping with world wide trends, and have been implemented successfully, albeit twenty years later. On the whole, an overview reveals a paradoxical situation – it is one of disorganised organisation, full of contradictions and confrontations. It is typical of chaotic change in a post-industrial society. In the next chapter teams and teamwork in restructuring health care organisations will be examined.

CHAPTER FIVE

Teams and Teamwork in Restructuring Health Care Organisations

> *We used to think that we knew how to run organisations. Now we know better. More than ever they need to be global and local at the same time, to be small in some ways but big in others, to be centralised some of the time and decentralised most of it. They expect their workers to be both more autonomous and more of a team, their managers to be more delegating and more controlling. (Handy, 1994, p. 34)*

Introduction

Teamwork takes place in a wider sociocultural environment that impacts on organisational practice as a whole. In this chapter relevant literature from health, sociology, and organisational management is reviewed; some basic terminology is clarified; work redesign and its effects on health professionals working together is discussed; and differences between teams and teamwork are highlighted. The aim is to extend the macro-analytical perspective to establish a baseline understanding of existing knowledge. Because this literature search took place after data collection, computer searches were narrowed to specific concepts emerging from the data analysis.

Some Basic Terminology

In the literature varying labels describe the working interconnections of health professionals from different disciplines. Leathard (1994) argued that interprofessional work issues had to be documented and debated because they were so new. Certainly, prefixes such as *inter*, *multi*, and *trans* appeared randomly in the literature. What do the words interdisciplinary, multidisciplinary, and interprofessional mean? The Chambers Dictionary (Schwarz et al. 1993) parallels multi with many. Multidisciplinary is

identified as "involving a combination of several (academic) disciplines, methods" (p. 1105). Inter is labelled as a prefix denoting "between, among, in the midst of; mutual, reciprocal; together" (p. 871). The term interdisciplinary means "involving two or more fields of study" (p. 872), while trans is explained as, "across; beyond; through" (p. 1838). Definitions are problematic. Descriptions seem imprecise in the professional literature so that there is no consensus on their meanings or distinctions.

Leathard (1994) sought to simplify some issues by identifying ideas according to concepts, generic issues, or processes. Clarification proved difficult when so many fine nuances, such as the type of context and service, affected interpretation and understanding. Sorrells-Jones (1997) took an uncomplicated approach:

> *Multidisciplinary* refers to a team or collaborative process where members of different disciplines assess or treat patients independently and then share the information with each other. ... *Interdisciplinary* describes a deeper level of collaboration in which processes such as evaluation or development of a plan of care is done jointly, with professionals of different disciplines pooling their knowledge in an independent manner. (p. 26)

The multidisciplinary concept was task-oriented while the interdisciplinary concept focused on team processes. This changing emphasis reflected modern expectations for health care teams to create new working arrangements in restructuring organisations.

Developments in Work Redesign

Modern work redesign demands collaborative interaction. Jones, Dougherty & Martin (1997b) noted that this is very different from the hierarchical relationships typical of hospital bureaucracies that established clear superior-subordinate interactions. In the past, competency and productivity were important while disciplines operated as discrete entities, providing compartmentalised patient care under medical control. Dialogical interactions tended to be formal and fragmented.

During the 1960s organisational psychologists began calling for a closer integration between the individual and organisational needs in order to reduce fragmentation (Morgan, 1997). Work was redesigned to motivate workers to increase productivity, improve quality, and reduce absenteeism. Job enrichment, job satisfaction, and job involvement were popular ideas. But, in the health professions, teamwork was still dominated by physicians (Fagin, 1992). Stein (1967) argued that nurses' advice has traditionally been tempered to support the hierarchical nurse-doctor relationship. Information was passed on in such a way that clues about patients and their progress were shaped to ensure that physicians remained in control of formal decision-making. Dialogue definitely occurred within disciplines but was less common between disciplinary groups.

Interdisciplinary interactions changed somewhat when primary nursing was introduced in the 1980s. Lyon (1993) argued that primary nursing was a useful strategy to claim professional ground; to remove responsibility from less qualified personnel; to extend registered nurse input into direct patient care; and to increase nursing autonomy. Existing team relationships were threatened though, because nurses challenged the status quo when they began assessing patient needs, and planning and implementing patient care using the nursing process. According to Klein (1983), primary nursing advanced professional nursing and furthered the legitimacy of the profession. In this modality of care, the emphasis on consultative relationships and accountability enhanced the visibility of nursing in the care process, but changed collegial roles and responsibilities. The move to an all-registered staff increased staffing costs, supposedly in the interests of quality care that could not be guaranteed if staff were not better prepared or educated. Eventually, modifications were introduced, not to further interprofessional relationships, but to improve organisational efficiency and effectiveness (Leddy & Pepper, 1993).

The result was *total patient care,* a client-centred approach to service delivery that was introduced to meet soaring health costs and decrease hospital stay. Work redesign gained momentum in the 1990s when

financial issues and evidence-based practice were clearly driving service delivery. Teamwork is undoubtedly a strategy for integrating care. Fortunately, interdisciplinary teamwork has matured over time to the extent that the recognition of all professional contributions that enhance patient care has developed (Stein, Watts & Howell, 1990). Now, effective teamwork is considered to be the foundation for improved service delivery.

Curran (1994) argued that the goal of work redesign was to improve continuity of care, to gain better patient and hospital outcomes, and to meet the fiscal responsibilities of health care reform. Minnen, Berger, Ames, Dubree, Baker and Spinella (1993) observed that hospital managers believed improved collaborative relationships were the key to efficient, effective care, but to date, the effects of competitive reform have not been evaluated (Maynard, 1994). Nevertheless, models of work redesign included patient-focused care, case management, and total quality management (Curran, 1994).

Patient-Focused Care

Johnston and Cooper (1997) explain that, in patient-focused care, a registered nurse supervises a team of assistants, and also assumes role responsibilities that are beyond the capability of lesser-trained staff. Clinicians are assigned to a team that has its own resources and services, which are organised around the patients instead of departments. Jones (1997a) suggests that "administrators have assumed that, if they redirect the attention of health care workers to the patient, they will improve client satisfaction and health care outcomes in general" (p. 8). This model of care supposedly streamlines services, increases efficiency and effectiveness, and improves access, continuity, and quality of care, as well as patient satisfaction (Jones, 1997a; Robinson, 1991). Cost savings drive patient-focused care (Kimble, 1997), but evaluation of its success in achieving its stated goals is anecdotal.

Research reports have begun to filter through, documenting the effects of organisational redesign on clients, the client-caregiver relationship, and worker job satisfaction. For example, Jones (1997b) advises managers to define roles and interactions before they direct attention towards the patient. Clouten and Weber (1994) think that role clarification is crucial when cross-trained caregivers join a multidisciplinary team. Although cross-training was introduced to increase productivity and staffing flexibility (Curtin, 1994; Shaw, 1995), it also extends role responsibilities to the edge of legal and credential boundaries (Jonhston & Cooper, 1997). It supports the assumption that job redesign and skill extension have the potential to increase worker satisfaction (Townsend, 1993).

There has been little research on the concept of multidisciplinary collaboration (Jones, 1997b). Jones used participatory action research to investigate how health workers in a 42-bed patient-focused unit defined multidisciplinary collaboration. Multidisciplinary collaboration emphasises teamwork in which roles are shared and work co-ordinated. Again and again, roles and communication recur as the most significant factors for successful teamwork (Birchall, 1997; Fagin, 1992; Goldman, Kilroy & Pike, 1992; Jones, 1997b; Ovretveit, 1993; Pike, 1991; Trueman, 1991).

Interestingly, in a quasi-experimental study, Jones, DeBaca & Yarbrough (1997a) reported decreased multidisciplinary collaboration when major roles were redefined, even though patient satisfaction improved and length of stay decreased. Declining collaboration occurred despite a two-year participatory planning program, twelve weeks of competency-based training, and sessions on communication, assertiveness, delegation, team building, and change. Adapting to change took time, and decentralising structures did not automatically alter traditional interprofessional relationships (Keatinge, 1995). Colleagueship was fostered more by changing attitudes rather than changes in organisational structure. Equally well, attitudinal change was dependent on collective accountability for team resource management.

Townsend (1993) decided that the well managed team displayed improved morale, autonomous problem-solving skills and decision making, as long as management continuously supported the change process. Constant management input was important when hierarchical relationships were abandoned (Evans, 1994). In contrast, lack of information, training, and staff support, fostered failure (Birchall, 1997). One way to preempt the negative staff response was by calling for volunteers for patient-focused care units, and psychologically screening potential personnel for coping skills, problem-solving aptitude, work commitment, and tolerance for ambiguity and uncertainty (Eubanks, 1992). Apparently, unmistakable administrative commitment was the key to success (Johnston & Cooper, 1997).

Success was linked frequently to cost effectiveness. Reporting on the introduction of patient-focused care in a hospital, Clouten and Weber (1994) noted discrepancies between departmental and organisational cost containment. Although separate departments were cost effective, organisational cost containment was more difficult due to the time-consuming coordination and documentation of services. Even if clinical service units were more efficient and effective, the drive for financial efficacy was non-viable unless the organisation altered structures, strategies, and introduced advanced information technology in the patient-focused care organisation (Simpson, 1993a).

Expenditure issues were well illustrated in a survey about the introduction of nurses' aids into three units. Bostrom and Zimmerman (1993) evaluated nursing care and client satisfaction during unit redesign. They reported that changed staffing mixes and new intravenous administration technology reduced costs. However, while task realignment shifted non-professional work to support staff, no statistically significant changes in levels of patient satisfaction were demonstrated. Also, work sampling pre and post change highlighted how documentation and reporting consumed substantial nursing time. Again, Simpson (1993b) argued that the absence of advanced information systems makes the introduction of new delivery

systems difficult when information technology is inadequate. However, charting by exception and critical pathways have been found to be useful strategies to streamline documentation and reduce duplication (Johnston & Cooper, 1997).

In addition, Shaw (1995) reported that professional cross-training was highly controversial when the issues of specialist and generalist practice were examined. Specialist clinicians defended expertise on the grounds that they provided more efficient care with fewer errors than a generalist did. Jones et al. (1997b) argued that some nurses were unhappy to supervise patient-care workers who had the potential to endanger patient care and break down the registered nurse workforce. Dialogue was important to support registered nurses, who faced role delineation, delegation, and new staffing mixes (Clouten & Weber, 1994; Townsend, 1993). Erosion of traditional boundaries and standards of practice were sensitive topics.

Although professional standards were supposedly integrated into multidisciplinary care maps and timelines (Hampton, 1993), disciplinary standards set by professional bodies were openly questioned during work redesign. Those issues, though, did not have to be reduced to crises of professional identity if staff learned to regard cross-training and multi-skilling as a way of sharing skills to improve patient care (Brider, 1992). Once more, change involved learning and clinicians needed time to reframe expectations, attitudes and behaviour in staff development programs.

Curran (1994) focused on the importance of staff development and suggested that collaborative education was a central issue in patient-focused care. Separate training classes were problematic if interdisciplinary teamwork was the desired goal (Seago, 1997). Likewise, Clark, Steinbinder and Anderson (1994) argued that the successful implementation of patient-focused care depended on an education program beginning early and being reinforced regularly. They also found that the clinicians who participated in change management from the beginning were the most supportive change agents. Part of the problem was the speed of change. Brider (1992)

observed that when health professionals were exposed to extensive change, processes slowed. Moving too fast and making too many changes at once was nonsensical, and made any alteration of well-entrenched behaviour unrealistic when structures were being changed simultaneously (Seago, 1997).

Successful change filtered through from a firm philosophical base that supported collaborative interactions. Planning care together was not new but, questioning the costs and validity of treatments, sensitively, was different (Capuano, 1995). Part of the problem was thinking through how to implement the clinical side of organisational change. Seago (1997) argued that change processes were enhanced if major stakeholders were involved from the beginning. Collaborative relationships were challenging and elusive in the busy world of practice, but were a worthwhile goal (Evans, 1994). When collaboration was synergistic it maximised individual contributions in a way that the whole became greater than the sum of the parts.

Case Management

Lyon (1993) recorded that case management originated in the social services and was incorporated into health settings to promote cost containment. Interpretations were developed to include quality and, eventually, the empowering of patients and families making health choices (Jones, 1995). Case management has multiple meanings. The terms Care Maps, critical pathway, and clinical pathway, are used interchangeably in the literature. However, the general aim of case management is to decrease fragmentation and improve quality and effectiveness. Like patient-focused care, the case manager coordinates teamwork, sequences interventions, and negotiates service requirements across the disciplines. Sovie (1991) identified case management as "a collaborative model of strategic management by nurses and physicians of an illness episode" (p. 461).

Graybeal, Gheen and McKenna (1993) observed that, in case management, all disciplines are accountable for outcomes. It differs from patient-focused care as, in some situations, critical pathways, provide standardised guidelines for care. These intensive protocols reflect multidisciplinary standards, and document and track variances during hospital stay (Curran, 1994). Regular evaluation of recovery is important, as hospital stays are reduced and the intensity of care increases. The critical pathway is a clinical pathway that provides a clear, proactive guideline for the multidisciplinary daily prescriptions of clinical care for a particular patient population from pre-admission to discharge (Graybeal et al. 1993). Critical pathways can also be seen as a form of rationing, as they are a means for managing care more efficiently by establishing clear priorities and targets (Lyon, 1993). The case manager is pivotal, supervising an episode of care, managing multiple clinical actions, and preventing costly complications within a fiscally responsible time frame (Zander, 1990).

Nursing case management reduces recovery time and length of stay, and increases patient turnover. Coben (1991) designed a quasi-experimental study to evaluate nursing case management and clinical costs for 128 patients hospitalised for caesarean section. A team of registered nurses, licensed practical nurses, and nursing assistants followed a critical pathway protocol. The length of stay declined by 19%. Although clinical nursing intensity increased, the length of stay decreased, and clinical resource control improved. However, common pathways for a homogenous group of patients, with variance analysis identifying aberrations, meant that the evaluation lacked precise costing of each pathway. Gardner, Allhusen, Kamm and Tobin (1997) concluded that the design of critical pathways must include the full effect of direct and indirect costs.

Clark et al. (1994) believed that critical pathways were useful tools to enhance professional practice and to further organisational research activities. This is problematic if a unit assumes it exists to serve the research interests and advancement of a professional discipline instead of the patient (Sovie, 1993). Recognition and integration of organisational

research activity is a two-way process that requires effort and commitment from managers as well as staff. Jones (1994a, 1994b) reminded clinicians that case management was about quality care that was embroiled with organisational economic operations. According to Jones, even if case management advanced cost-centred care, the potential to negate skilled nursing practice that could not be measured rationally still existed. That was less likely when case management developed as differentiated practice organised around specialist nursing roles (Blouin & Tonges, 1996). Generally, if the change is managed effectively, the introduction of a well-developed model of care should benefit everyone.

Strassner (1997) noticed that poor organisational planning undermined the successful implementation of critical pathways. General confusion reigned when people held unclear expectations (Seago, 1997), and when staff development was absent (Jones, 1995). Capuano (1995) found that, while nurses were well situated to introduce critical pathways, if change was poorly managed, they carried the brunt of departmental discontent. Change had to be managed if the goal of total quality management was to be a reality.

Total Quality Management

Total quality management has been described as "continuous improvement of every output, whether it be a product or a service, by removing unwanted variation and by improving the underlying work processes" (Tenner & DeToro, 1992, p. 24). The system is fundamental for accreditation. It is similar to patient-focused care in that most of the work is managed by an interdisciplinary team that organises service delivery while reducing nonessential steps that do not add value to patient outcomes (Jones et al. 1997b). Teamwork and collective decision making, fostered in a non-competitive, collaborative climate, enhance continuous quality improvement (Jones, 1994a).

Continuous improvement is advanced also through a customer focus, process improvement, and total involvement (Tenner & DeToro, 1992). Customer focus is about understanding clients and what they want. Organisations have internal and external clients. Internal clients include patients and colleagues; external clients are the public funding bodies that control financial inputs for service provision. In total quality management services, people, methods, and technology are integrated to optimise usefulness and outputs.

As a philosophy, total quality management drives operational activities (Triolo, 1994). Triolo evaluated 21 health care organisations using total quality management programmes. An emphasis on workplace processes identified service delivery waste in particular. For instance, wastage in "rework, unnecessary lab tests, turnover, errors, waiting times, patient complaints, [and] variation in practice" was evident (p. 321). Waste increased costs and caused significant client service dissatisfaction. Triolo concluded that success depended on unequivocal executive management commitment, physician participation from the beginning, and the processes being customised to the organisation.

Triolo (1994) believed that total quality management should cost less rather than more, but it depended on extra effort from workers. While her views may be correct they are less accurate if the increasing pace of work is considered. Unrealistic organisational goals and the desire for the quick fix are recurrent themes. All too often "new delivery models reported in the literature lack a thorough and unbiased evaluation of work realignment, costs, and satisfaction with care" (Bostrom & Zimmerman, 1993, p. 35).

Jones et al. (1997a) advise an organisational cultural analysis as a prerequisite for institutional change. They suggest that, if change founders, failure is difficult to identify when a baseline organisational cultural assessment has not been completed. Strategies for action are even harder to detect if the groundwork is not covered at all. Apparently dysfunctional

work groups are not necessarily blocking change deliberately, but may be simply committed to a different set of cultural values.

Triolo (1994) reported several other problems. Firstly, organisational commitment to total quality management required a long-term plan. Initial emphasis on cost-containment is misplaced. Thus, process improvement has to precede the cost reduction that follows if the first step is implemented carefully. Secondly, teams are not the only way of reorganising people. Total quality improvement is about paying attention to detail and solving problems. Thirdly, organisations have to resist the urge to develop an intensive quality infrastructure to introduce new systems. Rather, an organisation-wide change of values, from performance to learning mode, is much more important. Again, without adequate training and performance evaluation, the most committed team may fail to meet its goals.

Teams and Teamwork – What is the Difference?

Once health services were managed according to business principles the team concept was introduced as a way of coordinating service delivery in hierarchically-organised units that were being restructured horizontally (Kerfoot, 1996). Organisational change and the complexity of problems faced by health professionals have made it more difficult for any one occupational group to control overall care from within, using a distinctive body of knowledge. A collaborative approach to client care is necessary, and this demands cooperative action and dialogue across the disciplines.

Organisational downsizing and rightsizing have aimed to break down disciplinary power bases, replacing them with teams that function across traditional institutional boundary lines (Bresnen & Fowler, 1996). The team-based organisation is popular in management circles (Bolman & Deal, 1997; Lawler, 1992; Recardo, Wade, Mention & Jolly, 1996; Reich, 1987). Teams are one way of redesigning work to provide quality services. Manion, Lorimer and Leander (1996) suggested:

> The magnitude and complexity of these challenges are such that no individuals, no leaders, can meet them successfully without the full involvement and commitment of their employees. Teams are a way to tap into the potential of our employees – the potential to contribute in significant ways, to accept increasingly higher levels of responsibility, and to reap the benefits when employees feel the commitment that ownership of their work brings. (p. 3)

Teams and teamwork are not new in society. They pervade family life; are popular in the sporting arena; and are well tried in businesses and bureaucracies throughout society. Indeed, in recent years many New Zealanders have been much more aware of the power of two extraordinary teams, Team New Zealand and the All Blacks. Managed according to the vision-driven approach, which embraces teamwork, project management and values-based leadership, their success is well-documented (Mazany, 1995; Thomas, 1997). But, there is a scarcity of research evidence about teamwork in health care. Although there is much rhetorical literature on how to set up teams to manage change, the social structure of teams and the way clinicians relate towards each other, have not been studied systematically (Cott, 1997).

Teamwork is not the same thing as a team. Katzenbach and Smith (1993) were quite clear that the team is a means rather than an end, while teamwork is about performance and how to achieve the primary objective. Manion et al. (1996) took care to distinguish the differences between the concepts of team and teamwork. They noticed that when the words are used interchangeably meaning is murky, understanding vague. They reiterated that "a team is a specific structural unit in the organisation" (p. 5) and proposed that "teamwork is the way people work together cooperatively and effectively" (p. 5). They drew attention to definitions that incorporate structure and process and offer the following:

> A team is a small number of consistent people committed to a relevant shared purpose, with common performance goals, complementary and overlapping skills, and a common approach to their work. Team members hold themselves mutually accountable for the team's results or outcomes. (p. 6)

One of the earlier researchers into teamwork was the social worker Rosalie Kane. Reviewing earlier definitions of teamwork, Kane (1975) summarised recurrent themes as including a common purpose, professional contributions, skills, communication, coordination, cooperation, and joint thinking. Kane concluded that "a common objective, different professional contributions, and a system of communication" (p. 5) were important for interprofessional practice. Moreover, she recognised how complicated variables and structures affecting team practice reflected authors' biases. Unexamined assumptions covered up, rather than revealed, multiple problems that affected interdisciplinary interaction.

More recent authors have concentrated on problematic terminology and labelling (Engel, 1994; Harbaugh, 1994; Leathard, 1994; Ovretveit, 1996; Rawson, 1994). Rawson was less concerned with whether teams are interprofessional, interdisciplinary, multidisciplinary, or transprofessional, and returned to the basics. Acknowledging the semantic problems, he argued that the word professional is most likely to cause contention and confusion. Following Freidson's (1994) recommendations, Rawson referred to team practice as work – an all-encompassing definition. Arguing for the theoretical analysis of interprofessional work, he recommended study of occupational action. Researchers were advised to clarify what professional practitioners do and why; to discover how professional positions and tasks are integrated with perspectives that shape interprofessional work.

Ovretveit (1996) suggested that the topic of interprofessional work is much broader than teamwork. Although the most effective teams for a certain setting are not known, some understanding of different types of teams is a useful start to guide health professionals towards becoming effective, efficient team members. Ovretveit classified teams according to the degree of integration and the extent of collective responsibility for team resource allocation, membership, client pathway, and management. These dimensions identify team strengths and weaknesses, and clarify a common language and strategies for improvement. Clarification of fundamental team concepts provides a useful baseline for team managers.

When teams are skilfully managed and monitored they are powerful agents of change (West & Poulton, 1997). However, teamwork is antithetical to medical socialisation. Berwick (1996) argued that medical single-mindedness is contrary to the collectivity value inherent in teamwork, although it does not preclude individuals becoming team players. The "bigger picture, and the citizenship skills emphasise connections and interdependency, and have not been central to [medical] training or to [the formation of] their professional identity" (p. 972).

Few health professionals are taught teamwork skills. Hilton (1995), in an ethnography on physiotherapists, identified some reasons for teamwork failure. Poor understanding of roles, skills, and expectations, which blocked mutually supportive attitudes, caused conflict. Similarly, Pietroni (1991) examined undergraduate students from nursing, medicine and social work, and reported clear occupational identities and quite distinct negative stereotyping during the early stages of professional education.

Without doubt, sex-role stereotyping influences interprofessional understandings (Gamarnikow, 1978; Kendrick, 1995; Mackay, 1995; Pietroni, 1991). Gender hierarchy is not exclusive to the health sector and occurs across organisations (Morgan, 1997). Gender and social class reinforce typical male and female images of men and women in society – that doctors cure, while nurses care; that doctors are dominant, while nurses are passive (Stein, 1967). Campbell-Heider and Pollock (1987) contended that, while many physicians favoured authoritarian interactions in teams, nurses sought mutual collegiality with physicians. They argued that "nurse expectations of status enhancement through increased skill and knowledge ... fail to consider the deeply rooted structures of hierarchy, in particular gender hierarchy, that pervades medical care" (p. 421). Stereotyping impedes interprofessional understanding.

Clark (1997) and Hilton, Morris and Wright (1995) advocated that stereotyping must be addressed in the formative years of development in

shared professional education if interprofessional practice is a genuine goal. Carpenter (1995) confirmed interprofessional stereotyping among nursing and medical students but reported benefits from shared interprofessional learning. Lary, Lavigne, Muma, Jones, and Hoeft (1997) piloted a problem-based learning program involving students from dental hygiene, physical therapy, and physician assistant courses. Positive outcomes with increased interaction amongst the students and faculty, and strengthened collegiality overall, were reported. By contrast, Fagin (1992) urged starting from the top with faculty involvement in patient care and research. That approach was equally effective in improving relationships between medicine and nursing.

Many writers have concluded that the fragmentation specific to interprofessional work is the result of separate professional education programs where students are socialised initially to function within disciplinary boundaries (Beattie, 1995; Clark, 1997; Fagin, 1992; Stein, 1967). Isolationism is likely to foster dysfunctional relationships, and thinking that is narrow and discipline-specific (Hilton et al. 1995). It is also unlikely to forward the effective collaboration essential for cross-fertilisation between disciplines (Larson, 1995).

Gordon et al. (1996) described a multi-site collaborative interdisciplinary program designed for undergraduate health professionals that satisfied both students and staff once introductory obstacles were overcome. However, positive collaborative interactions cannot be assumed and Lynch (1984) believed that placing students in classrooms together does not guarantee collaborative interprofessional relationships. Participative learning experiences may nurture interprofessional practice but have to be extended into the clinical setting (Clark, 1997). Hilton et al. (1995) proposed a simple learning approach that continues for the duration of courses. Students would be involved in active learning situations where every single team member is required to practice "collaborative goal setting, planning and monitoring of care..." (p. 268).

Poulton and West (1993) reminded readers that there is little evidence to show that teams develop collaborative interactions as they work together. Team success depends on a team of mixed professionals having a single cross-functional management group responsible for following through collaboration and cooperation. West and Poulton (1997) found effective team function is difficult when individual team members have separate lines of management. They compared the performance of 68 primary health care teams with multi-disciplinary teams from the National Health Service, oil companies, community psychiatric teams and social service teams. Respondents totalled 1555. Team participation, support for innovation, task orientation and clarity of, and commitment to team objectives, were measured. Primary health care teams scored significantly lower on all factors. The most significant outcome was that the primary health care health professionals were unable to develop transparent, shared objectives. As a result, individual performance and collective outcomes could not be measured.

The clarification of shared objectives and goals depends on clear communication in the team. Often challenging, it becomes a barrier only if people are protecting personal reputations for efficiency (Chapman, Hugman & Williams, 1995). A more significant issue is cultural tension. In a one-day workshop set up to gather empirical evidence on the problems of collaborative practice, Chapman et al. brought together 21 participants from different community health services. The most notable barrier to teamwork was the cultural tension between the business culture and the culture of care. Although the tension was serious, it was not insurmountable when dialogue was developed through shared learning experiences. Clearly, team learning influenced team effectiveness.

Team effectiveness has been poorly researched. Although West and Wallace (1991) linked team effectiveness to team innovation, measurable indicators of the concepts were unclear. Pearson and Spencer (1995) reported that significant indicators for team effectiveness were "agreed goals and aims; effective communication; patients receiving the best possible care; and

individual roles defined and understood" (p. 133). Although these conclusions were based on a sample response of 137 that included many managers, team effectiveness was perceived as being created by paying attention to process and outcome issues in the workgroup. There was a peculiar absence of interest in performance or competency, the baseline pre-requisites to any teamwork.

Long (1996) used a qualitative approach to study team members' understanding of teamwork following a team building workshop. Ten participants were interviewed before and after the workshop. Results indicated that team members understood other's roles "only in light of their interactions with each other. Issues of hierarchy and leadership and interpersonal conflicts were also raised" (p. 935). Participants reported that the workshop improved their understanding of teamwork, enhanced communication, and clarified roles and responsibilities. Even though the benefits were positive, the three-day residential team-building course did not dissolve contentious hierarchical attitudes. The workshop was more an opportunity for listening and socialisation. When participants returned to work they were better prepared to address concerns.

Informal socialisation uncovers similarities and differences in cultural values. Platt (1994) focused on the cultural values embedded in social interactions and noted that "a team is a team by virtue not so much of its numbers but of process – the interactions among individuals gathered toward some end" (p. 4). Coordination across the disciplines is more difficult when individual skills and competencies are expected to be integrated into collective activity and interactions (Reich, 1987). Kerfoot (1996) advised that meaningful collective interactions create synergistic relationships that promote efficient, effective management of patient interests.

However, patient interests are not always central to teamwork. Griffiths and Luker (1994) explored intraprofessional relationships between community nurses. Organisational rules that were developed to improve team

functioning were not in the patient's best interests. Data from participant observation of 130 home visits and interviews with 16 district nurses revealed that the nurses used unspoken rules to support colleagues and avoid conflict. Those rules reduced patient choice and the quality of care cannot be assumed. Kezsbom, Schilling and Edward (1989) warned that all groups are not teams, and too many teams are simply groups. Also, they argued that an effectively functioning team coordinates group effort, complementary competence, and skills with the identified goals. Team synergy evolves when collective effort resolves problems more effectively than any one individual acting alone.

Collective activity is influenced by status. Wiles and Robinson (1994) interviewed practice nurses, district nurses, health visitors, and midwives from 20 family-centred practices. While many participants had attended team building workshops, attitude change did not always follow. Participants reported that attitude change was more likely if changing roles and responsibilities elevated status. Another survey of 93 health care workers in three interprofessional teams recorded collaborative teamwork that was confined to higher status staff (Cott, 1997). Lower status staff were active team workers but collaboration was restricted to task completion that was highly valued.

Value systems certainly effect teamwork. Successful teamwork depends on team members accepting a common world view (Waugaman, 1994). All professionals are socialised within disciplines but few understand the full meaning of cross-disciplinary collaboration. Wilmot (1995) reported that nurses value individualism, caring, autonomy, holism and patient well being while social workers internalise the collectivity, liberty, equality and justice. Attitudes are not fixed though and develop amidst mutual interaction and reflection in a dynamic social environment (Clark, 1997). Any emphasis on value differences should be treated cautiously as reports are anecdotal. While many clinicians are reserved about joint work, Chapman et al. (1995) reported that qualms disappeared once people experienced workshop encounters, which facilitated collective

understanding. In that account many participants reported surprise at sharing so many values with colleagues and found that the realisation promoted a very real sense of satisfaction and stimulation.

Ling (1996) documented the positive effects of working in a self-directed work team in a home health care agency. Self-directed teams were expected to improve job performance. Evaluation of a small sample using a quasi-experimental design suggested that the self-directed team performed better. Informal feedback from some participants revealed greater group cohesiveness, productivity, problem-solving abilities, and collaboration. Ling reasoned that team organisation may have facilitated a smoother response to the rapidly changing environment of health care.

Group structure influences teamwork in a changing work context. Pedersen & Easton (1995) specified the characteristics of a winning team. These include common goals, clearly defined roles and responsibilities, commitment, support and encouragement, trust, respect, communication, competence and skills, and the ability for team members to function as a unit rather than as a group of individuals. The authors used those characteristics to correct a poorly functioning unit but emphasised that "teamwork is not a panacea and does not occur overnight" (p. 35). Rather, it is something that has to be worked at by staff. Those ideas are consistent with the philosophy of collaborative practice, which is underpinned by cooperation and interdependence.

Evans (1994) was certain that autonomy and interdependence are disconnected in collaboration. "The collaborative relationship is more importantly a synergistic alliance that maximises contributions of each participant, resulting in an action that is greater than the sum of individual works" (p. 23). Autonomy suggests isolated decision-making that is inconsistent with collaborative interconnections. Collaborative practice is about joining together and bonding.

The literature reveals a new emphasis on the coexistent themes of synergy and collectivity (Evans, 1994; Kerfoot, 1996; Kezsbom et al. 1989). If synergistic relationships are desired among health professionals a change in perspective is advocated. Reich (1987) discussed "collective entrepreneurship, endeavours in which the whole of the effort is greater than the sum of individual contributions" (p. 78). Indeed, synergistic teamwork is driven by a wholistic world view that promotes joint activity.

Harbaugh (1994) argued that teamwork is essential because one health professional can no longer meet all client needs. Teamwork is a strategy to enhance disciplinary diversity. Interprofessional practice is a means to integrate extreme specialisation. According to Harbaugh, diversity is harmonised when team members share person-centred values, working together "with intention, mutual respect, and commitment, for the sake of a more adequate response to a human problem..." (p. 20). Dialogue is the key to success and is a important strategy to discuss the team philosophy, values and a shared approach to quality service provision (Wilmot, 1995). When dialogue is absent, conflict is more likely.

Conflict is a barrier to teamwork. Chapman et al. (1995) stated that professional autonomy is the major obstacle in interprofessional collaboration. Numerous anecdotal accounts document conflict among professional groups (Beattie, 1995; Griffiths & Luker, 1994; Hilton, 1995; Hugman, 1991; Long, 1996). West and Field (1995) and Field and West (1995) interviewed 96 team members, and concluded that effective teamwork is unlikely when professional boundaries are inflexible. Specific problems with status, power, educational levels, individual assertiveness, and leadership, were recorded. Likewise, when diverse management lines blocked team interactions it was much harder to arrange team meetings to facilitate the dialogical processes.

Bennett-Emslie and McIntosh (1995) reviewed fourteen general practices, interviewing a sample of 70 general practitioners, health visitors and health workers. The participants identified the presence and the frequency of team

meetings as the single most critical factor that fostered collaborative teamwork. Although practice meetings did not guarantee effective teamwork, they certainly improved interprofessional relationships. Unfortunately, too many practitioners are untrained in the art of interprofessional communication that is a crucial prerequisite for team success (Bennett-Emslie & McIntosh, 1995; Cartlidge, Bond & Grigson, 1987; McClure, 1984).

Petersen (1994) proposed that too many health professionals expend energy in competitive relationships that support existing collegial roles. This is non-productive and raises a barrier to social change in a health sector that is assuming new visions of reality. Any emphasis on individual professional contributions, the coordination of care and developing cooperation is limited if it does not dissolve the typical professional lines or further new models for transprofessional practice (Kerfoot, 1996). Transprofessional practice blurs boundaries, moving beyond the limitations imposed by disciplinary training (Nolan, 1995). It is practice that is based on trust, tolerance, and a willingness to share responsibility. Those variables are crucial for groups working together in times of change and will be discussed further in later chapters.

Conclusion

Many authors have examined collaborative practice and its effects on work redesign, teams and teamwork. Many concepts have been studied separately rather than linked across contexts or located in the broader sociohistorical background. Consequently, the picture of teams, their work and process is skewed, as emphasis on one topic is often at the expense of another. Many analysts have been caught up in the minutiae of inquiry. Nonetheless, the way teams are perceived has altered and been adapted for the modern sociocultural context. Essentially, the label assigned to people working together in restructuring health care organisations is relatively unimportant. What is important is what they do, how they do it, whether it helps the patient, and whether it fits in with the overall goals of the

organisation and the service funder. Health professionals have not been taught to work together. Many are learning how to be responsive to others as new interactions with clients and colleagues are forged in the responsibility-based organisation. This research will go some way to provide empirical evidence, grounded in practice, of the processes they use, as they work and interact together in the context of health care. In the next chapter, the research process will be presented.

CHAPTER SIX
The Research Process

Introduction

This chapter addresses the research process. Decision making along the audit trail is presented so that processes are transparent and open to scrutiny (Morse, 1994). The aim and purpose of the research, the location of the research, the sources of data, recruiting participants, access, and making connections with the teams, are explained. A short discussion of ethical issues follows and lastly, data collection and analysis techniques will be examined in relation to the study outcome.

Aim of the Research

The aim of this research is to use the grounded theory approach to discover the main concerns of health professionals working within interdisciplinary teams, and to explain the processes that members of the teams use to continually resolve practice problems in a restructuring workplace.

Purpose of the Research

The purpose of this research is to develop a substantive theory of interdisciplinary teamwork in the acute care hospital. The term interdisciplinary refers to people with different training and preparation (e.g. management, medicine, nursing, occupational therapy, physiotherapy, dietetics, and social work) who share common objectives but make differing, complementary contributions to patient care (Leathard, 1994). When the public health service is being restructured, the demands for new ways of working together are intensifying, so understanding how team members process their concerns seems appropriate.

The Participants

Location of the Research

The research took place in two acute care hospitals in a large metropolitan city. The hospitals are atypical New Zealand health care institutions in that they seldom admit patients requiring general health services. Attached to one of the country's leading medical schools, they not only provide care for people in their own locality, but also, the hospitals are promoted as centres of excellence that supply specialist services for the most complex patients from other regions.

Sources of Data

In-depth interviews and participant observation were the two main sources of data. Data collection was guided by *theoretical sampling.* Initial decisions for collecting data were based on a broad general knowledge of social behaviour and the problem area. Participants were selected on analytic grounds, according to theoretical need, depending on their purpose and relevance for the study (Glaser, 1978; Strauss, 1987).

Recruiting Participants

In grounded theory research the participants are chosen initially to access the problem area and then because they can clarify the emergent phenomenon being studied. The number of participants and teams that would be required to saturate the grounded theory was unknown. Ethical approval and entry to the hospitals was founded on an educated guess about a reasonable number of participants and places to go (Stern, 1989). However, the final sample size and composition were indeterminate. *Theoretical sampling* guided the process and participants were chosen as required, rather than being anticipated in advance (Glaser, 1978).

Theoretical sensitivity, which refers to the disciplinary knowledge and expertise that underpins the researcher's thinking, questioning and analytical abilities, shaped the general choice of participants (Glaser & Strauss, 1967). Sensitivity is developed from an understanding of disciplinary knowledge development, and also by the researcher's temperament and her ability to discern, and make sense of, the subtleties of significant situations. Participants were selected on the assumption that they could make a meaningful contribution to the quality and sufficiency of the data in relation to the emergent theory (Blumer, 1969).

As an *initial sampling strategy,* eight people (out of an eventual sample of forty-four) were selected because they were people who were knowledgeable about the general problem area (Glaser, 1978). According to Glaser, the inclusion of such people maximises the possibilities for data collection. In this study these people were mostly managers who were absorbed in the process of doing things differently in health care delivery. Although they were members of teams themselves, their teams were not studied per se. Inclusion of this group of participants was intended to "get a line on relevancies and leads and to track down more data and where and how to locate oneself for a rich supply of data" (Glaser, 1978, p. 45).

Access to the Teams

Access to three specialist service areas was negotiated with the organisational Research Adviser for both hospitals. Variation in team settings was sought deliberately, as Glaser and Strauss (1967) suggest that categorical development is much slower in a single location. "The basic criterion governing the selection of comparison groups for discovering theory is their *theoretical relevance* for furthering the development of emerging categories" (p. 49). Access to multiple comparison groups had to be available to ensure similarities as well as atypical, negative, and different experiences were included (Morse, 1989). Teams were chosen because they seemed sufficiently similar, yet dissimilar. Similarity and difference had the potential to facilitate theoretical sampling.

The Research Adviser was the institutional gatekeeper. Sometimes, an official gatekeeper is an organisational watchdog who blocks access to the setting in order to protect the organisation from politically sensitive projects or from researchers who have dubious credibility (Punch, 1994). In this instance, the initial approach was made to meet access requirements, but the informal contact was invaluable to facilitate communication with the appropriate people. Sponsorship from the Clinical Service Directors was arranged once the researcher's credibility was verified. Permission to access three specialist services in two hospitals was given. Two services were adult-oriented while the third service was a paediatric service.

Making Connections

The researcher entered the first team setting in a service where one clinician had been known to her as a student. As a lecturer in a post-graduate interdisciplinary program the researcher had contact with many clinicians. Students on courses were not usually well known to the teaching staff because of the large groups. Thus, the researcher was familiar, yet unfamiliar, with potential participants. Little was known about the actions and interactions that occurred amongst colleagues in a particular clinical world. The researcher entered each location as a stranger, not as an insider who was well acquainted with current organisational practice. Nevertheless, bias was indeed possible.

No research project is value free or bias free. What is important is that the researcher ensures participants are protected from prejudice or harm. Informal telephone contact with the one clinician, who had been a student, became a means for discussion of possible problems. Mutual reassurance left the researcher and participant free to arrange contact with the team. Because the researcher was reliant on each team's willingness to provide inside information, a copy of the research proposal was sent in advance, and information sheets (See Appendix A) were given out at the first meeting with team members. The first clinical director, more familiar with

quantitative research, was briefly disconcerted with the emergent nature of grounded theory. Yet, he rallied quickly and suggested that participant observation might be the place to begin.

In the second team a telephone discussion with the clinical director clarified questions about the research proposal and a brief opportunity for both parties to view each other was organised. Any researcher entering a setting as a stranger can expect to be asked to respond to critical questions that might give some indication of integrity and professional expertise. Access to the weekly team meeting was agreed. The general nature of the access permission made it something to be confirmed with each individual later. Decision-making was affected by the need not to offend those who were trying to support the research, but to protect possible participants from coercive entry into the study.

The third specialist service chose to contact the researcher directly. On hearing about the project at a management meeting, they were keen to explore participation because they were committed to a team approach. At the first meeting, ward access was discussed. An immediate tour was provided. The researcher was introduced to all consultants who were asked for instant support. Meetings were exceedingly brief and informal – about two minutes. Information sheets were distributed liberally en route to clinicians. In this situation, sponsorship from the clinical director secured collegial support. This was verbal consent in action and was very different from the demands of the ethics committees that people be given time to think about participation in research. These clinicians were very busy people who were used to making instantaneous decisions. Time was precious. If they agreed to do something, they had agreed.

The researcher was uncomfortable with the assumption of access to team members who were not encountered during the introductory tours. The informality of the process was at odds with the planned information giving documented for the ethics' committees (See Appendices A & C). This was passive consent in action (Berg, 1998). While the clinical directors

approved researcher entry, and assumed that all the staff would follow suit, entrance was regarded as tentative. Access to participants would still have to be negotiated individually.

During the recruitment stage the researcher aimed to communicate clearly and honestly. She often had to admit to not knowing exactly what would happen in this emerging grounded theory study. Clinicians accepted this with interest. After all, they were accustomed to working in teaching hospitals where personnel changed frequently and needed support as they settled into a new setting. All the researcher could be sure to offer was that she would keep in touch, let them know what she was doing, and check out whether her presence for observation was acceptable. The process was an ongoing consultation that involved everyone.

Characteristics of the Participants

Participants came from the initial sample group already discussed (p. 91), and four teams from the three specialist services. The sample size was forty-four and was predominantly female. Eight men and thirty-six women joined the study. The age range varied from twenty-two to sixty-five years. At least thirty participants had more than twenty years clinical experience in multiple settings in New Zealand and overseas. Six people had less than five years experience while the remaining eight health professionals had been practising for ten to fifteen years.

Four of the forty-four participants, all in the 55-65 year age group, had no formal qualifications. Thirteen people were trained within a specific discipline, exiting with a diploma qualification. Of those thirteen, five were pursuing either degree study or specialty post-graduate certificates. The remaining twenty-seven participants were educated to degree level. Of those twenty-seven one had a doctoral qualification, eleven had received a masters' qualification or the equivalent, and another seven were in the midst of a Masters program. The average team member had some post-

graduate education. Only twelve participants were not pursuing tertiary education. In the main, team members were highly educated.

The final sample was made up of seven doctors, seven nurses, five occupational therapists, seven physiotherapists, three social workers, one dietician, seven administration people, and seven managers.

The Teams

The first team offered speciality advice to every surgical team in the hospital. It was a highly mobile service set up especially to coordinate care for highly complex patients who were critically ill. The three core members included two surgeons and the case coordinator who was a nurse. Observation for several hours, two to three times a week, over a four-week period revealed a team that was unique. The team had worked together for a year, and was deeply committed to the delivery of integrated, quality care.

The second team provided care for children with chronic illness. The core group consisted of a doctor, a case coordinator who was a nurse, a physiotherapist, a dietician, and a social worker. A psychiatric liaison person, either a nurse or a psychiatrist, attended team meetings and clinics. Registrars joined the team for six monthly rotations. Three of the core group had established the speciality service and had worked together for over ten years. An intensely loyal group of women, each highly committed to providing the very best service for clients, they had grown together over time. That team was observed for several hours a week over a two-month period. Everyone was interviewed except for the registrar who had just joined the group.

The third service was a medical speciality delivering care to adults with multiple, chronic conditions. Two teams were interviewed and observed there, although the specialist service had four wards altogether. One ward offered sub-specialty care, two wards covered the main speciality service, and the fourth ward was a Day Ward that provided short-term

rehabilitation services. The researcher spoke to many people across the service although observation occurred only in two of the ward teams.

In the first ward team there were forty-three members. Although most team members were part-time nursing staff, there was a permanent core team that included two consultants, a charge nurse manager, an occupational therapist, and a social worker. Everyone else, the dieticians, the physiotherapists, the registrars, the speech therapists, and the house surgeons were on rotation. Apart from the registrars who were appointed for six months, others joined the ward for three-monthly rotations. This team was significantly different from the other three because of the high proportion of team travellers – those who had temporary team membership. The team was observed over a five-week period. Time spent in the ward varied from several hours a day, four days of the week initially, dropping down to one day in the latter stages of the study. The researcher attended team meetings three times a week, some family meetings, and a few ward rounds. A selection of clinicians was interviewed.

Observation also took place in the day-stay ward where health professionals were observed as team members for several hours a week over a four-week period. This fourth team had eight permanent members including a consultant, a charge nurse manager, two physiotherapists, two occupational therapists, and two nurses. The researcher attended several weekly meetings and interviewed many of the staff. Like the paediatric team, clinicians were women who had worked together for many years. That ward was hectic, as all the patients arrived at once and left en mass a few hours later. During the morning most of the patients would see a nurse, have a physiotherapy session, join in the occupational therapy activities, and possibly access the doctor or the speech therapist if required. Outpatient clinics were run in the afternoon.

Ethical Concerns

Prior to any data collection the Research Committee of the Department of Nursing and Midwifery assessed the project for scientific merit. Full ethical approval to proceed was granted from the Human Ethics Committee of Massey University and the Regional Health Ethics Committee.

Informed Consent

Throughout the project the researcher was responsible for protecting the rights of all the participants. A full explanation of the nature and purpose of the study was given to all team members who were assured that consent to participate was ongoing. Unforeseen events and consequences are always possible. Continuing facilitation and renegotiation were essential to protect participants' human rights. If interviews were interrupted, or delayed, even though the researcher wanted to talk to people, she had to offer the option of appointment cancellation with a sincere spirit so people had genuine choices.

Potential participants have the right to feel free from pressure or undue influence of any kind (Wilson, 1985). Every effort was made not to be over enthusiastic or to use persuasive language when inviting people to join the study. Participants were given an information sheet in advance and time to read that before the written consent was signed. Verbal consent was accepted as an initial agreement in team meetings. Participants also had the right to know the potential time commitment. Because it was impossible to advise participants when data saturation might occur, people were reminded of the right to withdraw from the study at any point. Of the forty-four participants twenty-six had one interview, four people were interviewed twice, seven people were interviewed three times and three people were interviewed four times. *Total interviewing time was 80 hours.*

In actively consenting to be part of the study, participants agreed to the tape recording of the interview. People were asked to pass on only that

information they felt comfortable sharing. They were assured the tapes, transcripts and computer discs would be stored safely in the researcher's home. When a transcription typist was used, participants were given the name of that person and asked if they accepted her listening to the discussion. The typist was asked not to discuss findings with others. Transcripts were returned to each individual for perusal.

Many participants were uncomfortable reading their transcripts although the choice to do that, or not, was individual. Some were embarrassed about their verbal expression. Others noticed they did not answer the questions. The researcher was philosophical about such issues. Everything was data. Most participants were willing to fill in gaps, to provide new leads, to explore ideas, to help the researcher understand more about team practice. Indeed, Strauss (1987) has suggested that the analyst believes everything but believes nothing. Any alternative view always advances connections and the synthesis of impressions into a coherent whole.

Anonymity and Confidentiality

Throughout the study no clinical data was collected on clients receiving care from anyone in the teams. Issues about the participants' anonymity and confidentiality were discussed fully prior to interview. Care was taken to ensure participants were not linked with specific data. Most clinical directors had high international profiles. Everyone was asked to choose a pseudonym as an interview name. The choice of a pseudonym was significant as, in any research project, findings will be shared with colleagues in seminars, conferences, and international publication.

Researcher Involvement

Although research in grounded theory attempts to limit the influence of a priori knowledge of the phenomena being studied, Glaser and Strauss (1967) stated that, once immersed in data collection, the researcher does not remain a passive recipient of impressions. Understanding participants

in the area of study is a complex process that also depends on the quality of the researcher-participant relationship, which, in turn, affects the rigour of the study. Once the researcher entered the field she was responsible for establishing an all-inclusive reciprocal relationship with participants.

Morse and Field (1995) believe that "the amount and quality of the data and the depth of analysis depend on the ability of the researcher" (p. 141). Throughout the project, the researcher was conscious of creating a sense of trustworthiness, which would enable her to gather significant information from the clinicians. Krefting (1990) believes that the nature of the rapport influences the passing on of sensitive material. Similarly, any sense of trustworthiness is likely to increase when the researcher actively uses strategies that promote credibility, transferability, dependability, and confirmability.

The researcher established her credibility with participants by spending time in the clinical areas, and by collecting data from various sources. The "prolonged field experiences" (Krefting, 1990, p. 217) helped the researcher to check out different perspectives, and gave the participants time to become accustomed to having a stranger in their midst. During interviews the researcher was conscious of creating a communication climate which conveyed her commitment to openness, honesty, and genuineness. The researcher worked to put preconceptions to one side, to be as open as possible, to uncover the meaning behind differences, as she encouraged participants to share their ideas. The collection of significant data depended on the researcher suspending prior knowledge and assumptions, and actively listening, so that responses and explanations were not preempted.

The researcher also appreciated that the assessment of trustworthiness would be judged according to the quality of the theoretical sampling and the density of the data. Every effort was made to follow up emergent leads, and to talk to new participants from the four teams who might introduce different understandings which could be compared with the existing data.

Krefting (1990) argues that the density of the descriptions supports transferability of the data. In this grounded theory study data density was achieved by the amount of data collected from participant observation and interviewing. There were eighty hours of interviewing and eighty hours of participant observation in this project.

The dependability of the data refers to the consistency of the findings (Guba, 1981). This was supported by the careful description of the research methods and the audit trail, by the constant comparative method of data collection and analysis, and by peer review of theoretical development. The process was pervaded by a deep commitment to the emerging grounded theory method, and an aversion to forcing the data in a direction that did not represent the reality of the participants. When the researcher became aware of questions, problems, or biases she took time to memo ideas, to reflect on her position, to talk through the issues with another grounded theory researcher, and to return to the participants to clarify emerging ideas. Peer debriefing with trusted colleagues (Lincoln & Guba, 1985) was useful to ensure the researcher was challenged for her biases and was working to keep herself honest in her interpretations. Prolonged engagement in the field may lead to an over-involvement with participants. Reflexive analysis was critical here (Krefting, 1990). The researcher was well aware that she was never neutral because of her involvement with the participants, so she was forever monitoring her self, as she sought some state of balance between subjective and objective meanings, which influenced her ability to interpret content accurately.

Confirmability in a grounded theory study occurs when the participants recognise the experiences being explicated. According to Krefting (1990), the interpretive process is dynamic, and its success is dependent on searching for multiple perspectives, and finding different slices of information, which "maximise the range of data that might contribute to complete understanding of the concept" (p. 219). Recognition and clarification of meaning was an ongoing process in this grounded theory, as constant comparative analysis meant that new data was always compared

with existing interpretations, and checked out with participants. Information emerging from one interview was checked at the next and so on, until the final interpretation was presented to some team members for their feedback.

Data Collection and Analysis

Concurrent Data Collection and Analysis

In grounded theory, data analysis is both inductive and deductive (Glaser, 1978; Glaser & Strauss, 1967). Initially, inductive reasoning shapes data collection. Emergence of data according to the way the participants see their world is critical. Glaser (1978) emphasised that, as the problem becomes obvious, questions regarding emerging incidents and concepts guide theoretical sampling. As the study becomes focused systematic deduction of theoretical possibilities helps identify hypotheses that "guide the researcher back to the locations and comparative groups in the field to discover more ideas and connections from the data" (p. 40).

Once data collection commenced reading was kept to the minimum to prevent going off at a tangent, consciously or unconsciously, and interpreting data according to vague speculations of what ought to be happening, rather than what was occurring (Glaser, 1978, 1998). Occasionally, the researcher could not resist reading about an emerging idea. However, interviewing was influenced by this concurrent reading so, in order to avoid forcing the story (Glaser, 1992), literature was put aside until selected literature was reviewed formally following the clarification of the theoretical codes and the basic core variable. However, a later literature review was significant for promoting critical reflection about the ongoing theoretical development.

Time was taken to constantly compare incoming data and to plan subsequent interviews, in order to assure rigorous theoretical development. Data collection occurred over eight months in three waves. The first wave

comprised the first twenty interviews when the initial participant group were interviewed, and the two teams were being observed and interviewed. A short break for intensive analysis followed until the second wave of interviewing began with the third team. Thirty interviews were completed. At that point the researcher had to decide whether to continue collecting data. Theoretical development was progressing but the work was ordinary. Emerging ideas seemed commonplace. Where was the originality? What was different about this research? Where was the grounded theory? There were no satisfactory answers.

At the time, the researcher did not appreciate that, the synthesis of emergent concepts into a coherent theoretical explanation of behaviour, takes time. Another wave of interviewing with a new team, the fourth team in the day ward, was organised. That final wave of interviewing was well worth while as systematic theoretical sampling was developed, and a denser conceptualisation resulted. Tentative hypotheses were checked for similarities and differences. Thinking became more creative and interpretations more adventurous and sophisticated, as the researcher examined options, synthesising ideas into a tight, integrated set of hypotheses typical of a grounded theory. In due time, one hundred and sixty hours were spent collecting data from interviewing and participant observation. Data collection was probably more extensive than necessary but was driven by a researcher engaged in a learning experience. Developing autonomy as a researcher was a gradual process. Charmaz (1983) suggested grounded theory is a practice better learned through apprenticeship. Glaser's (1991) advice was followed, albeit unwittingly:

> If the researcher achieves autonomy by taking her work out of the hands of teachers and colleagues and by developing her own plan of research with its own pacing, this is an immeasurable contribution to the honesty and theoretical richness and results of the work. [S]he should provide [her] own training, because [she] is going in a different direction. Then, later, when the analysis is finished, she should bring the work back to the sociological fold as a contribution. (p. 13-14)

The Interviews

In grounded theory research the beginning research question is very general. The earliest interviews were unstructured. The problem emerged as the study progressed and the researcher systematically clarified and developed directions of inquiry. In the beginning, participants were asked:

> I am looking at how teams operate in the health service and would like to talk to you about your experiences. Perhaps we could begin with you telling me a little about the work you do...

Questioning varied according to the person, the time of joining the research, and the context. Originally, questions were intended to encourage focused discussion. The first eight interviews, with the initial participant group of experienced health professionals, were completely freely flowing. Data was run open (Glaser, 1978). No attempt was made to ask everyone the same questions although participants were encouraged to remain with the general topic. Free expression was welcomed. The researcher invited people to share nuances and detailed understandings about team actions and interactions. Being open to everything is important in an emergent grounded theory study, as patterns do recur in what is said and what is left out (Glaser, 1978; Strauss, 1987). If something was left unsaid it was probably not important. In time, questioning moved to exploration of emergent analytical insights. Interview data informed participant observation so that the researcher's senses were sharpened and alerted to possibilities.

Participant Observation

During the project, teams were observed as people carried out their usual roles and responsibilities. Because human behaviour develops through interaction and action with others it should be checked out by observation so that participant information can be validated. Lofland and Lofland (1995) argue that participant observation occurs when a researcher spends

a reasonable period of time in the natural setting with the purpose of understanding scientifically the actions and interactions of the people. Observation in the four teams combined well with intensive interviewing, helping the researcher check perceptions and recollections, developing deeper understandings of the dimensions and properties of categories, and uncovering new events not evident in interviews. Observation of unexpected incidents produced fresh insights into everyday experiences.

Atkinson and Hammersley (1994) have clarified the differences between participant and non-participant observation. In the first instance the researcher is fully immersed, working with participants in the field. In the second situation the researcher is an observer. Ashworth (1995) criticised the latter role because separation perpetuates objectivity. The difficulty with that position is that positivistic objectivity is at odds with interpretive subjectivity and the development of a humanistic researcher-participant relationship. In this study an observer role was chosen deliberately by this researcher, who is no longer a clinician. Although the researcher was a complete observer (Morse & Field, 1995) in the sense that she did not take on a clinical role, she was by no means passive. The researcher was certainly not concealed in any way; she was visible to everyone; and she engaged in social interaction with participants and staff members. However, the researcher was certainly a stranger who was establishing rapport through intermittent social interaction over time.

Another criticism of participant observation is that people behave better when they are watched. Observed behaviour is expected to differ from a person's normal ways of acting and interacting. A research study that uses interview only as data may attract comment because participants may say one thing and do another. While that is possible, unnatural behaviour is harder to sustain when a researcher designs prolonged contact with participants into a study, and is observing people over time. Participant observation becomes yet another opportunity to validate data, regardless of the source.

It is argued here that the participants who volunteered for this research study were hardly likely to be those with something to hide. Health professionals are used to public observation. They are scrutinised constantly by peers and patients in the course of their work life. Observing participants in their workplace helped the researcher to be alert for anomalies, distortions, and biases that needed to be clarified by further questioning. As a field researcher, she was surrounded by a continuous flow of data. What was important was how that data was focused systematically to develop theoretical relevance and purpose.

Originally, observation of all team meetings (See Appendix C, D, & E) was intended although this did not eventuate according to the plan. At the team meetings people drifted in so the researcher was not always known to everyone. Berg (1998) believes that, morally, passive processes do not allow for full information giving, or provide potential participants with sufficient opportunities to refuse participation. While it was reasonable to assume that health professionals had non-coercive collegial relationships, some team members may not have supported the researcher's presence if they were given an opportunity to voice their preference. If anyone appeared uncomfortable, at the meeting end the researcher approached individuals directly, explaining her attendance. As researcher confidence improved, more time was spent being seen in a clinical area, so that introductions were secured and information sheets distributed.

The benefits of participant observation increased over time. Participants became more used to the researcher wandering around, taking notes, and asking questions. Seldom were clinicians interrupted in their clinical work. The pace of life was rapid. Time was precious. Questions were usually saved for interview. The interplay between data collection processes was brought home to the researcher early in the study when she set out on a morning ward round. The researcher noticed team members teaching colleagues. The researcher presumed "informal teaching" was an important clinical role. Reading about learning organisations had skewed the researcher's thinking towards notions of teaching and learning.

Preconceptions were revised during an interview with Marilyn (See Appendix F). In that interview Marilyn described the situated context of knowledge.

Participant observation alerted the researcher to the contradictions and paradox inherent in practice. Looking back on the field notes (see example in Appendix G) many other incidents were documented as well, suggesting that the "teaching" emphasis was somewhat simplistic as a later theoretical memo revealed (See Appendix H). In the early stages of the study the researcher was sorting out how incidents compared to each other and whether teaching was to be identified as a significant category. Hazy ideas about "informal teaching" were renamed several times as each incident was compared with others in the coding process. This kind of rigorous coding, a coding-recoding strategy, is essential if a study is to be true to the grounded theory method, and findings are to be trustworthy.

NUDIST – A Computer Tool for Analysis

Computers are a useful tool to explore impressions, to create new ways of looking at the data, and to assist the competent computer person to discover unrecognised ideas and concepts (Richards & Richards, 1994). NUDIST (Non-numerical Unstructured Data Indexing Searching and Theorising), is a code and retrieve system that is a useful tool to help the researcher edit and explore documents. NUDIST does not analyse data, the researcher does. In a grounded theory study "because the categories and meanings are found in the text or data records, this process demands data management methods that support insight and discovery, encourage recognition and development of categories, and store them and their links with the data" (Richards & Richards, 1994, p. 446). The computer is a technical tool for storing a large amount of data, and retrieving data quickly and efficiently (Berg, 1998).

Ready access to the data helped the researcher be alert to new or unexpected connections that were checked out quickly. To illustrate, if the

analyst noticed repetitive patterns, a word search was run to see how often and across how many interviews that notion occurred. If an idea occurred in three documents out of one hundred, the researcher concluded that it was probably unimportant. Ideas were scrutinised carefully, to see if they were upheld and supported by empirical evidence consistently. But, like all computer programs, NUDIST worked better when the operator understood the program.

NUDIST has two main systems, a document system that copes with document storage, and an index system. The latter is designed for "the user to create and manipulate concepts and store and explore emerging ideas" (Richards & Richards, 1994, p. 457). In the index system there is a series of nodes that are used to organise data. These are arranged hierarchically to allow the researcher to code a category and organise incoming information accordingly. Under a category, the analyst formulates various codes that are labelled according to the properties of that category. As the researcher used the causal model to examine categories, nodes representing the causes, context, conditions, strategies, consequences, and covariances of the category should have been developed. However, despite some elementary training in using NUDIST, this researcher's computer organisation skills were less sophisticated. Hindsight is a valuable teacher.

Using NUDIST had both advantages and disadvantages. The program was useful to manage and retrieve data. Because data could be copied and pasted, and moved anywhere, new ideas and creative links could be readily tested. Having a tool to move data about freely assisted the researcher's flexibility of thought. The main difficulty was in not taking enough time to learn how to use the program fully. The program had enormous potential that was not realised. Computer comfort level (Berg, 1998) is achieved with effort and time. However, despite that, computer technology was invaluable to manage the large amounts of data generated in this project.

helped the researcher sort out, summarise and synthesise incoming information, so that it could be used effectively.

As material poured in, data were examined line by line for similarities, differences, and consistencies in behaviours or phenomena (Glaser, 1978; Glaser & Strauss, 1967). Incidents were compared with incidents, incidents with categories, and category with category. In substantive coding, data were arranged according to common content organised around conceptual ideas that were combined into a category. Codes were labelled using phrases that summarised broad descriptions (See Appendix I). The natural language of the participants was used if possible. Those *in vivo codes* were expressions that conjured up a rich picture, a vivid image of what was happening in a particular context. The term *pioneering new structures* was an example of an in vivo code that was retained as a category.

Categorical analysis was complicated. For example, many incidents described roles. Role position, clarifying role, pioneering roles, redefining roles, ambiguous roles, hidden roles, and role confusion all emerged. Where did they fit? Which were the indicators? Were participants saying the same thing? Were there distinctions between the words? Was role a category? The researcher searched for answers asking how and why questions as options were explored (Charmaz, 1990). As data were sorted the indicators pointed towards a category of role redefinition. Role incidents were similar as all shared the role component, but differences existed in relation to position, definition, clarification, confusion, and ambiguity.

As analysis proceeded understanding deepened and some characteristics were merged into one idea. Role clarification and role position were combined into role understanding that seemed to be connected to a category of *blurred boundaries*. Roles and boundaries were closely connected in the data. How close were those connections? Should they be separated? Perhaps a more accurate category was *pioneering new structures?* Why did the concept of role understanding stay as an indicator instead of a category? Data were essentially descriptive and at the concrete

level of development. In contrast, *pioneering new structures* was more abstract. It subsumed a range of situations and had a broader meaning than a descriptive concept.

The analytical process is not linear. Overlap in categorical indicators is inevitable. Indeed, Strauss (1987) suggested that the interchangeability of indicators is a sign of category saturation. Even though fine detail might be slightly different, the general ideas "add up to the same thing" and "nothing new happens" in the data (p. 26). Whether an incident was lifted to the categorical level or not also depended on how well questions were asked, and the density, specificity, of the discussion. Did people tell the researcher anything new? Was it significant? Ideas that occurred early on in the study did not always retain their importance when data were sorted again, and recoded as conceptual density and explanatory power developed. Sometimes, a promising description simply disappeared from the data analysis, as its importance lessened and the analyst took the study in another direction once selective coding was under way (See Appendix J). Concepts and incidents were compared and verified as the theory was refined and categories saturated (Glaser, 1978).

Glaser (1978) has commented on the interchangeability of indicators and suggested the analyst decide on what is reasonable. Indicator interchangeability means other researchers will make different interpretations of the data. Right answers do not exist. What was important was that codes were developed systematically using the *concept-indicator model*. "This model provides the essential link between data and concept, which results in theory generated from the data" (Glaser, 1978, p. 62). It is quite different from concept analysis techniques where concepts are constructed by adding up indicators (Rodgers & Knafl, 1993; Walker & Avant, 1988). In the concept-indicator model indicators are compared to each other as the researcher is "forced to confront similarities, differences and degrees of consistency of meaning between indicators" (Glaser, 1978, p. 62).

The search for scientific uniformity was involved. The researcher monitored the process by constantly returning to the data, to confirm conceptual accuracy and recurrence. The computer program NUDIST facilitated specific word searches. Sometimes the researcher thought that an idea was common only to discover that a NUDIST search did not confirm such a perception. Stern's (1989) view that qualitative researchers work with words as well as numbers was well founded. "We use words, clustering them, ordering them, and building them into a picture of reality. We map data and draw pictures about it, and we try to see how it moves and changes" (p. 137). So, even though interpretive researchers work with words rather than numbers, numbers assist in analysis and interpretation of data as long as they "do not blur the vision of the researcher" (p. 136).

Visions were clarified once data were examined minutely, and compared and contrasted with the overall picture. As analysis progressed and categories were saturated, it was harder to treat categories as single entities. Many were interconnected. It was up to the analyst "to weave [the ideas] together into a *processual analysis* through which she can abstract and explicate the experience" (Charmaz, 1983, p. 117). For example, when the researcher questioned the different types of roles, analytical inquiry was developed from the data. The researcher used knowledge of a situation to help decide which leads to cover next. Did role connect with competency? Perhaps roles were a strategy in *breaking stereotypical images*? Could it fit anywhere else? As leads were pursued the depth of description was sufficiently intense to enable conceptual reduction, simplification, and synthesis into a coherent explanation revolving around a basic core variable.

Memo Writing

Memo writing was another procedure essential in the process of theory development. Analytical memos were the researcher's independent notes that represented the continuing dialogue the researcher had with the self while conceptualising about the data. Memos helped the analyst

summarise codes as she developed the properties of categories, and considered relationships and linkages between codes and categories (Glaser, 1978). Memo writing compelled the researcher to reason through, in order to verify categories, their integration, fit, relevance, and work within the theory. Memos are critical to knowledge development if premature closure is to be avoided. Memo writing occurred throughout the research process, and was a pivotal step in "breaking the categories into components and elaborating the codes. By writing memos, the researcher moved directly into analysis of the data. Bits of data and early codes were systematically examined, explored, and elaborated upon" (Charmaz, 1990, p. 1169). During the coding process, whenever the researcher had an idea, it was documented so that the thought was captured, to be crosschecked later on (Glaser & Strauss, 1967).

During memo writing the researcher drew on her disciplinary training to interpret ideas. For example, data about trustworthiness was compared with Erikson's (1968) theory of psychosocial development. As participants spoke of different levels of trust the researcher noticed that the notion of naive trust was different from traditional theoretical frameworks. Ideas were recorded, ready to be followed up at a later date. Memos were a place where the researcher talked ideas through with the self. Thoughts were free ranging, moving unhindered in many directions, as all sorts of perspectives, relationships, and hypotheses were considered during comparative reasoning (Glaser, 1978). Memoing was also underpinned by the researcher's willingness to reflect and review those unexamined assumptions, preconceived notions, biases, scholarly baggage, and commitment to over-determining ideas that most people carry on the life-long journey. Memos extended thinking. Memo writing provided "the content behind the categories, which became the major themes of the theory later presented in papers or books" (Glaser & Strauss, 1967, p. 113).

Because memo writing is a way of thinking the important thing is to get the ideas out regardless of grammar, spelling or expression (Glaser, 1978).

Details are polished up later if ideas remain in the theory. Appendix K illustrates an early memo. Descriptive analysis was unsatisfactory, as the point of memo writing is to move beyond description to conceptualisation. Description does not go far enough. It tends to tell those who know an area well, what they know already. However, thinking was a dynamic, continuous process that was extended again and again when the researcher was writing up the theory. Eventually, description was subsumed in ongoing analysis (Glaser, 1978).

In contrast, Appendix L was better developed. Self-dialogue was apparent. Re-reading the memo many months later the researcher noted that many of the ideas needed to be moved onwards within the theory. Sifting and sorting through memos was never really finished.

Finding the Basic Core Category

The emergent core category in this study is **pluralistic dialogue.** The identification of a basic core category is important in any grounded theory study in order to provide a central focus that draws the findings together and facilitates selective coding. If a core category is not identified the theory "will drift in relevancy and workability" (Glaser, 1978, p. 93). Charmaz (1983) summed up the stage succinctly suggesting "the process is selective because the researcher has already weeded through the materials to develop a useful set of categories" (p. 116). Analysis has moved beyond description to the conceptualisation stage (See Appendix J). The search for a core category/variable was important, as the theory is generated selectively around the core category.

Constant comparative analysis was confined "only to the variables that relate to the core variable in sufficiently significant ways to be used in a parsimonious theory. The core category becomes a guide for further data collection and theoretical sampling" (Glaser, 1978, p.61). The researcher deliberately develops specific questions about conceptual categories as she

analyses how they are inter-related with the core category. For example, the researcher took the conceptual category *negotiating service provision* (See Appendix K), and considered its relationship with **pluralistic dialogue.** Understanding grew as the causes, conditions, context, strategies, consequences, and covariances of *negotiating service provision* were refined (Charmaz, 1983; Strauss, 1987). Glaser (1978) advises the analyst to theoretically sample "to maximise differences in [the] data to help saturate the categories" (p. 95). Theoretical development was not a neat and tidy process though.

Several criteria shaped thinking here. Glaser (1978) suggests that the basic core category links the emergent categories and their properties into an inter-connected whole. Centrality means that it accounts for the wide variations and differences between negative and positive cases. The researcher seeks relevant categorical connections, but these cannot be forced. The core category is variable, so that it changes as the conditions change; it recurs frequently, crosses the data, and is transparent throughout the research. Clearly, **pluralistic dialogue** was "a stable pattern" (Glaser, 1978, p. 95), that joined data together because communication processes were everywhere. The core category was meaningful and integrated all the conceptual categories. It was evident that the conceptual categories of *breaking stereotypical images, grappling with different mind-sets, negotiating service provision,* and *engaging in the dialogic culture,* were processes that were definitely communication-dependent. Those particular conceptual categories also demonstrate how a basic core category is "completely variable. ...Conditions vary it easily" (Glaser, 1978, p. 96).

Because the basic core category is a dimension of the problem, it intersects every category. Therefore, it is argued that **pluralistic dialogue** confines the problem of *meeting service needs,* as the discussion of differences is essential while team members think through and construct new ways of working together. When the basic core category fits it works right across the data, and is a catalyst that enables the researcher to formulate an

integrated set of hypotheses about correlations with the conceptual categories. Most categories were *saturated*. Major patterns were continually repeated and new ideas did not emerge. What was implicit in the data had become explicit (Charmaz, 1983).

Generating the Theoretical Framework

Two key theoretical codes, *rethinking professional responsibilities* and *reframing team responsibilities* were eventually developed. These were subsumed under the basic core category that was also a basic social structural process. As such, it had two complementary, emergent stages. Glaser (1978) argues that "the stages should differentiate and account for variations in the problematic pattern of behaviour" (p. 97). In this study team members had concerns about *meeting service needs*. They were able to resolve those concerns by *rethinking professional responsibilities* and *reframing team responsibilities*. The rethinking and reframing processes fitted the theoretical requirement that a process occurs over time and changes over time. However, Glaser has also noted that stages that can be predicted are likely to be connected with social structures. Stages that are perceivable prior to experience are realisable once people are consciously aware of them. Stages have a beginning and an end, although these points are not fixed.

In this study, "the critical juncture" (Glaser, 1978, p. 99) between the stages was marked by the confirmation of competence, which occurred over a period of time. Competence was especially significant to team members working in interdisciplinary teams. Once a health professional's competence was confirmed by colleagues, respect followed, and the collegial attitude developed. The team was then ready to *grapple with different mind-sets* together. Competence was a critical variable throughout because it influenced the *negotiation of service provision*, and the trust that underpinned subsequent *engagement in the dialogic culture*. Competence was so important to the team that, once a health professional was defined as being competent, this person was instinctively trusted and treated as an

equal. Definition of professional competence gave automatic access to *engagement in the dialogic culture*. However, the person did not have to pass through the processes associated with *grappling with different mind-sets* or *negotiating service provision*. That was consistent with the grounded theory method. "... the occurrence or non-occurrence of a particular critical event (or whatever) will determine whether a new stage is entered (a stage is skipped, one of several possible stages is entered) or the previous stage is maintained" (Glaser, 1978, p. 99). Many team members reported variations in how they passed through the processes.

As a basic social structural process, **pluralistic dialogue** refers to "social structure in process" (Glaser, 1978, p. 102). This means that, the discussion of differences which supports team members who are rethinking and reframing the way they work together, facilitates the continually changing social conditions that are typical of the restructuring health care environment. As a social process **pluralistic dialogue** "optimises change, fluidity, and unfreezing of behavioural patterns" (p. 103). This social structural process is a catalyst to changing the traditional hierarchical interactions that are typical within the health services, as it assists health professionals to forge the cooperative interactions, which are essential to the wider sociocultural transformation of society.

Overview of the Grounded Theory

To summarise, it is argued that interdisciplinary team members express a concern for meeting service needs, and continually resolve that concern through the process of **pluralistic dialogue**. This is a means for discussing differences, that supports team members who are thinking through and constructing new ways of working together. It emerges as various health professionals integrate multiple perspectives, which contribute to the clinical and organisational management of the client service. **Pluralistic dialogue** has two phases. These are *rethinking professional responsibilities* and *reframing team responsibilities*. Rethinking and reframing are theoretical processes that are underpinned by team learning, and, by new

ways of managing changing service structures. Therefore, it is suggested that, in an interdisciplinary team, health professionals must *break stereotypical images* in order to meet service needs in a context where teams are constantly *grappling with different mind-sets*. Team members continually resolve their concern for meeting service needs by *negotiating service provision*. As a result, the health professionals are free to *engage in the dialogic culture*. An outline of the theory of pluralistic dialogue, follows.

Table 1

The Grounded Theory of Pluralistic Dialogue – *Basic core category*

Rethinking Professional Responsibility – *Theoretical code*

Breaking Stereotypical Images – *Conceptual category*

Coding Family	Properties of the Conceptual Category	Indicators
Causal Conditions	Blurred boundaries	Certain-uncertain expectations, role understanding, disciplinary knowledge
Context	Pioneering new structures	Opportunities, enthusiasm, new positions
Action/Interactional Strategy	Confirming competence	Performance, reliability, confidence, credibility
Consequences	The Collegial Attitude	Equality, hierarchy, respect, expertise, skill

Grappling with Different Mind-Sets – *Conceptual category*

Coding Family	Properties of the Conceptual Category	Indicators
Causal Conditions	Pluralistic world views	Individual beliefs and value systems, different perspectives and philosophies, learning opportunities
Context	Differentiated commitment	Dedication, vocation, integrity, altruism, moral code
Action/Interactional Strategy	Practising a team philosophy	Common purpose, direction, shared vision, goals, aim, values, partnership, united front
Consequences	Collective practice	Integration, collaboration, cooperation

Reframing Team Responsibility – *Theoretical code*

Negotiating Service Provision – *Conceptual category*

Coding Family	Properties of the Conceptual Category	Indicators
Causal Conditions	Continuous information coordination	Sharing, exchange, withholding, clinical input, client continuity
Context	Business-humanitarian clashes	Economic scarcity, efficiency, bureaucracy, constraints, optimisation
Action/Interactional Strategy	Deciding together	Discussion, communicating, challenging
Consequences	Collective accountability	Reviewing, abdication, resource management

Engaging in the Dialogic Culture – *Conceptual category*

Coding Family	Properties of the Conceptual Category	Indicators
Causal Conditions	Interprofessional Safety	Openness, honesty, trust, listening, confidentiality, subversion
Context	Pluralistic Leadership	Facilitation, people management, encouraging, communication
Action/Interactional Strategy	Tolerating Personality Differences	Self-awareness, sensitivity
Consequences	Sense of Community	Willingness, team person, support

As the theory took shape, the researcher then proceeded with the formal literature review to check the emerging theory with existing literature so that the write-up could be completed.

Theoretical Frustrations

While Glaser's (1978) six-C coding family was used to code data originally, in the final weeks of writing the researcher was worried about the extensive detail in the theory (See Appendix M). The theory did not fit Glaser's (1978) call for the ten to fifteen codes that are typical of a parsimonious substantive theory. Breaking the data down into causes, conditions, context, strategies, consequences, and covariances had resulted in a model that was full of intricate ideas. The researcher returned to the data to reflect on the possibility of collapsing categories further. Glaser states that theoretical sorting for integration prevents the analyst from becoming "bogged down in endless description" (p. 118). Perhaps this researcher's theoretical sorting was less well developed by a researcher-in-training, who was also teaching herself how to become a grounded theorist, minus mentorship. Sheer frustration drove the researcher towards Strauss and Corbin's (1990) coding paradigm. The axial coding system was seen as another way of linking data together according to causal conditions, context, intervening conditions, action/interactional strategies, and consequences. Eventually, after much soul searching and questioning a change in the research model at such a late stage, an exhausted researcher decided to recode the data using the Strauss and Corbin model with a minor modification. In the interests of parsimony the causal conditions and intervening conditions were subsumed. A tightly integrated, grounded theory resulted. Theoretical completeness was achieved. The researcher had explained the behaviour and problem under study with the fewest possible concepts, the greatest possible scope, and as much variation as possible (Glaser, 1978). Although that decision was thought to be reasonable at the time, hindsight would suggest that continued recoding within the original model would have achieved the same outcome, and remained consistent with the original theoretical model.

Theoretical generation is seldom complete although the grounded theorist always aims to present a theory that has scope, density, and parsimony (Glaser, 1978). According to Glaser, a grounded theory is ready for sharing

when "it explains, with the fewest possible concepts, and the greatest possible scope, as much variation as possible in the behaviour and the problem under study" (p. 125). Sharing the theory with participants to confirm fit, credibility, and relevance of the ideas, is yet another stage in generating a grounded theory. The theoretical outcome must be tested in practice, and discussed again and again, so that modifications can be made. This theory was confirmed with individual participants and teams at a later date.

Conclusion

In this chapter issues in relation to the research process have been presented and discussed. Influences on access to sources of data have been explained as well as ethical concerns and issues pertaining to data collection and analysis. Grounded theory is a highly complex method that is not for the faint hearted. The health professionals themselves will consider the meaningfulness of this study and confirm its theoretical significance. Any scholarly contribution will be scrutinised and judged according to the principles of rigour and scientific merit. Grounded theory is an intensive method for knowledge development in the health services. The credibility of the research will be evaluated according to this researcher's ability to generate a theory that explains working in interdisciplinary teams in a way that is relevant and true to the practitioners that were involved. Data that emerged from the study will be presented in the next chapters, beginning with discussion of the basic core category, **pluralistic dialogue**.

CHAPTER SEVEN
Pluralistic Dialogue

> *[In team work] one has the sort of satisfaction which comes from working with others in a certain situation. There is, of course, still a sense of control; after all, what one does is determined by what other persons are doing; one has to be keenly aware of the positions of all the others; he knows what the others are going to do. But he has to be constantly awake to the way in which other people are responding in order to do his part in the team work. That situation has its delight, but it is not a situation in which one simply throws himself, so to speak, into the stream where he can get a sense of abandonment. ...Team work carries a content. ...Fruitful assistance has to be intelligent assistance. ... The sense of team work is found where all are working toward a common end and everyone has a sense of the common end interpenetrating the particular function which he is carrying on. (Mead, 1967, p. 276)*

Introduction

The purpose of this research is to develop a substantive theory of interdisciplinary teamwork in the acute care hospital. When the public health service is being restructured, the demands for new ways of working together are intensifying, so understanding how team members process their concerns seems appropriate.

As already discussed interdisciplinary team members have expressed a concern for meeting service needs, and continually resolve that concern through the process of **pluralistic dialogue**. This is a means for discussing differences that supports team members who are thinking through and constructing new ways of working together. It emerges as various health professionals integrate multiple perspectives, which contribute to the clinical and organisational management of the client service. **Pluralistic dialogue** has two complementary phases. These are *rethinking professional responsibilities* and *reframing team responsibilities*. Rethinking and reframing are theoretical processes that are underpinned by team learning, and, by new ways of managing changing service structures. Therefore, it is

suggested that, in an interdisciplinary team, health professionals must *break stereotypical images* in order to continually meet service needs in a context where teams are constantly *grappling with different mind-sets*. Team members continually resolve their concern for meeting service needs by *negotiating service provision*. As a result, the health professionals are free to *engage in the dialogic culture*.

Pluralistic dialogue is about largely apolitical professional people practising in an increasingly political context that is shaped by a cooperative-competitive spirit[7]. As interdisciplinary team members they manage the tensions and contradictions of their practical life by drawing on formal-informal connections[8]. As a result, the teams are liberated to engage in both-and thinking[9]. All told, **pluralistic dialogue** has the potential to challenge, to empower, to transform. Or, it can perpetuate mediocrity and anonymity. The decision to dialogue mindfully with others is essentially individual. Any variation in an individual's commitment is covered by disciplinary associates but seldom challenged by colleagues from a different professional group. The basic social structural process of **pluralistic dialogue** is summarised in Table 2.

Table 2

The Basic Social Structural Process of Pluralistic Dialogue

Pluralistic Dialogue	
Rethinking Professional Responsibility	**Reframing Team Responsibility**
• *Breaking Stereotypical Images* – the apolitical-political approach • *Grappling with Different Mind-Sets* – the cooperative-competitive spirit	• *Negotiating Service Provision* – formal-informal connections • *Engaging in the Dialogic Culture* – both-and thinking

[7] Explained in Chapter One, p. 7. Refer also to Tjosvold & Tjosvold, (1994).
[8] Explained in Chapter One, p. 7.
[9] Explained in Chapter One, p. 8. See also Zohar & Marshall (1994).

Pluralistic Dialogue

The one variable that recurs constantly in the research is interaction. Participants were always talking, talking, talking. Talking is so commonplace that we tend to regard it as a ubiquitous process. Hewitt (1997) notices that talking is the cement that binds social order together. It is the means by which people confirm the world of objects in which they live. In this study, everyone continually sought different information in order to meet service needs. While most clinicians have specialist knowledge, they also pooled information, shared ideas, and made constant connections so that they could continually manage service needs. They talked formally and informally; they interacted collectively and casually as they moved around the clinical contexts. Clinicians agreed, disagreed, discussed, debated, explored, explained, liaised, listened, networked, negotiated, questioned, challenged, connected, and communicated. Right from the beginning of this study the participants were clear that interdisciplinary teamwork was all about communication.

The specific nature of that communication was revealed when clinicians were observed in action. Deeper meanings were discovered during the interviews. Over and over again the researcher noticed team members conversing together. They propped up walls; they liaised in lifts; they chatted in corridors; they mused at meal breaks; and they discussed disciplinary differences at team meetings or in spontaneous conversations that took place when they bumped into each other as they moved about the two hospitals. Informal dialogue pervaded collective practice and was confirmed as the essence of successful interdisciplinary teamwork.

Pluralistic dialogue emerged as the means for drawing together diversity and divergence as professionals from very different disciplines worked with complex patients in a context where time pressures, tension, and change prevailed. As a basic core category it is a social structural process that enables clinicians to integrate their individual actions and interactions so

that joint action is possible. **Pluralistic dialogue** helps clinicians to redefine situations as they search for shared meaning. As a result, constant, continuous, ongoing communication contributes to effective organisational function. Dialogue eases cooperation between disciplinary groups, and is the medium for channelling and converging differences into a mutually beneficial collective practice. This basic social structural process is ongoing, never-ending, and repeated over and over again.

In **pluralistic dialogue** there are two clear stages that account for variations in the problematic pattern of behaviour (Glaser, 1978). These are represented in the two theoretical codes, *rethinking professional responsibility* and *reframing team responsibility. Rethinking professional responsibility* is the process of deconstructive thinking that team members use in order to meet their concerns for service provision. The nature of professional work in the restructuring environment means that health professionals must find different approaches for actualising their professional responsibilities. Rethinking absorbs *breaking stereotypical images* and *grappling with different mind-sets*. This explains more clearly how health professionals respond to structural reform, as they seek new ways of fulfilling functional responsibilities for the organisation. *Reframing team responsibility* is another way that health professionals make sense of their world, which is in the throes of social transformatory change. Reframing complements the rethinking process. It enables clinicians to redefine values about an unfolding reality, so that new strategies to achieve quality client outcomes can be created. Reframing embraces *negotiating service provision* and *engaging in the dialogic culture*. Clinicians continually seek new solutions for action, by resynthesising their thinking.

As already mentioned, during the rethinking process, the confirmation of competence emerged as a critical junction. Thinking through alternative ways to meet service needs is possible once competence is confirmed and a clinician is accepted into the team, which then becomes engrossed in *reframing team responsibilities*. By contrast, the individual, who has a weak, limited, or developing knowledge base must be covered by the rest of

the team. Health professionals who are inexperienced or poorly prepared for specialist clinical situations jeopardise the team and its capacity to meet service needs. Colleagues are slow to accept that person as a full member of the team, because he or she cannot be fully trusted to contribute in a meaningful way that supports the team purpose. Client service delivery is already problematic, so team members who compromise it further by dubious competence, are less than appreciated. In this study, meeting service needs is the catalyst for continuous collective discourse that facilitates political and cultural change in organisations, which are increasingly pluralistic.

Indeed, Morgan (1997) suggests that in any pluralistic organisation the miscellaneous interests, conflicts, and sources of power that construct organisational life are highlighted. Also, he observes that, politically, pluralism has the potential to check authoritarian control by recognising the diverse claims of different, powerful interest groups. Drucker (1989) reports that pluralism is not new in society. However, historical pluralism is rather different from the modern-day version typical of post-capitalist society. Earlier pluralisms were based on power, while new pluralisms focus on function and performance.

In the past, political pluralism was exclusively collective. Morgan (1997) discusses the pluralist organisation where individual and group interests are arranged in a loose coalition that, very often, has tenuous interests in the overall formal organisational goals. Drucker (1989) takes a very different view, contending that modern social pluralism is apolitical in the present-day pluralist organisation that is knowledge based. Drucker (1995) explains that, although knowledge is the primary resource for society and the economy, specialised knowledge is ineffectual when it stands alone. Knowledge is productive when it is task-oriented. "And that is why the knowledge society is also a society of organisations: the purpose and function of every organisation, business and non-business alike, is the integration of specialised knowledges into a common task" (p. 76). Organisations are defined by tasks.

Hospitals are designed with a common task in mind. They carry the social responsibility to take care of the sick, and provide specialist services and expertise in certain areas. Because the hospital product is a discharged patient, specialised knowledge workers are organised in teams so that specialist knowledge supports organisational function and performance. The functionalism underpinning pluralism is a two-way process, which must be balanced. Professionals need collective organisational resources and power sources to support the individual expertise required to fulfil organisational tasks (Drucker, 1995). **Pluralistic dialogue** emerges as a means to improve organisational function.

Effective function in the team-based organisation is more likely if an organisation activates "the full human potential to thrive on change and complexity" (Zohar, 1997, p. 18). According to Zohar, the need for meaning is primary within every individual. Productivity and creativity are likely to increase when people work together in small teams that share a vision, goals, and a meaningful purpose. This world view symbolises radically new ways of thinking, and a social appreciation of pluralism that is congruent with twentieth century science that is characterised by "relativity, quantum mechanics, chaos, and complexity theory" (p. 9). Social pluralism emerges in a world where meaning is contextualised amidst paradox, uncertainty, and complexity. Since contradiction and tension are deep-rooted, pluralism evolves as a functional means for inquiry into idiosyncrasy. **Pluralistic dialogue** was identified as the collective mode of inquiry into inconsistency, and fostered exploration of multiple points of view. It is similar to Zohar and Marshall's (1994) idea that dialogue actualises various ways of experiencing reality so that unitary understanding is possible. In this study, health professionals reached a common understanding by rethinking and reframing responsibilities within **pluralistic dialogue**.

The two theoretical codes, *rethinking professional responsibility* and *reframing team responsibility*, emerged as basic social structural processes that mirror the dialogue process described by David Bohm (Bohm & Peat,

1987). Bohm has proposed a dialogue process that encompasses deconstruction and resynthesis. During the deconstructive stage people let go of their personal viewpoints and withhold their usual ways of looking at the world. Personal perspectives are compared, contrasted, and considered along with those of others participating in the dialogical conversation (Zohar & Marshall, 1994). All points of view are analysed for meaning, cultural presuppositions, and underlying assumptions so that long-held connections with personal consciousness are extricated as insights are revealed (Bohm, 1994). If self-images, prejudices, and emotions are unveiled the flow of meaning between people begins.

Dialogue "holds out the possibility of direct insight into the *collective* movement of thought, rather than its expression in any particular individual" (Nichol, 1994, p. xv). Individual revelation creates potential for redefining thoughts through social interactions with others. Indeed, dialogue is about the person behind the assumptions. Discourse simultaneously changes interpretation and understanding of the whole (Bohm, 1994). In this research that letting go process commences with the *breaking of stereotypical images.* Comparisons and analysis proceed as team members *grapple with different mind-sets* when they examine alternative world views in team learning situations. Frustration declines once people realise that professional responsibilities can be reconstructed if thinking changes. Rethinking is an unlocking process. Clinicians must identify the routine images first, to open up the customary mind-sets as it were, and to find out exactly what shapes existing uniformity and agreement before they are free to loosen conventional ways of thinking, and begin to change interactions and behaviour. Rethinking does not happen as a neat and tidy process but takes place as clinicians explore options for meeting service needs.

In the second stage of dialogue, resynthesis is possible. "When the rigid, tacit infrastructure is loosened, the mind begins to shift in a new order" (Bohm & Peat, 1987, p. 244). Bohm (1994) argues that the dialogue process moves forward again when people discover they are listening to

others because they have found a common ground. As a new way of looking at the world emerges, previous ideas and experiences are synthesised into shared understandings. In this study, differences are diffused when the client is identified as the common reason for collective action. It is always easier to let go of the old ways of thinking once the patient is the centre of attention when the team is *negotiating service provision*. Likewise, once the traditional frameworks holding practice together are bent beyond the conventional breaking points, innovation and creativity emerge as the team *engages in the dialogic culture*. By *reframing team responsibility* the health professionals "gave rise to a unity in plurality" (Bohm & Peat, 1987, p. 242). This discussion is summarised in Table 3.

Table 3

Deconstruction and Resynthesis in Pluralistic Dialogue

Pluralistic Dialogue	
Deconstruction	**Resynthesis**
Rethinking Professional Responsibility *Breaking Stereotypical Images* *Grappling with Different Mind-Sets*	**Reframing Team Responsibility** *Negotiating Service Provision* *Engaging in the Dialogic Culture*

Breaking Stereotypical Images

Quite clearly, hospital organisations are pluralistic. Drucker (1994) has discovered that workers in the new pluralistic organisations are always seeking something from the government in order to do a better job. In modern-day social pluralism, power is not necessarily used competitively to take over territory or specialist services but is used to support resources and decision-making. Everyone is challenged "to make the pluralism of

autonomous, knowledge-based organisations redound to both economic performance and political and social cohesion" (Drucker, 1995, p. 95). Many clinicians tended to be slow to understand pluralistic responsibility, and were perceived as being apolitical people practising in political situations:

> And a lot of groups haven't wanted to throw their hat in the ring in case it's the wrong ring! And health people are notoriously apolitical. They're great at gossip! Terrific at gossip! But really, in managing the political process they're hopeless! But that's because they're health people! (Janeanne, Int. 2, p. 23)

Health people may be apolitical but, generally, most learn rapidly, and are highly creative when challenged. Bohm (1994) states that when people are divided into sections, knowledge is fragmented, and thinking is divisive. Part of the deconstruction process is undoing existing images of the world so that the team can restructure thinking about a new form of interdisciplinary practice. Contradictions and tensions associated with disciplinary responsibilities are exposed when health professionals are *breaking stereotypical images.* Cross-disciplinary communication facilitates **pluralistic dialogue**, especially when political issues surface as internal interdisciplinary matters:

> In the beginning I approached the other disciplines to create a source of contact whereby if they had any issues that crossed from their discipline into nursing I would know about them and communicate with them where nursing was going. They could communicate where their discipline was going with the patient so we could work more collaboratively together – for the patient. I wanted to establish direct communication so that they had a point of contact, a point of discussion and a point of debate. (Carol, Int. 16, p. 227)

Discussion and debate are intrinsic to **pluralistic dialogue**. Clinicians must first fracture stereotypical images of reality before they are free to reshape practice. In this study, apolitical people were more likely to retreat to familiar territory, thereby increasing the deconstructive tensions and cognitive incoherence. Few practitioners spoke about the power of thought, and many failed to realise that they could not defend something "without first *thinking the defense*... Thought defends its basic assumptions against

evidence that they may be wrong" (Bohm, 1996, p. 11). The natural impulse to defend unconscious assumptions and opinions reactively and emotionally, during times of upheaval and change, blocks dialogic interactions. Then, the interdisciplinary team struggles to connect at a deeper level, as deconstruction must occur within the whole team if **pluralistic dialogue** is to be realised:

> For all the groups in the hospital the patient is still the strongest tie. So if ever there's an issue they don't think as an interdisciplinary team to sort it out at the team level. They go back to their disciplines and fight from that corner. That's where their strength is. And that's also their greatest weakness because they are seeing things from their own point of view rather than looking at the whole aspect. (Mark, Int. 46, p. 638)

Despite the fact that some team members withdrew to familiar disciplinary positions when change was overwhelming, others were ready to rethink personal perspectives. The political leader is influential, and in a position to move an apolitical group forward by creating a safe communication space where thought processes can be explored individually:

> Politically you may not have much time to do things. Politically we have to respond quickly so we end up with emergency meetings and planning strategies. That's not a good way to manage. ... The ones who are moving forward by themselves are the ones who come and talk. ... We just chat. We talk about ideas and they come and bounce ideas off me and I bounce ideas off them. And then they go off and move the others forward. (Lilly, Int. 5, p. 69)

Discussion is critical as people think about what they know, and redefine how knowledge might be shaped for changing political situations. Apolitical people work in a political environment that shapes their interpretation of professional responsibilities. In this context, understanding of professional responsibilities must change when they are reduced to a matter of survival:

> What you have to have today is a new discipline, which has people coming in from different angles. It's the core competencies. ... There is a need for destiny here. People are feeling vulnerable as the money dries up and there is competition from other hospitals. How do you survive? Our service survived by getting together and each contributing, and working out what the goals and targets were. And

> then we have to achieve it. In that process of thinking, if teamwork is about the organisation surviving, then we come together with all of our experience and we facilitate each other – the goals are interdisciplinary anyway. And if everybody is doing the same thing, no matter what their discipline is, then you will survive. If the survival attitude is about goals according to their merit, not according to the discipline, we will work as an interdisciplinary team. We're thinking it; we're setting our goals there (Wayne, Int. 90, p. 1243).

Grappling with Different Mind-Sets

The deconstructive stage of **pluralistic dialogue** is an active learning process whereby team members struggle with the familiar ways of looking at the world, as they *grapple with different mind-sets*. Yet, team learning is never completely individual. Freire and Shor (1987) suggest that "dialogue seals the act of knowing, which is never individual, even though it has an individual dimension" (p. 4). **Pluralistic dialogue** assists team members to suspend differences until they are ready to examine situations openly, honestly and actively engage in discourse with colleagues:

> There is an expectation of discussion – it's not necessarily agreement but if there's a problem, let's talk about it. ... I'll start a conversation because I honestly don't know what something means. ... Team members are usually very good at something so often we will have a conversation where there's this learning thing going on. And we learn from each other. So it's not just discussion. We want to understand. (Marilyn, Int. 12, p. 163)

The commitment to understanding better and the willingness to analyse personal assumptions is fundamental to deconstruction and collective discourse. Health professionals must overcome the well-documented competitive spirit that blocks opportunities for cooperation. Bohm (1994) argues that thought is possessive, that it takes over to produce limited fragmented descriptions that never change unless the source is examined. That was evident in this study where the culturally inherited values and beliefs transferred in disciplinary socialisation tended to polarise issues and overemphasise the debates between the professions. The old ways of looking at the world are challenged in the letting go process:

> I see the doctor-nurse relationship as absolutely symbiotic. We need them and they need us. Our knowledge bases are totally different. We come from different perspectives but the two complement each other. ... Now, the client is getting a less fragmented approach to care and everybody knows what everyone else is doing. ... They are sharing and asking questions and beginning to work as a team. ... If you are going to sit together everyone has to feel confident that while the professions don't necessarily agree they do have a relationship where there is potential to discuss issues without conflict. (Ann, Int. 3, p. 35)

The struggle to reconstruct their world and explore conflicting views is seemingly impossible in some teams. When automatic thinking is well-entrenched, thought is reflexive as thinking turns backwards, into the past. Bohm (1994) observes that, while it is seldom a person's intention to produce such situations, they do not recognise that deeper, hidden thinking reproduces conditioned meanings so problematic thinking continues. Thus, automatic thinking perpetuates non-cooperative actions and interactions. Competition is grounded in Newtonian thinking that emphasises separation, certainty, simplicity and absolute truth. **Pluralistic dialogue** is constrained when thought processes are fixed and static:

> Some adults cannot think outside of the square thinking and they operate largely on a concrete base. ... When you get into situations that require more abstraction and rethinking, some people will not be able to do that. They hold things together at the concrete level whereas the abstracters and fantasisers operate on a different level ... for some it is difficult to rethink the processes. (Kate, Int. 95, p. 1482)

Those who struggle with the rethinking process are seemingly unaware that "thought is a very subtle set of reflexes which is potentially unlimited; you can add more and more and you can modify your reflexes" (Bohm, 1994, p. 53). Some people insist on defending their thoroughly entrenched thought processes:

> There are always some that won't see themselves as changing, or growing, or adapting at all. That doesn't work very well in teams. ... People who adapt most might be the people who are able to listen ... Change is only possible if there's dialogue among teams so that what is possible, or not possible, is clearly spelled out. And that will probably cut some professionals out. Not necessarily just doctors

> but those people who are not able to recognise that they are finding it harder to change. (Emily, Int. 96, p. 1506)

Change is easier if dialogue is seen as a joint act of knowing. Freire and Shor (1987) define dialogue as "the sealing together of the teacher and the students in the joint act of knowing and re-knowing the object of study" (p. 100). *Grappling with different mind-sets* is very much about trying to understand the wider picture. Bohm (1994) was convinced that some things could not be broken up. False divisions and unifications lead to fragmentation, causing a distorted view of the whole that causes fictional thinking. The cooperative-competitive spirit thrives when colleagues appreciate the need for finding a common ground:

> So, where do we start from when the world views are wide apart? Do we accept the world's really complex out there? What is the common ground in our work? We can't marry the worldviews of the disciplines. There is just no way health and commerce will come together! If you are trying to manage doctors and nurses and physios and OTs and you are coming from management, you look through management's eyes. Don't look through medical eyes, or nursing eyes! So I do think there is a common thing and it depends what the goal is. If you are trying to manage a ward, well where is management sitting there? Which perspectives are useful and which arguments do you value in the group? Do you agree on this approach? Yes, we do! OK! That's how we'll approach it! And there the compromise occurs for the discipline. (Jade, Int. 8, p. 108)

In **pluralistic dialogue** there is always room to agree to disagree, although Zohar (1997) observes that compromise implies powerful interactions that clarify winners and losers when someone is forced to give way to a more powerful colleague. Senge (1990) argues that "dialogue can occur only when a group of people see each other as colleagues in mutual quest for deeper insight and clarity" (p. 245). However, some team members are unwilling to let go personal assumptions in an environment where traditional adversarial interactions have threatened cooperative interactions. Letting go of assumptions is seldom easy, particularly if team members are not used to examining conjectures or working together in a cooperative participatory learning environment. Understanding a specific

disciplinary focus is critical if team members are to listen to alternative world views and consider new ways of thinking.

Negotiating Service Provision

New understandings and meanings emerge as clinicians *negotiate service provision*. That is consistent with Bohm's (1996) idea that resynthesis is a continual movement, backwards and forwards between people, that draws out new content common to everyone. In dialogue, "each person does not attempt to *make common* certain ideas or items of information that are already known to him. Rather, it may be said that the two people are making something *in common,* ie, creating something new together" (p. 2). **Pluralistic dialogue** is dynamic. Meaning constantly changes in formal-informal connections:

> A good team might work completely independently. And in other cases inter-relationships might be intertwined between team members. You have to be able to do the same thing in conjunction with each other. It's almost like a choreographed dance. Everybody has to be doing a similar thing to end up in the same place. (Sophia, Int. 81, p. 1008)

Team action is a blend of formal-informal connections. Talking together casually is critical. So many of the interactions pervading **pluralistic dialogue** centre on solving problems about patients, meeting service needs, when in fact there are no clear-cut solutions. Hewitt (1997) states that talk shapes our view of social order. Team talk, whether it is formal or informal, helps health professionals understand disorder and problematic situations. The formal-informal connections are invaluable as colleagues question inconsistencies, contradictions, and confusions together, as they seek some coherence in an incoherent whole (Bohm, 1994). Mutual role taking and actions clarify social interactions as the team *negotiates service provision*. Negotiation forwards **pluralistic dialogue**. Negotiation helps colleagues "turn aside for each other and to adjust and adapt, which admits that there is some contingency in what they thought was necessary" (p. 70). Yet, this social negotiation between team members is a delicate process:

> A team that works well has a collective responsibility for the patient. I would never talk about anyone else's work. Although I might know what should be done I am not the practitioner registered to give that information. I am very careful there. I have been in the team a long time and I know how far to go and what appropriate dialogue is in relation to patients and our roles. ... I leave the [discussion] to the other professionals but at the same time I have to have a good understanding of what the other team members do and what they might say. But, it's not kosher to say it! (Rhonda, Int. 41, p. 508)

Understanding the roles others take, and what manner of dialogue is acceptable publicly, shapes the formal-informal connections. Although Bohm (1996) questions whether dialogue is possible in bureaucratic organisations where superior-subordinate relationships prevail, in this study, competency, respect and trust forge a team dynamic that includes reciprocal interactions:

> The team is a two-way thing. It's like a jigsaw – a moving jigsaw. It is a moving pattern. And so a new person has got to fit in and the team is a new pattern once they come in. You've got to have that pattern working. It's not just the new person but it is the team as well. And that leaves us free for re-creation. That way everyone gets involved and it builds in itself. ... People can go out from the team as individuals completely and they are entitled to do that. And we are very happy that they do that. They go out in their own right and stand as an individual. Your persona belongs to you but it gives to the team and the team gives back to it. (Alice. Int. 95, p. 1394)

Recognition of the uniqueness of the individual is essential if active engagement in **pluralistic dialogue** is to be possible. Negotiation that moves beyond the persuasion of others to an all-inclusive unitary interaction is important in resynthesis. Negotiation that fosters free discussion guides the spirit of inquiry intrinsic to **pluralistic dialogue.** Freire and Shor (1987) think that communication may transform an individual's reality so that people are "able *to know what we know,* which is something *more* than just knowing" (p. 99). Dialogue supports collective reflection on what is known or not known so that the team can then "act critically to transform reality" (p. 99). As clinicians come to know each other better, collective thought becomes more coherent. Bohm (1996) argues that "thought is actually a subtle tacit process" (p. 14). The process

is shared and is more than explicit communication, as "we have to share our consciousness and to be able to think together, in order to do intelligently whatever is necessary" (p. 15). In this study, that tacit level of thinking and knowing takes place informally. Facilitation is critical:

> A lot of things are done by informal communication on the ward. With a bit of luck that informal communication should occur because people are bumping into one another. But if we are talking of teams relating to each other we need some formal strategies to make sure the communication happens. Some people aren't skilled at imparting information or understanding how it is important. Yet, they know it. ... It's to do with the questions that are asked, the way they are phrased. When you talk about the group responsibility for the team process there are helpful ways of intervening and unhelpful ways of intervening. And things that summarise, or reflect, or check out everything all add value to the process. Black and white statements may be appropriate sometimes but they can also stymie the process so it drops dead. People dry up and withdraw. ... It involves management of the self as well. Not only do you have to be skilled at manipulating and presenting information you also have to have the ability to understand what is happening in the process. And that's getting towards wisdom. Wisdom's the step above, which is having the intuition that, given this complex set of circumstances, what would be a sensible way of dealing with it? And that's based on experience of whether we are likely, or unlikely to make progress by adopting a certain way of doing things. (George, Int. 38, p. 422)

Engaging in the Dialogic Culture

Wisdom moves the formal-informal connections associated with *negotiating service provision* towards the both-and thinking that underpins *engaging in the dialogic culture.* Both-and thinking reflects the ability to think simultaneously in parts and re-look at the whole, that is always much greater than the sum of the parts. Both-and thinking echoes resynthesis.

Clearly, interdisciplinary teams look at the bigger picture. Even though most individuals enter the team with specialist knowledge and expertise, clinicians recognise the need to redefine individual contributions to be consistent with collective action. That is possible, because over time, the team develops a cooperative symbolic interaction (Charon, 1998) typical of *engagement in the dialogic culture.* Again, Freire and Shor (1987) observe

that communicating, knowing, and changing are social processes, which have an individual dimension although the individual outlook does not explain the complete process of knowing. Dialogue thus "seals the relationship between the cognitive subjects, the subjects who know, and those who try to know" (p. 99). In this study, the dialogic culture emerges as a united front, a common front for joint action:

> We have worked quite closely together for a long time. ... We stick up for each other. We are quite loyal. We put up that united front. We all gel together. We have to gel together. If you don't gel you may as well not be there. ... With the united front it's important we are all giving the same messages. (Jan, Int. 14, p. 191)

The united front makes joint action possible. Team gel, the collective mode of thinking, is typical of **pluralistic dialogue**. Those findings are consistent with Blumer's (1969) idea that "too often we fail to recognise that the joint action of the collectivity is an interlinkage of the separate acts of participants" (p. 17). Collective action is the team culture, as, from the symbolic interactionist worldview, culture is a shared perspective (Charon, 1998). Culture helps to create continuity over time and guides the collective action and social interactions to channel collective energy effectively. The dialogic culture is created everyday in shared action:

> That team gel is interesting. We have been to management and team building days away. ... team building is a fallacy! I think you need to get to know each other and get on with each other and understand each other before you can challenge each other and be open with each other for the better. This whole business of going away together and going on hikes together is nonsense! Team building happens as the team works together day by day by day. You can't build a team by going away for two days. You build a team over three hundred and sixty-five days of the year. (Margaret, Int. 21, p. 469)

Building a team and *engaging in the dialogic culture* is an ongoing, dynamic activity. Bohm (1994) observes that dialogue works best in a dialogic seminar of thirty to forty people that represents a microcosm of society. But, in this study, the dialogical group encompasses numerous colleagues, and a changing contingent of patients and relatives. The dialogic culture is an integral part of the everyday reality, and is not fixed in time and space.

Pluralistic dialogue is universal. It is a constantly moving construction that emerges from a resynthesised way of thinking.

In resynthesis, thought is an all-inclusive concept. Bohm (1994) redefines thought as a composite of body, emotion, intellect, reflex and artefact that is integrated into "one unbroken field of mutually informing thought" (p. xi). That way of thinking is quite different to Cartesian either-or thinking that emphasises logic and linearity, cause and effect relationships, and objectivity. Zohar (1997) considers that, in Newtonian-type bureaucracies, a constant unresolvable tension exists between the individual and the group. Acute care hospitals are especially vulnerable as they are driven by dynamic fluctuations of time, change, and movement as very sick people enter for care, recover, and exit as rapidly as possible. Both-and thinking requires team members to reframe their own individual activities in ways that support the actions of others. Dialogue challenges existing patterns of domination (Freire & Shor, 1987). Refusal to acknowledge problems that are culturally embedded blocks the potential for mutual inquiry, and thinking stays static:

> It's about how you create a team and what gives it meaning. A lot is to do with where the ownership lies and whether people are more willing to give things a go or not. Kiwis have more of that English reserve where you say one thing and probably think another! People do think and yet they are running counter to what they probably feel. People really aren't direct when they've got a problem or an issue. It tends to filter back through other people and is addressed in a roundabout way and that I guess lacks honesty. ... If we were being facilitative we could be open and talk honestly. ... There are communication problems everywhere! It might be personality driven but the group wouldn't address the issues at all. ... I guess it's all about developing a culture. When new people come in, can they actually fit in with what's there? (Mark, Int. 48, p. 658)

However, people who do *engage in the dialogic culture* are willing to explore differences with colleagues. Culture is about thinking and agreement connecting actions. It clarifies shared understanding, shared language and knowledge, and the rules that govern action (Charon, 1998). In this study, clinical experts used both-and thinking to look beyond the familiar disciplinary boundaries towards an integrated collective practice. Bohm

(1996) states that resynthesis is more likely when team members listen carefully to others, and reflect on personal barriers that may block collective action:

> Now we work as a group and the consultants are listening and prepared to admit that they don't know what is the best type of treatment for this patient. But perhaps the physio knows? Or, perhaps the OT? Or, perhaps today it's the nurse who's doing the transferring. Ten years ago the House Surgeon would have been doing that ... the complexity and uncertainty of the work are part of the problem. At least people are aware that teamwork is complex but it's not fragile. In the past the team was too fragile for a new grad to give their opinions at a team meeting, whereas now the team is complex but its not fragile. The team is not going to fall apart if someone says something out of place. (Bob, Int. 27, p. 574)

There is collective strength and energy in a team that is *engaged in the dialogic culture*. Acceptance of diversity creates a climate whereby members of the team engage freely in **pluralistic dialogue** that facilitates innovative thinking. Both-and thinking is Zohar's (1997) quantum thinking that "gives us our intuitive, insightful, creative thinking, the kind of thinking with which we challenge our assumptions and change our mental models" (p. 120). When collective thinking emerges, anything is possible:

> Everyone gets involved in the team. And the way the new person sees us all relating – that builds on itself. ... It's role modelling from every single person in the team. It's become a culture and it builds on itself. ... It's our expertise and it's our manner of relating to people. ... It's a very synergistic thing. I would not have the reputation I have without this team. I wouldn't know about a lot of the things I do. It builds on itself – like a snowball! The team keeps on building and we all build on each other. But it is a win-win situation. We are not taking from anyone else in the team. (Alice, Int. 20, p. 724)

The win-win situation typical of the dialogic culture involves a common consciousness. Sharing ideas, opinions, and thoughts without hostility is the crux of resynthesis in **pluralistic dialogue**. Bohm (1996) explains people thinking together as, "somebody would get an idea, somebody else would take it up, somebody else would add to it. The thought would flow, rather than there being a lot of different people, each trying to persuade or convince others" (p. 26). Trust is fundamental to *engagement in the dialogic*

culture, if team members are to turn pluralism into an integrated functioning for the client service. The cyclical process is driven by an interest in the common humanity of others and a genuine concern to cooperate together to meet service needs.

Pluralistic dialogue is fundamental to the culture of care that contains shared meanings. It supports Bohm's (1996) beliefs that, in dialogue, the stream of meaning flows among, between and through people and "is the 'glue' or 'cement' that holds people and societies together" (p. 6). In this study, shared meanings are integrated by *rethinking professional responsibilities* and *reframing team responsibilities.* These processes are very much connected with issues of problem and paradox that are explored in the succeeding chapters.

Implications of Pluralistic Dialogue

Pluralistic dialogue does not evolve in a purist, theoretical sense. Most dialogue is self-activated by highly motivated practitioners who have an ongoing enthusiasm for learning and personal-professional development. The dialogic process is self-imposed and self-generated because individuals appreciate the advantages of an individual-collective responsibility for team action. **Pluralistic dialogue** is very much a responsive process that facilitates collective action and interaction in an acute care environment where time is precious. While **pluralistic dialogue** seemed to be better developed in the three smaller teams in this study Bohm (1996) warns that small groups are accomplished at making "cozy adjustments" (p. 13) whereby people are polite to each other as they avoid dealing with the contentious issues. Bohm (1994) suggests also that dialogue is unlikely to happen if a group does not set out with the deliberate intent of entering into dialogue per se. According to Bohm, dialogue begins better when there is discussion about thinking processes and talk *about* dialogue, as conditioned social responses and reflexive thinking block the openness of thinking required. "If people who have no notion of this whole process of thought and dialogue get together it's possible that they might find a way,

but chances are they would not" (p. 194). The teams studied in this research project were rather different.

The **pluralistic dialogue** generated from the data in this study is possibly tenuous and dependent on particular personalities in a certain context, because it emerged in action and was not dialogue that occurred in a forum separate from the usual actions and social interactions of practical life. Clinicians learned quickly how to share meaning informally as they carried diverse role responsibilities for patients. As they worked closely together they discovered common problems that had no easy answers. Close connections in adversity foster fellowship and mutual participation (Bohm, 1994). Health professionals had to create **pluralistic dialogue** in action because it was well nigh impossible to release complete teams from specialist acute-care areas for weekends of dialogical seminars. Health services are twenty-four hour services that operate seven days of the week. Professional and team responsibilities must be explored and examined in action. There is no other way in the current climate.

Although the explication of the grounded theory contains ideas that vary to some degree when compared to Bohm's (1994, 1996) conceptions of dialogue, it is certainly consistent with McWhinney's (1997) notion of meta-praxis. According to McWhinney, "conflict arises out of attempts to make changes. The resolution of conflict and the resolution of complex issues share the same framework: Both depend on dealing with differences in the image of reality maintained by the various parties to the issue or conflict" (p. 8). Like Bohm, McWhinney agrees that differences in views of reality are deep but, in contrast, he argues that difference is stable, not something to be wrenched out, examined, and changed. Meta-praxis is about the mapping of alternatives because "it is a means of moving out of one's own construction of reality and entering into a dialogue with multiple realities to reframe one's own and others' experience in alternative frameworks" (McWhinney, 1997, p. 8). Therefore, it is concluded that **pluralistic dialogue** emerged from the data in this study but also combines elements of Bohm's dialogue and McWhinney's meta-praxis.

Conclusion

In this chapter the basic core category, **pluralistic dialogue**, has been examined in relation to interdisciplinary team members involved in collective action and thinking. It has been argued that, **pluralistic dialogue** is unique in that it is a particular form of dialogue in action, which is created by clinicians challenged with health restructuring in acute care hospitals. Indeed, dialogue emerged as a fluid, evolutionary process that is time-dependent and affected by the conditions of practice that are constantly changing. Involvement in the basic social structural process of **pluralistic dialogue** was always individual, as people always chose to be involved with others, or not, as the case may be. Successful team practice respected individuality, welcomed it, and moulded it into a collectivity that benefited everyone, clients and colleagues alike. In Chapter Eight the meaning of the theoretical codes, rethinking and reframing, will be explained.

CHAPTER EIGHT

Rethinking and Reframing

Introduction

In any grounded theory study conceptual categories are abstracted to a higher level of conceptualisation by creating theoretical codes. In this chapter the meaning of the two theoretical codes that formulate **pluralistic dialogue,** introduced in Chapter Seven, is presented. These are *rethinking professional responsibility* and *reframing team responsibility*[10]. Whenever any health professional joins a team, joint activities and interactions are fine-tuned so that individual contributions enrich collective action. Distinctive experiences are channelled into a shared sense of direction, as interdisciplinary teamwork develops in action. **Pluralistic dialogue** is the key as informal conversations facilitate changing thought patterns during the rethinking and reframing processes. Overall, learning underpins the processes. Many clinicians may practise new skills, relearn out-of-date skills, and all the while find new ways of interprofessional action and interaction.

Rethinking Professional Responsibility

Rethinking professional responsibility is the process of deconstruction in which health professionals are actively involved in **pluralistic dialogue.** Rethinking absorbs *breaking stereotypical images* and *grappling with different mind-sets.* Those conceptual categories, both processes, explain how health professionals respond to structural reform, as they seek new ways of fulfilling functional responsibilities for professional work.

[10] In this chapter actual findings are presented using the past tense, even though the theoretical dimensions emerged from the data, in active dialogue. The present tense is used in the general discussion.

In the acute care setting the deconstruction process is generally stimulated by a need to solve complex problems. Problem solving is seldom straightforward as the intrinsic simplicity, linearity, and fragmentation of the process is inconsistent with the nature of being a sick person. Contrariness is common when patients are admitted to hospital with acute episodes of chronic illness, or, previously healthy people suffer a sudden, life-threatening event. In this study, most patients entered the specialist services in acute care with medical conditions that were perplexing.

Acute care hospitals divide health-related problems into medical model specialities that support division. When medical problems are broken up into parts the inextricable interconnections typical of crisis or chronic illness are distorted. Bohm (1994) claims that simplistic problem solving is in fact the source of problems. McWhinney (1997) is quite clear that problem formulation is paradoxical when people try to apply convention "accepting the irrationality of using rules and values and data without reference to the realities from which they derive" (p. 81). Equally well, when roles were subdivided into neat and tidy compartments, disciplinary divisions made practical work exceptionally awkward, because few problems had firm, crystal clear boundaries:

> We all felt that nursing and doctoring have had their day. ... Today there is this need to get together in the interdisciplinary format. It is making sure that the discipline is about achievement, not where you came from. To make the best, ultimate team to attack the problem - and we had lots of problems - you have to have a team full of different experiences. We used to define them as previous disciplines. But we couldn't continue that way. You cannot have new teams with singular or unilateral disciplines. (Wayne, Int. 90, p. 1241)

Most interdisciplinary teams are established to manage contradictory challenges in a discontinuous context. Paradox pervades interdisciplinary practice. From the beginning of this study paradox stood out as so often clinicians said one thing and, in the same breath, immediately contradicted the self, and moved simultaneously in a different direction. It was no longer possible to manage services in a way that kept practitioners in rigid, precisely defined role responsibilities. That did not mean doctors became nurses, or physios changed into occupational therapists. What it did mean was that all team members needed a broader understanding of collective

practice as well as a specialist comprehension of professional roles and responsibilities.

Open-minded attitudes assisted clinicians to break through the hierarchical, stereotypical structures that constrain practice. It was especially noticeable that open attitudes fostered inquiry. Interestingly, Schwarz et al. (1994) define open as being "not shut; allowing passage in or out; exposing the interior;" open mind suggests "freedom from prejudice; readiness to receive and consider new ideas" (p. 1183). When experienced clinicians recognised ambiguity and incoherence in practice, many realised that thinking had to change. Zohar (1997) argues that, although meaningful change evolves from rethinking, transformational change requires people to reconstruct thought patterns and emotions that are maintaining existing structures in the first place.

Changing thinking did not happen in a vacuum, but in a rather messy context where *boundaries blurred* when people were *pioneering new structures*. Dissidence and diversity abounded. Clinicians across the teams in this study responded with varying degrees of sensitivity to new ways of seeing and acting in the world:

> It's about people and how they manage change ... they have been exposed to so much change ... it's the face-to-face communication and talking through the issues ... If people's livelihoods are threatened they immediately go into siege mentality without really thinking through that there may be a better way to do things. (Lilly, Int. 4, p. 104)

Fragmented thought is often problematic, especially when we take action in isolation from others and without consideration of the consequences for the whole. Conversely, Bohm (1994) explains that some people have the capacity for a deeper perception, insight, or intelligence that is separate from their basic thinking system. Those abilities enable them to perceive incoherence. What appear to be states of confusion to some are simply stimuli to activate alternative ways of thinking for others. In this study, experienced practitioners in all teams usually thought through alternatives, moving easily across actual and perceived boundaries, activating

contingency plans as required. The ability to work with alternatives was rooted in competency.

Over and over again participants emphasised the crucial need to have colleagues who are competent workers. The emphasis on *confirming competence* suggested that proficiency was never taken for granted in teaching hospitals where most teams have a never-ending stream of team travellers passing through on rotational learning assignments. Although every professional group has particular protocols for checking disciplinary competency, if someone is incompetent every team is expected to cover that person for as long as three or six months. That situation has the potential to place enormous strain on a team that is already operating beyond capacity in an environment where the pace of work is commonly hectic, with little room for additional extras on top of existing pressures. Although part of the problem rests with disciplines stretched to the limit by restructuring, it was also evident that most teams did not usually have anyone to manage such issues. Managing competency was even more complicated when gender issues surfaced:

> I work with men and men being the nature that they are they like to be liked and they like everything to go just fine! They don't like dealing with the hard bits. So we've decided that because I don't offend people I'll take on the hard bits and that's fine by me. ... And the other side of that is that the medical fraternity never picks on their own! They do not! Ever! They might be really angry with each other but they never pick on their own! Nurses have no problem doing that. The registrar might talk to the houseman and the houseman might listen or he might not. Registrars might have a conversation but they will never say, "You were wrong!" (Marilyn, Int. 7, p. 95)

Although some disciplines did not manage competency issues at all across the teams, supposed inadequacy had to be scrutinised carefully as, very often, structural boundaries created an illusion of incompetence that was questionable. Many practitioners recognise collegial connections as human relationships (Curtin, 1995), and set up interactions to promote deconstruction of difficult learning experiences that are turned into positive interactions. Nonetheless, when rational thinking blocked competent actions and **pluralistic dialogue**, individuals resorted to innovative deconstructive thinking:

> The majority of people in this building are patient focused and if you ask them what happened when something went wrong, they will tell you, "I was trying to get to the patient and my locater wouldn't go. The theatre nurse was so bloody rude to me when I wanted to get the patient to theatre that I was powerless! I went down to the Emergency Department and they said, get your patient out of here! They wouldn't let me see the patient and the patient didn't need to be admitted but they wouldn't listen to me. So I ended up having to admit a patient that didn't need to be here and then I had to get the patient out of hospital! I know they shouldn't be here! I know they should be discharged! But the nurse started yelling at me and then the consultant told me to get that patient out of hospital!" So I keep talking and find out what they will do if that happens again. And they will ask you, "What would you do?" I can say how the nurses handle it. ... I will always help people who are here for the patients. ... Most people want to do what's right but they're up against the system. (Marilyn, Int. 7, p. 95)

Although many team members are experienced clinicians, they often work with newer graduates, immersed in learning, who needed assistance in managing the processes of practical life in large city hospitals. Yet, most participants realised that perceived incompetence was unlikely to be caused by a knowledge deficit, for most students enter the clinical setting having passed formal examinations that confirm safety to practice. But, sometimes, competency and *the collegial attitude* became confused, and this was potentially hazardous:

> People have to get on with each other in the team but I don't think it's the most important thing. We had someone here who was sociable – she was friendly and helpful and got on with everyone. But she was the worst nurse in the world! And because some people are so nice and friendly and ready to help you at any time you don't realise how bad they are! They don't know how to do their job. She was incompetent but everybody liked her. ... If you have a very friendly person that you like it is hard to get them out of the team if they are no good. If you don't like someone you are looking at them all the time but if you like them you make excuses like they're having a bad day! We all learn to work at the professional level, to ignore feelings and just talk about the patients or the service. (Margaret, Int. 21, p. 469)

Emphasis on traditional professional attitudes perpetuated stereotypical thinking. *Rethinking professional responsibility* involves the questioning of assumptions, personal prejudices, and value judgments that block dialogical thinking. Bohm (1994) believes that thinking is an

interconnection of neuro-physiological, emotional, and intellectual factors. When objective thinking takes over, and the emotional and intellectual aspects of thinking are ignored, self-deception is possible. Ideally, deconstructive thinking is a group activity, a team process that is often at odds with traditional disciplinary knowledge acquisition, experiential learning, and performance.

Certainly, few participants across the teams discussed deconstructive thinking per se but many demonstrated it in action. In essence, they were all working in what could be best described as an organised disorganisation, in a reality where people spent much of their time responding to interruptions and re-prioritising their work according to almost minute to minute changes. Clinicians were adept at rethinking responses to highly complex circumstances that changed constantly. Those who insisted on maintaining habitual thinking constrained **pluralistic dialogue** in every team. Flexibility of thinking was critical to counteract the limitations of logic, reasoning, and structure:

> So much is about chaos. I've made this rule now but suddenly something else has come along and I've been given the word by someone who is bigger than me that today, we've changed our minds! [Some people] are pedantic black and white thinkers. There is no grey in the world. You can get away with chaos until you come up against the black and white thinker. The black and white view tells her that the beds have been closed, the staff has taken annual leave and she's sticking to her guns! Now there are two patients to come up and we should not be compromising patient care because we won't open the beds. I've rung around the other wards and had a conversation and we think we'll be able to discharge someone else. And those people are patient focused enough to understand that it is a bit grey here but we need to get patients out. Let's not make an issue of it. Let's have a conversation about it and move the others upstairs. The patients keep coming and there's a little group who has collaborated there ... Most people say, "They're patients! Just let them come!" And that's the attitude of most people – they're going to come anyway so let's just get on with it. We are in the business of looking after patients. (Marilyn, Int. 7, p. 86)

As the patients continued to enter hospital, one significant factor that stood out in the teams that were *breaking stereotypical images* was that clinicians were expected to simply get on with it. Organisational input supporting a team-based learning environment was notable for its practical absence. One

team had regular weekly meetings and teaching sessions but teaching was confined to the specifics of specialist knowledge, and did not include any organisational input designed to alter thinking or further the development of collective thought. The organisations had not assessed the pre-existing organisational culture before the introduction of workplace changes. Jones et al. (1997a) argue that the "administration of a baseline multidisciplinary cultural assessment survey prior to any change effort (to evaluate as well as redesign units) is essential to success in any work redesign effort" (p. 73). Understanding the underlying cultural values and beliefs prior to change is especially important if organisations want to grasp why change is ineffectual.

The change process is involved and, more often than not, is based on time-consuming trial and error learning experiences, and associative thinking. According to Zohar (1997), associative thinking helps a person form associations between ideas until regular patterns are recognised and practised. Deeply embedded in emotional and physical experience, learning is essentially experiential. But learning is limited if it is confined to the tacit because the learner may not be able to explain how learning has taken place. Emphasis on feeling and doing skills may not stimulate thinking or the analysis of specific skilled-based experiences. Yet, it is a useful learning strategy, as learners become proficient at managing nuance and ambiguity. Nevertheless, it is slow, inaccurate and habit-bound. Alterations in thinking are implicit, as symbolic actions and interactions are examined.

As participants *grappled with different mind-sets* it was noted that they were struggling with existent thinking that was no longer helpful. Zohar (1997) maintains that deep transformational change is possible only if people literally rewire the brain and grow new neural connections. "That means we must *feel* the old wires being wrenched loose. We must feel in the pits of our stomachs all our old mental associations and their accompanying emotions being brought first to the surface of awareness and then restructured" (p. 3). The depth of feelings that surfaced when *pluralistic world views* were discussed in this study indicated that personal values and beliefs were hard to examine and deconstruct. When world views were beyond comprehension redefinition of the situation was unrealisable:

> I truly had to be a facilitator because where they would move was not the pathway that I would take. It's not just the culture! It's the paradigm of thinking that they work within! They come from a discipline that values a lot of empirical knowledge. There's nothing wrong with that. It's a way. It's a world view. But when you try to mix the disciplines, what does that mean for what we are trying to do? How do you foster what we are trying to achieve together when they don't value what you are doing because what they are valuing is great and they do it individually? They are very, very able people who recognise that there are problems but they are limited by their paradigm. But also, it's very important that they do value that because that's what's valued by their discipline. On a continuum, when I work with them, they're way along the other end from me! They're way out there valuing stuff that's beyond my knowledge. It's so different it can't even be comprehended, let alone be made empirical! (Jade, Int. 8, p. 100)

Recognition that deep-seated values and beliefs beyond the realms of comprehension exist is illustrative of insight into contrasting approaches that influenced *pluralistic world views* and *differentiated commitment*. Many participants appreciated the need for a commitment to the whole that encompassed far-reaching issues that surrounded the client, colleagues and the organisation. Apparently, clinicians realised that individual team members needed others to have a sense of what the whole was really about:

> I think that we do commit ourselves if we are in a team that we have some commitment to. That might not necessarily be the whole team. If the team is lead by a person we don't trust commitment to the goal is not what it could be. We don't take enough notice of that filtering down of high leadership. Although we might have integrity at our level, we question our commitment to the whole at times. When you stand back sometimes and look at what you are doing as an individual in an organisation you question your commitment to it. What am I doing this for? If I have a commitment there I will have an honest rethink and will honestly try to grapple with those conflicts and to move myself ahead professionally. (Kate, Int. 95, p. 1484)

As a result, most of the **pluralistic dialogue** in *rethinking professional responsibilities* and *grappling with different mind-sets* occurred informally, as clinicians *practised a team philosophy* together. Generally, opportunities for philosophical discussion were almost non-existent so differences were explored while clinicians moved about the practice environment. Potential for deconstruction was limited when the pace of practical life was such that,

in-depth discussion was well nigh impossible, and development of a collective philosophy was slow and painstaking:

> I felt quite uncomfortable about this team because I think they were coming from a particular theoretical perspective that I could not value so much as respect. But I felt they weren't opening themselves up to critique or evaluating their own practice or thinking about it in different ways. ... It was a very threatening environment for patients and I felt uncomfortable about that. And the dilemma was – I found it difficult for the patients - but I also realised that if I withdrew myself entirely that I wouldn't be a part of the team any more. So I tried to stay in there, but in a gentle sort of way. The longer I was there the more often I was asked my opinion of things and I could carefully introduce a different perspective on things. (Jane, Int. 9, p. 111)

More often than not changing individual philosophical perspectives were stimulated via post-graduate education. Although many participants appreciated the need for ongoing learning, many remained isolated from team learning opportunities. That was unfortunate as Zohar (1997) argues that "the self thrown back entirely on itself, with nothing but itself as a source of meaning, truth, and value, has no nourishment on which to draw" (p. 158). Nevertheless, experienced, confident people encouraged colleagues to learn informally in *collective practice* where opportunities for collaboration and cooperation were generated in action. Paradoxically, collective exploration of issues was constrained by time, although potential insights associated with **pluralistic dialogue** were revealed over time. If team learning was slow, so was team development. Everyone needed opportunities to question each other, to examine existing assumptions, to explore possibilities, to move beyond associative thinking into the realms of quantum thinking. Movement into a new paradigm of thinking depended on team members' willingness to raise issues and conflicts as they explored the customary ways of looking at the world. Awareness increased when various points of view were considered. Although thinking was loosened up, and unlocked when controversies and meanings were uncovered, behaviour did not always change. Changing behaviour was an interactional process that evolved as members of the team *reframed team responsibilities*.

Reframing Team Responsibility

Team responsibilities are constantly changing in a context where increased throughput and efficiency are expected to enhance organisational function. Mostly, people understand situations partially. Yet, when they are trying to unravel complexity, a broad, holistic understanding of varied approaches goes some way to weaving new expressions. This demands a framing and reframing process so that complex realities can be understood from a multiplicity of perspectives.

Reframing is one way that health professionals make sense of a world in the throes of social transformatory change. It is an ongoing social process that enables clinicians to redefine values about an unfolding reality so new strategies to achieve constructive outcomes for the client can be created. Reframing is intrinsic to **pluralistic dialogue.** Like the rethinking process, it is also an active learning process that drives, and is driven by **pluralistic dialogue**. As a process, reframing embraces *negotiating service provision* and *engaging in the dialogic culture.* Throughout, thinking expands, and indeed changes, as new solutions are devised in action, and resynthesised into shared understandings with colleagues.

Amidst change, people redefine situations so that mutual expectations are clarified, and conduct reorganised (Hewitt, 1997). Professional health practitioners are trained to understand and control change. They are prepared to act and coordinate activities with others so that client care is optimised. But, "human conduct is always situated. Our acts, along with the expectations and interpretations on which they are based, are rooted in our cognition of the situations of which we are a part" (p. 56). Because situations convey meaning, practice is mostly reframed in action, as clinicians are responsive to the collective actions of team members.

Reframing often diffuses disciplinary influence and control. In this study reframing was evident in relation to *continuous information coordination.* Tracking patients through the organisation revealed many different issues that had to be redefined, and reframed, if joint actions and interactions were to be coordinated for the common purpose.

McWhinney (1997) argues that difference demands reframing, or "changing the apparent rules of the game in such a way that both (all) contending positions are included within the accepted whole" (p. 170). Resolution of difference necessitates negotiation that Bohm (1996) interprets as a beginning stage of dialogue. "Negotiation is trading off, adjusting to each other" (p. 18). It is an invaluable part of the dialogue process. In this study, when people had very different viewpoints, talking had to begin somewhere:

> If you are going to challenge you have to do your homework. Nobody listens to you if you say, "Well, I don't agree with that!" You have got to be able to articulate why something is unacceptable and for what reasons. You have to identify the effects of those decisions and why they are unacceptable. You also need to have some beginning evidence of problem solving – providing alternatives. So if you are looking at the team and challenge you really have to sort out who thinks like you do and what you can do to understand the external factors. That is being politicised and looking at what might influence a decision. You can't say, "We don't like it and we're not going to do it!" You end up with a no-win situation and you have to do it anyway. So how feasible is your idea for a solution? It takes commitment to try to work on a solution, to find out who's making the decision. Where does the power lie? What are the lines of communication and where does the responsibility lie? And how are the patient's needs being met? You have to be adaptable to be able to work with that change. (Diane, Int. 11, p. 150)

The large ward team *negotiated service provision* generally in team meetings. Individual differences were not discussed in depth but put aside and raised again informally as clinicians moved about the ward. *Continuous information coordination* was time- and person-dependent. Across the study, participants either spoke in glowing terms about sharing information with others or, they expressed enormous frustration about the barriers that besieged the process. Information was not always easily accessible. Although individuals exchanged information unceremoniously, collective participation was frequently blocked because too many health professionals mismanaged information exchange. Information was poorly coordinated. Individual attempts to reframe, to dissolve issues, caused enormous frustration when collective opinions were offered without thinking. When **pluralistic dialogue** was completely unrestrained resynthesis was impossible:

> The best example of information exchange was when I tried to organise a CPR lecture last year. I tried to find information on somebody who could come in and give us a lecture. I rang a circle of people that became continuous because finally, I got back to the same person in the end. And in the end, people started ringing me, and saying, 'I understand you're running a CPR course'. And so I got onto this wretched circle! That really told me that this place is too big, and nobody was responsible, and then I joined the circle! I had people from downstairs ringing me up very angry because I had not invited them to the CPR course that I was running! "Why hadn't I thought of them?' I just couldn't believe it, especially when people rang me up and abused me because I hadn't invited them. Information is a huge issue. All information, any information - trying to get statistical data, trying to get information services to get information, is a real problem! (Caroline, Int. 92, p. 1125)

Although anomalies in information exchange were accounted for in various ways, reliance on informal information flow usually kept the channels of **pluralistic dialogue** open. While many individuals made sincere efforts to keep in contact with colleagues, poor co-ordination emphasised an underlying uneasiness that was further perpetuated by *business-humanitarian clashes*. Almost all participants reported that the economic scarcity argument was irreconcilable with symbolic, historic humanitarian interests. McWhinney (1997) contends that the central emphasis on economic cost and rationalism highlights differences that tend to become exaggerated if thinking narrows. When thinking is polarised people have time to refine the conceptual boundaries, to redefine situations, to continue the dialogic process, despite misgivings:

> We are being driven to find efficiencies and productivity that feeds the reduction of resources. To some extent our productivity is the ability to do more patients but the equation is whack out of balance! Somebody's productivity is working an extra three or four hours and also doing more within their normal hours of work. But that is predicated on the basis that the staff want to go with you. And in the health industry we have the luxury of staff wanting to go with management because they are there on behalf of the patients. And after several years, that's wearing thin. It's fine when resources are constrained and that is productive. But what happens when there's a problem or a crisis? We've moved from patient-focused care to patient-focused everything - management, support, structure, everything! That is the pivot of all this! The patient is the centre of our attentions. We think our product – the patient – is a very nice product. But there's this *indecent haste! It's not like a factory! You can't just crank the conveyor-belt up!* Its people who are getting faster and better motivated. (Wayne, Int. 4, p. 52)

Although reframing has the potential to dissolve issues so that they fade away, looking at the world through an altered lens does not actually remove previously defined situations. While some team members may have altered perceptions, others insisted on labelling alternative ways of looking at concerns as deceptions. Negative thinking was unconstructive because, if differences were denied, "once on the path to opposition, it is difficult to backtrack" (McWhinney, 1997, p. 173).

In this study, reframing remained a constructive process if team members defined it as a positive learning process. Handy (1990) believes that "reframing is the ability to see things, problems, situations, or people in other ways, to look at them sideways, or upside-down; to put them in another perspective or another context; to think of them as opportunities not problems, as hiccups rather than disasters" (p. 65). Akin to lateral thinking, reframing releases people from their usual ways of looking at the world:

> Reframing is learning about the people in the team, and how you fit within that team. ... It changes in teams. I think the teams that are the most rewarding for people are not always the teams in which they are being heard. It can be quite different. It can be a team, which you are absorbing and spinning off a person. (Kate, Int. 95, p. 1630)

Evidently, spinning in different directions facilitated a flexibility of thought that enhanced collective thinking and *deciding together*. Charon (1998) claims that informal social interaction encourages a shared view of reality that influences definitions, decision making, and the general direction of action. Even though shared thinking fosters progression towards a common goal, decision making is optimised when people acknowledge pluralistic thinking. In this study the quality of decision-making depended on the size of the team and the subsequent depth and scope of discussion. Dialogue tended to be more limited in the large ward team that had many more patients and minimal time for discussion. *Deciding together* required the reframing of situations that included wider contextual determinants:

> Functioning is getting the thinking of the various professions so that they are not just dealing with one technique or one aspect of care. It's actually transferring some of the decision-making responsibility over to the patient in their situation rather than it being the hospital's exclusive domain to deal with problems. Patients live in the community and the hospital episode is an interim period. We need to change people's thinking around, rather than professionals thinking about their specialist role. We must think about alternatives and what care means for the patient rather than what it means for me as the clinician. (Laura, Int. 55, p. 703)

Some teams always included patients in the decision making process while others did not. Despite processes differing, all decisions had to be justified rationally. Flexibility entered the equation only if resources were freely available. Yet, every individual had the opportunity to influence the process:

> People bring their usual way of doing things with them. ... How that re-frames happens in two ways ... Some people kind of suss out the team situation and adapt. Whether they are aware consciously or not they just sort of think, "Oh! So this is how it works!" It happens easily. Some people automatically are good at that. And some people find it more difficult. (Emily, Int. 92, p.1515)

Those who struggled to address difficulties may have been thinking differently. Bohm (1994) believes that, although people understand the necessity for sharing meaning, sometimes they simply cannot change their thinking. **Pluralistic dialogue** cannot be forced any more than reframing can. As social processes, each evolves from interactions with others. Joint actions and interactions have the potential to emphasise the need for collective thought although the realisation underpinning *collective accountability* is more difficult. As a result, shared understanding of the meaning of collective accountability varied according to a series of complex circumstances:

> We are in a world that is trying to reduce uncertainty or unexpected outcomes. You have to respond quickly to someone with chronic care needs, within a given time frame, across a diverse group of health care professionals. There are times when you accept responsibility for doing something that would normally be within the boundaries of someone else. You do that and you don't feel that you are stepping over boundaries. There is mutuality in those teams. And reviewing is an ongoing process. You are running with a hundred different things at once so it's that checking, coming back to base, checking out, being sure of yourself, and what you need to do. You need to know

> what other people must do and how you will connect in constant change and guaranteed uncertainty. (Louise, Int. 59, p. 877)

The extent of *collective accountability* was questionable in some teams in this study. Generally, the small teams were doing it well but accountability in the two ward teams was hazy, managed more by the goodwill of individuals than by the mutual efforts of the group. Abdication of collective responsibility was clearly evident when team size increased to such an extent that sheer size fostered anonymity. Katzenbach and Smith (1993) argue that "no group ever becomes a team until it can hold itself accountable as a team" (p. 60). Similarly, Ovretveit (1993) reports that professional responsibilities are more likely to govern client management over and above "the team's collective responsibility to serve a population" (p. 87). *Collective accountability* was undoubtedly complicated:

> The team dynamic will never succeed unless people are empowered. ... If you don't give them the power the team dynamic will simply be an insular one. If they are truly charged with the outcome for all those patients, they may change the type of service, they may change the level of need. So the collective responsibility is grown, rather than given. What you do is give the collective accountability and be serious about it. "What am I up for?" Sit down and discuss it. "How would I do that? I don't even know how to add up a budget!" "OK. Here's finance, now negotiate some expertise!" "I don't know anything about drugs!" "Here's the pharmacist. Negotiate some pharmacy. Listen to the options." The team has enough brains and enough strategic mass to come together with their disciplines and listen. And we grow together. Let's sit down and discuss it. Life is about empowerment but life is also about risk. I'm charging you in the future with accountability. At the moment the CEO is accountable and always will be for the mass, the whole organisation. It's his call as to how much goes in to the extent that you mature, that you are willing to take accountability with the appropriate responsibility. And the team must demonstrate that they understand the budgets and that they can deal in an interpersonal sense with the heads of departments, and come up with a compromise. If you can do that, can prove that, you can have the lot! But remember - the day you take it over is the day that I'm coming looking for you! Because I have the collective responsibility of the whole group and if I see you didn't even add up your budgets right or didn't even bother to talk to the pharmacist because you don't like him – that's the day I'll be there! The team has to demonstrate they have the capacity to push on and negotiate in a good spirit. (Wayne, Int. 90, p. 1253)

While a willingness to negotiate is important, any bargaining process implies disagreement and compromise. Although dissension is inherent in the rethinking process, in resynthesised thinking, the spirit of negotiation must be reframed in collective inquiry, as teams look at the whole, weaving interconnections into a flow of team meaning. Reframing is subtle as shared meaning unfolds when understandings and values are redefined in keeping with the common purpose. In this study collective thinking was possible when conditions of *interprofessional safety* existed, once the team was *engaging in the dialogic culture.* Then, individuals were free to examine common values and consider how the self was situated with others seeking shared meaning:

> It's getting to know them. Getting to know some of their values and some of their ways of thinking, ways of dealing with things. You get to know a little bit more about them and that opens up trust. ... So as you work together, the more you see them dealing with your patients - the trust develops with them. ... It's mainly to do with their attitude toward the patients. Respecting their privacy and dignity. ... I found out quite quickly that I could trust the other nurses. And I got to know them quite quickly because I was working closely with them - more than the rest of the team. So I felt safe asking them questions so they would point things out to me. I could trust them to ask questions. (Betty, Int. 81, p. 950)

Trust nurtured engagement, nourishing a sense of belonging. Sharing honestly went some way to create what Hunter, Bailey and Taylor (1997) call "a conscious, collective mindfulness" (p. 133). *Interprofessional safety* was forged over time. The intensity of professional work means health professionals are accustomed to forming intimate, trusting relationships with strangers very quickly, but safe interactions with colleagues are created gradually. However, team leaders may be influential as they are well positioned to foster a cooperative communication climate (Barczak, 1996).

In this study *pluralistic leadership* was important because, in pluralism, power is distributed. A shared sense of leadership provided a forum for individual clinicians to advise and direct colleagues according to their expertise in particular client care situations. Leaders and followers were integrated, as diverse clinical responsibilities altered the leadership position according to the needs of the client service. While the official team leader ran the team meetings, in most teams that person moved into a supporting

role when a colleague's expertise and knowledge were required to enhance client management. Indeed, difference and diversity were celebrated in teams that were flourishing. However, the most successful teams also had a recognised higher-level leader who was the team visionary and the contact with the external organisation. These people stood out because they facilitated a safe dialogical culture where everyone was encouraged to voice contributions:

> But they are heard. It gets back to feeling valued. Even if you're not agreed with, someone's listened to you so they value what you have to say. It doesn't mean to say that they will entirely accept it and the world will change overnight as a result. (Diane, Int. 11, p. 149)

When thought flowed freely, people *engaged in the dialogic culture* while they were thinking together. That supported the notion that meaning is not static (Bohm, 1994). Collective inquiry drives the joint action of the collectivity that is an interlinking of the separate acts of each person (Blumer, 1969). Blumer believes people "share common and pre-established meanings of what is expected in the action of the participants, and accordingly each participant is able to guide his own behaviour by such meaning" (p. 17). Shared meaning thus holds a group together. Ellinor and Gerard (1998) think that the shared meaning that arises from collective thinking precedes and leads to all action. Clearly, reframing is a mutually interactive process:

> That's where the reframing comes in. You are confronted in your everyday work, with a plan of innovation and change which is essential to be enacted, to allow progress to be made. You are working with staff who don't want to have anything to do with this, as it is too hard ... too difficult ... and too confronting for them. For me, the reframing comes in here. You have to assess just exactly what you think the group will tolerate and how quickly one might be able to push them. It is a question of experience as to what to do next. If you think the group may be able to cope with a bit of push, then you go for this and work with the manager of the area, emphasising the need for change more rapidly than planned. Sometimes you have to be provocative to jolt the group into change and upset their complacency. This can be painful for the group and doesn't earn you any brownie points for popularity. However, one is not in the management game for popularity, but for results for the greater good of the organisation as a whole. (Lilly, Int. 4, p. 296)

In many ways leaders may display multiframe thinking (Bolman & Deal, 1997) that represents a commitment to the paradox of durable values and elastic strategies. According to Bolman and Deal, that multiframe thinking is valuable because it frees leaders to draw on different logic, according to changing frames of reference. Certainly, that was noticeable amongst the visionary leaders, but was less obvious in the clinical leadership of clients. It was evident that the clinical leaders tended to focus on specific detail in relation to the client at the expense of organisational responsibility.

Furthermore, even though all the teams had formally acknowledged leaders, some interdisciplinary teams, especially the large ward team, appeared to be poorly managed. Participants reported this as a significant issue. While two of the small teams had a clinical coordinator, sometimes that role was a de facto leadership role, in that highly experienced staff were clinical managers, although they were not overtly acknowledged as such.

Interdisciplinary teams are more effective when they are well managed. However, Hunter et al. (1997) believe that teams can manage themselves and that it is much more important for people to understand management processes than have a specific manager. The organisational focus on health management was gradually filtering through into the clinical services in this study:

> These teams just happen. There is no direction. People might take offence at that. But in terms of a managerial direction there is none. When a difficult issue arises - like 'the difficult family' - who takes responsibility for getting things to move? So, when push comes to shove, is it the doctors who stamp their feet? Or, is it the charge nurses? Every situation is different. (George, Int. 62, p. 928)

It was noticeable that in the rapidly changing context a team manager was well positioned to promote unity. While clinical leadership was fluid in day-to-day case management, clear management was essential to ensure individual strengths continued to be used collectively and effectively. Organisation of the processes was the key when the interplay between role making and role taking was delicate, since team members were likely to be redefining disciplinary power issues and forging cooperative social interactions. Differences had to be addressed if full *engagement in the*

dialogic culture was desired. Right across this study it was plain that participants were accomplished at *tolerating personality differences*. However, tolerance and denial were closely intertwined. There was little evidence of people trying to work through individual personality differences that blocked effective team function:

> Everybody is important! But I can't do what the others do and I don't want to do it either! So why can't I be satisfied with what I've got? But in some areas people are not satisfied with what they've got because actually they don't like the person or they thought they should be the person-in-charge or they were superseded. Or, it was their idea to do this and somebody else took it over so they are unsure of where they sit themselves. So rather than admit that, they throw out all these negative vibrations. Because they have been undervalued for years they haven't understood that the value has shifted somewhat. They're playing that "I'm not valued role" when in fact they are. I know I am valued. If I felt I was not I would make sure my contribution was valuable so I will be. (Marilyn, Int. 7, p. 298)

Indeed, the dialogic culture improves when colleagues put aside self-interests. Hewitt (1997) argues that examination of the self and the situation from another's perspective is critical to understanding how individuals engage in role making because, in routine situations, attitudes influence interpretations and behaviour. Ellinor and Gerard (1998) note that, while differences may cause conflict, they also add zest, renewing collective energy and spirit. Many people "equate belonging and peace with being alike" (p. 146). In this study, health professionals tolerated much. Differences usually related to styles of communication that were accepted as long as the person was a competent clinician. What was more difficult to endure was the dysfunctional personality.

Experts at managing dysfunctional clients and families, team members described graphically the sheer frustration of working alongside those who were seen as being destructive. Some team members apparently had life circumstances that were challenging, insolvable, and ongoing. Personal and professional lives are inevitably intertwined, so it was not particularly unusual for a team member to express personal anxieties in their work roles, in order to seek some fulfilment of affective needs. This affected social relationships, and how that person acted, and interacted with others. Indeed, people understood and tolerated human experiences and recognised

the wholeness of each person. While many participants acknowledged human frailty and were tolerant of difference, they also recognised the need to support each other discretely. Constructive interactions may be necessary to challenge a colleague who is seemingly unable to change their behaviour:

> When there is a tension in the group because of the behaviour of one or more members, there is a temptation for others to focus on that behaviour and to demand it change. But when a disturbed person is focused upon, he or she becomes fixed in that behavioural pattern, becomes locked into a role, and remains alienated from the group. Things usually work out better if the group can learn to communicate indirectly, can learn just to be together, without focusing on any one member. Then a sense of their group cohesion usually re-emerges. (Zohar & Marshall, 1994, p. 116)

In contrast, some teams ignored differences by accepting diversity, whereby they established a *sense of community* that supported colleagues to develop in ways well beyond any imagination. Here, individual-collective efforts were transformed. Simply being a member of some teams facilitated personal-professional growth and the development of unrealised potential. When people really *engaged in the dialogic culture* they were responsible to each other, and for each other. Team interaction was a learning process that promoted collective mindfulness and transformation:

> We weren't the best when we came to the team. I wasn't the best when I came to the team but because of the team, I am the best. Because of my colleagues I have become my knowledge base and because of the facilities I have been given - to go overseas and learn – my knowledge base is so great I consider myself to be one of the best therapists in the country. Not *the* best, as in the most brilliant, but the best with the broadest knowledge base because I have had access to learning. Not because I'm a marvellous person – you mustn't think that! My access to learning has been so great. The team develops you as a person and allows you to become part of that superb team.... And [the consultant] is a good consultant because she listens. So if you look at [another speciality] they lack as consultants because they do not listen to the other professionals. They see themselves as brilliant. They don't need help from anybody else! But because everybody in this team listens to everybody else and accepts advice from other people it makes them more able to learn and therefore gives them more knowledge. So it makes them a better professional. When I moved here I wasn't a great therapist. Certainly – I was fine. Here, the other members of the team have given me power. I am still the same Sarah average. But I've had much more access to people who are prepared to teach. (Sarah, Int. 18, p. 266)

Two of the small teams certainly turned the dream of transforming professional practice into reality. These teams encouraged a participatory learning environment that was catalytic in creating new ways of thinking, new realities for practice. They had learned how to read the changing reality and change practice together. Social and cultural transformation embodied the full appreciation of others as human beings, who had much to offer, and were willing to give of themselves to foster the interests of others, to forge new expressions.

Conclusion

In this chapter the theoretical processes *rethinking professional responsibility* and *reframing team responsibility* have been analysed. The rethinking process was quite individual as people explored their usual ways of looking at the world. The reframing process in contrast, required collective examination. Effort was needed from everyone if the team was to develop collective inquiry to optimise team effectiveness and input for meeting service needs. Significant variables that influenced team performance were confirming competency, pluralistic world views, information exchange, tolerating personality differences, and, pluralistic leadership. These variables will be discussed with others in the coming chapters.

CHAPTER NINE

Breaking Stereotypical Images

Introduction

In this grounded theory study, *breaking stereotypical images* is one of the four conceptual categories that emerged from the data. This particular pattern of behaviour was noted in the four teams as clinicians integrated their responsibilities for meeting service needs with those of the other professional groups. Cultural stereotypes pervade role socialisation and interprofessional interactions in the health professions, and traditionally, these have blocked the full expression of difference between colleagues. As a social process, *breaking stereotypical images* explains, in part, what prompts clinicians to think differently about their collegial interactions and how they come to *rethink professional responsibility*. Rethinking is a theoretical code that complements the second theoretical code, *reframing team responsibility,* and makes up the basic core category of **pluralistic dialogue.** Table 4 situates *breaking stereotypical images* within the overall grounded theory.

Table 4

The Location of Breaking Stereotypical Images within the Theory of Pluralistic Dialogue

PLURALISTIC DIALOGUE	
Rethinking Professional Responsibility	Breaking Stereotypical Images
	Grappling with Different Mind-Sets
Reframing Team Responsibility	Negotiating Service Provision
	Engaging in the Dialogic Culture

Rethinking involves questioning the traditional assumptions, breaking long-established habits, and questioning the well-accepted world views. As team members take on newly established role responsibilities they must also learn to integrate their individual responsibility with the collective requirements of the team. Many redefine situations in order to change conventional conceptions of practice and find new ways of working together. Original thinking is critical to the process if clinicians are to cope with the complexity and uncertainty typical of collective practice that involves the discovery of new attitudes and behavioural patterns.

In this chapter it is argued that when health professionals work in an interdisciplinary team, boundaries blur as they are *breaking stereotypical images* in a context that is pioneering new structures. Clinicians handle uncertainty and change by confirming competence. As a result the collegial attitude is established within the team (See Table 5). The meaning of these categories follows. Although these are analysed in a linear fashion, in fact many occur as mutually influential aspects of practical life.

Table 5

The Properties of Breaking Stereotypical Images

Breaking Stereotypical Images

Coding Family	**Properties of Category**	**Indicators**
Causal Conditions	Blurred boundaries	Certain-uncertain expectations, role understanding, disciplinary knowledge
Context	Pioneering new structures	Opportunities, enthusiasm, new positions
Action/ Interactional Strategy	Confirming competence	Performance, reliability, confidence, credibility
Consequences	The collegial attitude	Equality, hierarchy/non-hierarchy, respect, expertise, skill

Blurred Boundaries

As health services are restructured, the boundaries of practice are blurring, and health professionals are *breaking stereotypical images*. Boundaries of practice fluctuate, often becoming unclear, in a constantly changing context. Boundaries are perceptions (Hirschhorn & Gilmore, 1992). Hospital culture is shaped by a history that has a significant influence on contemporary thoughts and practice. Historically, familiar professional boundaries promoted common hierarchical behaviours that maintained stability. Presently, boundaries are often perceived as barriers. They block creativity and versatility, promoting compliance and complacency in a way that restricts initiative and innovative thinking.

Boundaries may limit practitioners' abilities to discard comfortable but outdated divisions as team members *rethink professional responsibilities*. Indeed, Morgan (1997) claims that understanding how boundaries blur requires a very different way of thinking in institutions where fluid processes demand the management of contradictions and tensions. Sorrells-Jones (1997) reports, nonetheless, that the notion of the organisation without boundaries is also likely to cause conflict and confusion, as responsibilities overlap and become increasingly ambiguous to employees and managers already grappling with uncertainty and change.

The term blurred boundaries explains the causal conditions that influence *breaking stereotypical images*. The main indicators for this conceptual category are certain-uncertain expectations[11]. Role understanding and disciplinary knowledge are the intervening conditions that facilitate or constrain actions and interactions among team members.

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[11] The term certain-uncertain expectations, is the researcher's interpretation of data. Participants discussed expectations that were both certain and uncertain, at one and the same time. The concepts have been combined to deliberately include the paradox that is implicit in the descriptions and in order to convey the constantly changing nature of a highly complex context.

Most individuals enter a team with expectations about their professional work. But, when a new team is formed, or strangers enter a group, members may be unsure where boundaries begin or end. Signals from colleagues indicate explicit expectations. In this study, **pluralistic dialogue** helps clinicians identify shared role responsibilities:

> It means all parties being quite clear around what the boundaries of their personal, absolute responsibility is. ... When you talk about shared responsibility it still has areas of defining where the boundary is. ... There is a collective responsibility to address the issue if things aren't going OK. So if I think about the team that I work in - there would be expectations of each of us individually. But if there was a problem there would be a shared expectation that the team would combine to find a solution or to trouble shoot it or something like that. But, I still think there has to be some idea of what each person does and what each team member can rely on the other people to do. (Emily, Int. 93, p. 1498)

Manion et al. (1996) support that stance, claiming that self-directed work teams expect boundary control to assist a team to define its work, skills, competencies, and decision-making domains. Tsoukas (1994) suggests that uncertainty might be clarified by collecting more facts, but ambiguity is not so simple. In this study, understanding the practical work of others was a challenge when explicit guidelines for team functioning in an equivocal environment were unclear. While that might be so, clearly, changing perceptions influence thinking as clinicians interpret situations in light of new experiences. Nevertheless, clinicians are continually plagued by the paradoxical, indeterminate nature of practical life that is simultaneously known, yet unknown:

> I'm not sure if it became clearer or not. We were all doing completely new jobs - there were no guidelines, no boundaries. We could just fit into the system to achieve what we wanted to ... I'm not sure you can have boundaries because every patient is different and has got different things that need to be sorted for them. So you can't afford to have rigid "this is what's going to happen in this situation" because it doesn't work like that. ... Everyone is different and has different problems. (Richard, Int. 13, p. 183)

Difference defies rigidity and structure. Indeed, Senge (1990) suggests that "nothing undermines openness more surely than certainty" (p. 281).

Boundaries cannot be clear-cut in such conditions. Conversely, when boundaries are pushed beyond the limits of what is acceptable to one or more team members, perhaps by newcomers, uncertainty may block collective action and interaction.

It was evident that, although new teams were less affected, the long-established work groups very often took a relatively silent stance as they challenged newcomers surreptitiously. If an outsider unwittingly stepped across sanctioned boundaries the critical eye of colleagues was certainly felt initially:

> With the boundaries, you go in there with a particular view and go to put that approach into practice but then you start to pull back when you realise that the boundaries are there and they're pushing in on you. ... it's a matter of re-negotiating those boundaries - you are weaving, expanding, broadening the boundaries. ... And then you are challenged a bit - usually in a subversive way rather than an overt, open way. So you might pull back a bit, and then gradually expand. ... I would try and get into some sort of conversation with the people I was getting these responses from to try and uncover a bit more of what they were thinking. And then I would try and introduce a bit more of my perspective as well, and my rationale for that approach. The boundary would then be left and then it would expand a bit. So it was like moving boundaries in and out ... balancing ... expanding the boundaries, but not upsetting team members. (Jane, Int. 9, p. 98)

As stereotypical images are broken and thinking deconstructed, team members sometimes feel anxious and upset. But, recognition of unfolding interconnections amidst professional work is vital to stimulate different patterns of thinking:

> This is the first team that I've worked in where the boundaries are blurred and there isn't fighting about it. It is just exceptional... quite astonishing really! I have had plenty of experience working in multi-disciplinary teams of different disciplines. And there have always been issues. ... In part it is just the simple logistics of sharing an office. Some of it is as simple as that. People hear each other talking about issues and realise that the person does actually know about such and such ... The facilities are very close so it is easy to have joint treatments. The team can discuss their patients really easily because they are right there. (Caroline, Int. 92, p. 1155)

Dynamic interactions are fundamental to *breaking stereotypical images*, as familiar assumptions are laid open to scrutiny. When quality care is the goal, and all efforts are being made to streamline and improve care, patients require access to broad expertise across disciplines. As blurred boundaries evolve practice becomes flexible and fluid:

> If they're experienced people within the team they will not necessarily overtly change their roles but boundaries shift. And that's what makes that team responsive and reflexive to an immediate or predicting need. Things happen and it only requires looking at someone to let them know that you are moving in this direction, or that direction, to respond. ... Roles are not fixed. They're fluid. That's the essence of the team. Of course every situation, wherever it is, is unique. The person that is highly valuable is the person who has that broadness to their approach. It is the person that can meet other people's identified needs within their role. (Louise, Int. 10, p. 313)

Successful teams stood out for their readiness to work amidst blurred boundaries, to expand roles and learning situations to the utmost. Individual responses were melded with the common purpose. Some people found this hard to do. More used to responding to bureaucratic control, they became alarmed and anxious when expectations altered. Perhaps it is inevitable that some clinicians are uncomfortable, indeed unhappy, when new inspirations, or even hypothetical possibilities, are being sought:

> When I look at a particular group I am always worried about their credibility because they're not experienced enough. ... they focus on the tiny things, not the wider picture. We've got to look at the whole, focus on the common good of the entire centre. They will only look at their narrow little bit and won't look outside the boundary. It's the boundary jumping they won't do. ... Some people are very parochial; they don't want to share within their team. They sort of clutch stuff to their breasts and are a bit secretive. ... Change is all about new ideas and a willingness not to say it can't be done. ... And I have said to people "I don't want to be told it can't be done. I want you to leap outside the boundaries and tell me how you can do it! And don't be constrained! Don't think of the rules and the regulations!" ... Some people can't manage that. They find that very, very difficult. And that's about working in ways we have never dreamed of. (Lilly, Int. 84, p. 1206)

Unable to deal with the abstract, and incapable of envisioning a future that may not be reduced to absolutes, these team members were loath to step

beyond the familiar safety zones of their practice. Hammer (1996) reports that, once organisational boundaries become more flexible, neat cognitive distinctions crumble as the old clear-cut borders disappear. Parker (1998) observes that some people think that giving up the tried and true is more like a nightmare than an exciting adventure. In this study team members who happily *break stereotypical images* were able to think beyond habitual realities:

> I think one of the main things in the changes has to be that this team has jumped our boundaries. We're now working with groups, which are not the traditional disciplinary groups. We're working in different ways but there's a much closer interaction between each other. ... There's greater depth of knowledge in the teams so they've gained knowledge along the way and they can understand what's going on. We are broadening the boundaries, managing wider types of groups. (Lilly, Int. 86, p. 1385)

Although most leaders in the study welcomed the management of wider groups, some team members regarded blurred boundaries as a threat. Underlying this may be a partial reluctance to comment on how other disciplines act and interact. Rather than be put in that position, these people were adept at avoiding controversial issues altogether.

Hirschhorn and Gilmore (1992) interpret disagreement signals as a team approaching a boundary requiring management. When tasks and roles change, clashes of values, beliefs and opinion are inevitable. Trained to help others, health professionals are practised at smoothing over dissonance, skilled at steering clear of unmanageable problems with patients. Many were less comfortable when handling collegial disagreements that likely took valuable time to sort out:

> The expectations you have of each other - you don't have to say anything. I suppose none of us in health do that. ... Health breeds that sort of person. ... Conflict is avoided at all costs! It's not until you know you are safe to challenge somebody, and you know that they're not going to not speak to you for the next year because you've upset them, that you can actually do it. ... Where [teams] aren't united, where they aren't together and things are just sailing along – nothing's happening! Nobody's developing! We haven't got time to fight! We haven't got time to unite! (Margaret, Int. 54, p. 758)

Time to discuss change is always at a premium. Change also creates room for movement when the organisational structures are becoming different. Blurred boundaries need not be regarded as confrontations to be stamped out but become opportunities for practising differently. When boundaries blurred coalitions were pivotal:

> Now if they're going to work with other professionals you have to know what their expectations are. And they have to hear what our expectations are. And, is each person getting what he or she wants? ... It's the client who is in the middle of this all! And if you can clearly accept that some needs would be better met by this person or that person. ... So you have to keep the client as the focus because that's the only reason we ever get together. (Diane, Int. 11, p. 147)

As organisational boundaries disappeared, the ability to respond pro-actively to meeting service needs pervaded team interactions, and collaboration developed into a genuinely achievable goal. In this sense boundaries blurred, subtly and indistinctly, as knowledge and skill were shared as well:

> Boundaries are blurring. ... Some things seem to have become physio things and some things are OT things. And it's the same with nursing. But I think a lot of the things don't necessarily have to be physio things. Like the walking. To me it's not just a physio thing. It's a people thing. Everyone needs to walk. ... There are no clear, distinguished roles. (Carmel, Int. 47, p. 546)

Roles and disciplinary knowledge do affect the extent to which boundaries can blur. However, although everyone brings some ignorance to the team, the naivete of the novice practitioner often stands out. It was evident that novice practitioners, fresh from educational experiences that support fragmented professional boundaries and role responsibilities, struggled with the blurring of boundaries:

> Novices bring their own specific knowledge but also their own specific ignorance of what other disciplines do. ... It's the discipline; it's the training. It's the old system where medicine was split into medical and surgical departments and the doctor was the important person and all the other people were incidental. I coordinate there and say to the physiotherapist that the occupational therapist is doing this for this reason. They've both got different reasons for what

> they are doing. Normally, physios see their role as being the most important. And indeed, the doctors usually see the physio as being the important one and the OT as being incidental. ... The roles are very similar but they're also very different. (Bob, Int. 27, p. 572)

In contrast, experienced practitioners frequently stand out as being ready to move beyond historic work roles, to forge new roles for uncharted territory:

> They are actually seeking out new roles. It's not that it has been assigned to them. ... They really are pushing themselves into that role. Almost pushing the boundaries of that role. (Kathryn, Int. 77, p. 1002)

White and Begun (1998) believe able practitioners are willing to think creatively, to be innovative, to take risks, accept new roles, as they adapt a wealth of experience to find new solutions amidst the reform upheavals. In this study though, the wider hospital community was generally much more sceptical about blurred boundaries, preferring to hold fast to traditional roles that had a tendency to disappear altogether. The well-accepted expectation of a professional person being open to lifelong learning (Bernhard & Walsh, 1995) is seemingly forgotten when interdisciplinary teams are pioneering new structures in the redesigning organisation.

Pioneering New Structures

When team members are willing to accept opportunities and challenges to do things differently, to pioneer new structures in the interdisciplinary team, the *breaking of stereotypical images* follows. The nature of restructuring is such that, more often than not, organisational order appears disordered. Tsoukas (1994) suggests that "events, processes and experiences in organisations are rarely transparent, self-evident or completely fixed, but are intrinsically *ambiguous* and, therefore, open-ended in the interpretations that can be attached to them" (p. 10). When uncertainty increases and work organisation becomes more complex, people seek greater control in a world that appears to be moving out of control. Rational action seldom helps. Rapid reaction and resorting to the

well-tried rituals often makes things worse. This is pioneering country where the practitioner does not know, indeed cannot know what will come next and how best to respond. The indicators of pioneering new structures are opportunities, enthusiasm, and new positions.

In this study, pioneering new structures is a means for re-examining professional work and the usual ways of doing things. Pioneering is allied with entrepreneurship. White and Begun (1998) believe that the entrepreneur "perceives an opportunity and assumes the risk of planning and creating a means to pursue it" (p. 44). An entrepreneurial stance facilitates adaptation within a turbulent workplace. Similarly, Parker (1998) claims that pioneers are recognisable for their knowledge, imagination, mental toughness, energy, and courage to carry ideas to fruition. While that may be so, in this study talented practitioners needed the support of the team leader who was influential in the organisation:

> The opportunity presented for us to do something differently. ... That manager is a live wire! She has a nursing background. She is very entrepreneurial, very keen, very motivated. She's a person you would never constrict. You give her a free reign to run her area as she can and she'll come up with the innovations and change that you want. ... And we couldn't just have anyone in those jobs. We were looking for very high calibre, knowledgeable people who could do the job and pioneer a new structure. We wanted something new and this was where there was conflict. It's about enhancement. We wanted the best! We didn't want second best and some of the nurses were definitely second best. Why would you want them if you were pioneering a new structure? They didn't have the experience or the knowledge. You need something that will work. (Lilly, Int. 4, p. 56)

Pioneering new structures requires people that are prepared to think outside of the professional box, to give up the old "we have to do it this way" thinking (Kerfoot, 1996, p. 123). This is difficult, as so many semi-professionals have been trained to think in a linear fashion, to take a fragmented approach to client care. But, when clinicians were given an opportunity to think differently, many responded to that positively:

> When we interview for jobs we look for the potential to take tremendous initiative and work independently and want to do things better all the time. We look for people who basically have those

> qualities. So when you put them in the right environment, then this happens. ... We need someone who is prepared to have a go! Some of the people we have taken on have had no experience of this ... We need to be satisfied that they are actually wanting to have a go, that they have something inside them that says, "I'd really like to do this even though I'm scared about it. ... There's a sort of keenness about them. ... it's an enthusiasm.... an enthusiasm for all aspects of the job. ... It's someone who is brave enough to face the challenges. ... Someone who is prepared to look into the uncharted waters and would quite like that challenge - as long as you can guide them through it. (Alice, Int. 20, p. 290)

Usually, pioneers are enthusiastic people. Pioneers welcome the rare opportunity to practise differently in spite of the hospital bureaucracy. Any freedom to break away from the commonly accepted ways of acting and interacting was highly prized:

> I was offered an opportunity to get it right for the patient, to follow them through. However I did it, was up to me. I chose to follow them, to see that they do get the service they should be getting, and if not, why not; and then to initiate changes if they need to be made, and to assist people along the way to understand why the patient didn't get that service. Well! You would kill for that sort of thing! Especially if you've worked in this system! (Marilyn, Int. 7, p. 89)

Explorers of unknown territory displayed a readiness to engage in the deconstructive thinking underpinning **pluralistic dialogue**. A willingness to examine both the known and the unknown demonstrated flexible thinking that is invaluable when pioneering new structures. Eagerness to break the symbolic rules and take on new challenges suggests that many pioneers are dialogical thinkers, keen to explore alternatives to the status quo. Bohm (1994, 1996) suggests that they are not bound by roles that carry pre-set assumptions and opinions about the way things should be. When people do not accept what exists unconsciously, the self is free for further inquiry. Individuals though, had to be willing to turn thinking upside down:

> It's the sort of thing "You can't do that because you are a nurse. You can't do that because you are a technician" rather than saying "You are this. What do you think you can do?" There are obviously certain things like prescribing drugs [the person can't do] but a person who is a nurse would never ask to prescribe a drug. That's not part of the things that she is legally allowed to do. ... there are no bounds to

> what they can take over. ... like with the nurse practitioner role ... where they're resuscitating babies and doing the same things as the paediatric registrar - there are no bounds as long as the person is adequately prepared and trained for the task. (Alice, Int. 20, p. 426)

Organisational structures often constrain practice. When new structures are created, while clinicians depend on organisational patronage to facilitate new roles, they must be well qualified and able to create new positions as well:

> The setting influences things quite a lot. I've noticed a change in nurses' expectations of themselves as practitioners ... they recognise the need for knowledge development and actively seek it out and take themselves further and expand their professional roles as they go. ... There is quite a move to take back some control and have a clear mind as to how nursing can fit with other disciplines. It's almost as if they're saying, "Look! We do have the knowledge!" They're overt about it now. They're really claiming a place. Unfortunately, they're doing it in a climate where I'm not sure health managers are necessarily supporting that ... Nurses are moving further into post-graduate study and that's where we are seeing the changes. That is not happening as a result of the organisations. In the current structure there hasn't been a great deal of support for encouraging that development. If you just take a global view on that, the organisational structure that nurses work in very often limits their capacity to realise their potential. ... The health care providers need to develop opportunities for nurse practitioners. (Diane, Int. 11, p. 138)

Although opportunities to pioneer new structures are rare, Larson and LaFasto (1989) report that "a key factor differentiating high- and low-success teams is the structure of the team itself" (p. 39). In this study the teams that had an opportunity to create a new structure had little problem at all in *breaking stereotypical images,* envisaging different ways of practising. Pioneering new structures is so much easier if old roles do not have to be adapted and there is freedom to forge new structures from the beginning:

> I think it is quite hard to sort out a system that is egalitarian and also have a structure, organisation, and a formal process of responsibility and handover for that. ... We've had an enormous amount of leeway really to do what we think is appropriate, or, not to do things. To a certain extent we've been able to dictate our own terms because we came into a situation where there wasn't a service.

> ... We can be quite creative because we do not have to adapt ways that previously existed. A lot of what we do is new. There was some resource constraint ... but it is much easier to put something in place where there wasn't anything before. Generally, when people are quite grateful that we are here at all, they are less likely to grumble about how we do it! We've reached a point now where we need to develop some more formal structures just to keep in touch with the clinical issues for everyone. (Emily, Int, 96, p. 1512)

Pioneering new structures is definitely simpler in a small team. It was obvious that disciplinary approaches were discussed informally as team members worked together. Once the ground rules were changed, functional expertise was fused to benefit the patient:

> This job is new. There weren't any ground rules. It's about contacts really. It's much easier for non-medical people to have good contacts into other areas of the hospital – particularly the physios, the OTs and the nursing side. It's a lot easier for non-doctors to have pull in those areas. It doesn't have to be a nurse in that position. Doctors have not been involved much in patient care. You use everyone else to help you get your patient better but you are not necessarily involved with it. (Richard, Int. 13, p. 172)

Pioneering new structures challenges even the most experienced person. The practical reality makes it impossible to be explicit about precise responsibilities in complex situations, which demand ongoing exploration of possibilities. Lumby (1996) believes that current discontinuity offers opportunities to rethink the old ways of working as individuals and as teams of individuals. Rigid thinking though, had the potential to block team action and interaction:

> It depends on the individual. ... There is opportunity for communication and discussion but I think at times, individuals won't take that. Sometimes individuals can get quite pedantic about things in bureaucratic systems. They say things like, "My department says I do it this way so that is what I am going to do, even though it doesn't fit in with you! ... It could be due to insecurity. ... It is a way for people to use their professional responsibilities as some sort of a shield for their own lack of confidence, or insecurity, or whatever. You can use a pedantic sort of system to say "This is the way it's done and you can't make me do it any other way!" That doesn't really work in the long run. (Sophia, Int. 82, p. 1056)

Pluralistic dialogue therefore helped allay apprehension that was especially noticeable among newer practitioners who were fearful of losing their professional connections in direct service attachment. In contrast, well-experienced clinicians were quite philosophical, realising that survival might depend on individual attitude change. Although either-or attitudes maintain a sense of control in the practice domain, practical life is seldom black and white. Rather, it is grey with uncertainty:

> When people are practising in particular areas and are experts – when someone new comes into the team who may not be doing what the team have done before – that sometimes causes problems. But the nature of the teams is such that the team gets used to it.... People who are very good stand out! And by the time you get to work in those teams you've worked with other professions in other places in the health system so you are used to it really. But, the nurse practitioner role is new. Some of the doctors don't know what we do, and some of the charge nurses have difficulty with what we do, and some think we do nothing at all! I was accepted because I was associated with a team that was well respected. But I still had to prove myself. The others have a standard. (Alec, Int, 37, p. 485)

Proactive attitudes helped professionals rethink their responsibilities for the future. Rethinking is about developing new attitudes, new values, and changing mind-sets (Culbert, 1996). Rethinking involves moving across boundaries, in a period of history in which Newtonian thinking no longer works, and where paradigms of thought are changing subtly but inevitably. As organisations become more flexible and open, as boundaries blur, and new role responsibilities are created, competence is crucial.

Confirming Competence

Competence is a most critical variable that influences teamwork. The stereotypical image that all professionals are competent is not always upheld in practice. Benner, Tanner and Chesla (1996) report that, increasingly, health professionals acknowledge that colleagues do not always have enough experience to deal with specific situations. Fagin (1992) observes that, traditionally, medical competence is assumed until incompetence is proven, whereas every other health professional has to

prove competence in each new learning experience. Individual competence influences collective competence and team effectiveness. Team effectiveness involves numbers of individuals carrying out their duties and obligations adequately. The indicators for confirming competence are performance, reliability, credibility, and confidence.

Confirming competence begins on immediate entry to the team so the team affirms, with confidence, the real extent of the new person's professional contribution. Performance encompasses technical competence and knowledge application with new patients in different situations. Benner et al. (1996) state that competency also includes experiential learning once practitioners learn to handle the situated possibilities and constraints of practical life. This is important in a teaching hospital where it is inevitable that newcomers have varied experience:

> With competence you've got a mixture of staff, some of whom are starting out on their careers. You need to be tolerant there. Some of the House Surgeons are not completely comfortable in their role. That can be frustrating for the team that have to rely on them because they hold such a focal place. (Maire, Int. 51, p. 621)

Newcomers cannot be passive here. Everyone must prove their competence. Manion et al. (1996) state that competence means doing a delegated job capably and in the expected fashion. Oddly enough, in this study, there was an implicit assumption that team members would cover colleagues who did not perform as required. The more experienced clinician expected to cover the gaps, making up for any deficit in the overall team competence:

> Before you can start telling people what to do you've got to be seen to be able to perform yourself and have some credibility around the place. ... This service is accepted because of its profile and recognition of those who work in it. ... With others, you're looking at their performance and whether they're performing as you would expect. The way the team works depends on everyone's individual performance and you adjust yourself or your sphere of activity to fit into everyone else's performance. You'll find in medical teams, with registrars, house surgeons and trainee interns, there might be a problem somewhere in the system - a weak link, or someone who's not up to speed. Everyone else adjusts the job to cover that weakness in that particular person who tends to become less and

> less a member of the team. What you do is sort out everyone's performances and what they are going to deal with and what they don't deal with well and what you need to change. That's where the team functioning comes in. And once you've worked out what people's abilities are you expect everyone to perform at roughly the same level the whole of the time. (Richard, Int. 13, p. 181)

March (1994) believes that much of what distinguishes a good team from a bad team is how well it achieves the trivia of everyday relations with clients and manages day-to-day technological problems. Competence is sometimes compromised as, on the one hand, the pressure of work means that any help at all is welcomed, and on the other hand, all specialist teamwork presupposes a certain level of clinical reliability:

> To me competence would be the overall, over-riding issue. Performance and credibility might almost be parts of that overall competence. Competence would be a broad, overall, encompassing thing. ... You could be competent in your day to day performance but maybe lack in your knowledge. You might lack insight. And another team member might not see that, when you watch a colleague at work, but in a crisis it comes out. Performance is the day to day actions – competence is how you do something. (Kathryn, Int. 75, p. 990)

Though new team members might bring extensive experience to the teamwork, they enter the team as an amateur who must rethink their competence and how it will be best integrated. Highly experienced practitioners do not always know exactly what they are doing immediately, but most carry transferable skills to carry them through new situations until they are able to contribute fluently to collective practice. Reliability is always scrutinised, albeit surreptitiously:

> You do have to be reliable. ... The people you pick competence up in first are the nurses and the doctors. And, if it's a physio that's incompetent, they say, "Talk to her! She doesn't know what she's doing! We can't have that one here!" So they have to be not only reliable but they also have to do what they are supposed to be doing. (Margaret, Int. 54, p. 754)

Even though clinicians had limited control over a colleague's practice, the reliability of each member is fundamental to cover functional responsibilities. However, rather than counsel clinicians from different

disciplinary backgrounds on standards for professional practice, or pass formal judgment on professional competence, many team members ignored the issues altogether, or pressured other members of a specific discipline that had a weak team member. Team members recognised that the responsibility for competence was individual, but team leaders were much more conscious of the collective responsibility for the overall quality of care and team effectiveness:

> It's all very well having the eight core team members, but there are another fifteen nurses that are coming in and out, and liaising. And you don't necessarily have control over their ability. What you want to do is instil in them that they want to do the best for the client. It's not your responsibility to ensure they are competent, but obviously you'd give feedback to somebody if they thought they'd completely lost the plot. (Grace, Int. 94, p. 1695)

Wide-ranging clinical abilities were evident in the large ward team that had unique problems created by team travellers, those practitioners who had to rotate during their specialist learning experiences. Individual credibility was critical:

> To me credibility means the ability to make good judgements, to have good reasoning skills. I don't think it means you have to be the best clinician or the best expert or the best professional possible. But it does mean you have to be professional in the sense that you have good rational judgement skills. ... There are levels - according to the experience and skill you bring in. And it is to do with the talent you might have. But it is really about being able to work well because you are making good decisions. ... You draw your decision making from your experience. It is how you draw that together and how you practice with it that makes you credible. ... There are different levels of experience - it doesn't make the new graduate any less credible. The capability they bring is limited by their experience. (Sophia, Int. 81, p. 1006)

Although feedback was given on performance, problem-solving ability, and collegial interactions, the evaluation of professional growth in large teams did not appear to be accepted as a team responsibility. So many specialist clinicians were outstanding as practitioners and were willing to cover colleagues as required. Paradoxically, they could tolerate the less talented, as long as the team could meet service needs. Connections between competence and reliability, trust and confidence were subtle:

> Trust simply means that somebody says they're going to do something and they'll do it. ... Trust in that sense, is almost reliability. But the other sense is confidence. That means that you have to acknowledge a particular opinion that a person has got because of your confidence in their abilities in one way or another. So it can mean both of those things and obviously you expect people to be reliable and you trust them ... If people don't perform then they're not likely to get very far. But it is also about having people in whom there is confidence in their abilities ... They are likely to be much better both as team members and as team leaders. (Ian, Int. 17, p.245)

The team confirms competence once clinicians demonstrate the required specialist and generalist capabilities. Interdisciplinary teamwork requires clinicians to meld individual work activities with collective practice. Indeed, Hammer (1996) argues that tasks alone do not benefit the client as it is "only when all [tasks] are put together [that] the individual work activities create value" (p. 5). Tasks relate to parts whereas the processes of collective practice implicate the whole. In this study, many clinicians spoke of actively seeking new learning experiences that extended the self personally and professionally:

> Part of pushing myself to be the best sort of team member is that I do my tasks as well as I can but I also push myself to be sensitive to those other whole issues around the patient. ... You need to have competency in both. You need to be pushing yourself to be skilled as a specialist but also the big portion as a team member is also to try and push those general skills. ... It is a critical role of being a professional and not just a worker. A worker is taking orders but is not self-questioning or self-analysing. You have to be judging the work that you are doing. You are taking responsibility for it. (Kathryn, Int. 56, p. 539)

The way a neophyte clinician accepts individual responsibility is scrutinised in teaching hospitals that train students from many professions. Initially, most teams have a generous attitude towards new learners but, at the same time, many become uneasy if learner behaviour does not change relatively quickly. There is a need to maximise patient management in situations where students are slow to learn. Yet, team members seldom criticised others openly:

> Competence is important ... it is a high priority. It's a bit difficult to comment if you're talking about people being incompetent. ... Obviously it makes it hard if somebody isn't coping with the workload or isn't getting things done. It's hard to work for the team... competence may be a factor. But I wonder if it might be the interdisciplinary thing if people aren't grabbing hold of things and aren't doing things because they don't feel it's their role? I often feel that that's happening. People just aren't doing stuff because it's not their job. Whether that's the competence thing ... confidence affects it as well. I wouldn't like to comment on another's competence. I've certainly noticed a lack of confidence. ... You have confidence in those who are competent. (Carmel, Int. 47, p. 555)

When people acted independently team thinking was likely to be fragmented, and participants reported that interconnected actions tended to break down. But, when team members had confirmed competence, performance was continually evaluated during discussions that were turned into a team learning opportunity. This was so much easier in the small, well-established team:

> Competence is important. If you are not performing you soon hear about it. You hear about it in the corridor after you have seen the patient - "Why did you do that?" You aren't necessarily told you have done the wrong thing. But you are questioned as to why did you take that tack or make that decision. And then maybe it would be discussed at the team meetings - was that really the right way to address that situation? (Rhonda, Int. 41, p. 527)

While clinicians passed judgment informally, confirming competence or incompetence in fellow team members, few teams monitored individual performance or gave formal feedback on progress. Many participants reported that, when performance was appraised within a discipline, individual contribution to the collective was not reviewed at all. Larson and LaFasto (1989) suggest that, if an individual's performance is not assessed in relation to the team, it is impossible to determine accurately, or fairly, how a person should be rewarded, what development needs are required, and how to increase responsibilities in the future.

The Collegial Attitude

The collegial attitude is actualised when clinicians are mutually confident that each individual is offering a unique, unmistakable contribution towards the team purpose. The traditional stereotypical images that have impeded collegial interactions between doctors and nurses (Campbell-Heider & Pollock, 1987) have been broken. Kerfoot (1989) suggests collegial relationships involve interactions between individuals who occupy both equal and unequal status. Equality in organisational life, more often than not, concerns the subtle, and not so subtle, power relations that influence attitudes and behaviour associated with a gender-influenced hierarchy (Morgan, 1997). In this study equality, hierarchy/non-hierarchy, respect, skill, and expertise are indicative of the collegial attitude.

Perhaps because the participants in this study were predominantly female, equality was understood differently from the commonly accepted meanings. The health services have a long history of relationships built on male values and male dominance. In this research, many of the participants were females who were introducing new cultural values and approaches into a previously male-dominated arena. Traditional assumptions were examined in interdisciplinary relationships:

> I think one of the difficulties with that system is that the old medical system that the medical school pertained was incredibly patriarchal. Usually two consultants "owned" a ward and all of the staff on it! They "owned" their charge nurse and their nurses. The only strength there was that usually there were a couple of consultants and junior staff and the charge nurse and they had morning tea together. ... I think the system meshed because there were these disgusting ceremonies like the morning tea that was made by junior nurse but ordered by the charge nurse! The tea was poured and handed to the consultants! No one wanted that to continue. But what got thrown out was a structure of responsibility ... the consultants were listening to the charge nurses and woe betide them if they didn't! The junior staff listened to the charge nurses because the consultant said, "If you upset my sister you'll get a D for this run!" It was hierarchical but at least there was a structure. Now that seems to have been lost in teams because there are multiple consultants and people don't have morning tea together! (Emily, Int. 94, p.1510)

Traditional authoritarian interactions founded on paternal benevolence continue in some places today, blocking the development of a collegial attitude. Kenny and Adamson (1992) report that the majority of health professionals do not feel that doctors understand the work of other health professionals, or regard them as equals. Historical social interactions still persist to some degree:

> When I first went to the hospital I always remember the first meeting of the executive. The general manager at the time was a typical doctor. I was introduced to a couple of people and then I introduced myself to a couple of professors. Well! They looked absolutely astounded at a person doing that! And we all sat down and the general manager turned to me and said, "I'll have a cup of tea, thank you!" And I said, "Well I'm sure you know how to make a cup of tea, feel free to get one. Don't we all get our own cups of tea here? I'm not the typical matron that serves you all". I got up, got my cup of tea, and sat down. They did the same and as they were sitting down I said, "I didn't know you had handmaidens in this organisation". They were very uncomfortable. ... I refuse to be a handmaiden. It was the typical stereotype - that the director of nursing would serve all the others. Well! I wasn't going to do that! We've moved on since those days! (Lilly, Int. 86, p. 1397)

Myths surrounding male-female relationships are breaking down slowly as service structures change and women move into higher management positions. As responsibilities are restructured, many health professionals are learning to explore habitual ways of thinking as they interact with others in a collegial way. Respectful collegial interactions evolve if the team recognises the need for balanced – equal - contributions:

> That word equality is an awkward word really because it brings in all sorts of connotations about the hierarchy of systems and of professionals. It's to do with stereotyping and some professions are seen to be much more superior in the sense of comparing them to others. To me, equality is really about being able to work together with mutual respect. The people identify each other's role and place within that team and respect that. ... That is what makes you equal. It is not that your responsibilities are equal or training, or skill. That is varied. But I'm just as good as they are. The trouble is there is an awful lot of historical stereotyping that goes on. I think the health system is changing incredibly fast and I don't think people's perceptions are changing at the same speed. It is probably up to us to forge the understanding. (Sophia, Int. 81, p. 1018)

But, thinking changes slowly and the collegial attitude emerges over time. It is a two-way process dependent on positive interactions between people functioning as a team. Women, conditioned culturally to see themselves as offering less in the medical hierarchy, gradually learn to sense the wealth of experience they offer.

In this study, a supportive team environment promoted deconstructive thinking that prompted colleagues to re-examine taken-for-granted assumptions and beliefs. Colleagues empowered colleagues by drawing the person in, and respecting individual strengths, until the fullness of a team place was completely appreciated:

> That helps us with our own image of ourselves. I have come to recognise that I have got something to offer to this team. I do know what I am talking about. I am a specialist. And I suppose that is reassuring my position in the team - yes, I should be there. And, I should be accepted by the team, for what I am and the knowledge and skills I bring. I think of everybody in the team as being equal. Lots of people put doctors on a pedestal, and think that they are better than everyone else but I think everyone has something specific to offer in this team. And we are all treated as equal and what we say in discussion is considered. I think we need to appreciate people for what they are, what they do, and what they bring to the team. (Rhonda, Int. 41, p. 503)

Acknowledging individual value sometimes requires a redefinition of the self. It was evident that, many team members, trained to place the doctor at the top of the management pyramid, struggled to think of the self being as coequal with colleagues. More used to social divisions where open recognition of individual contribution is rare, many did not actively seek equal opportunity in teams. If traditional expectations persisted the collegial attitude was affected. Interactions were especially difficult when one professional group tried to dominate others:

> She works in close collaboration with the medical practitioners and is working as an equal colleague. Equal, but different. ... And that's the way I see nursing working in the future. They need to have the knowledge and the expertise to work in that way. And I believe that many nurses do work like that but they are not recognised for it and they themselves may be part of that. They don't recognise their

> worth. ... It is important they learn how to become articulate about that and feel a good professional self-esteem about that because they carry a lot of responsibility. But talking about the team that functions really well, you can only do that when you are of equal ability and you get back to that equality thing again and being seen as having some sort of equality. You can be different but equal. And where that works between nursing and the medical profession it just works superbly. And I guess we've all had experience of that sort of thing. And where that isn't so you feel compelled to say "Now look here! What you're expressing is a view I don't share with my own profession. Could we not just come a bit closer on this?" (Diane, Int. 11, p. 146)

Different viewpoints originate in professional education and the confidence and proficiency engendered therein (Jolley & Brykczynska, 1993). Many nurses and some therapists have been trained vocationally. Well trained to respond to practical situations, they are less well prepared to question decisions or to think outside the box. These people needed encouragement to *break the stereotypical images* and to engage in **pluralistic dialogue**:

> And I think one of the things we have developed, as a style is that all members are treated equally ... And whatever level of the so-called hierarchy you are at, people are expected to make equal contributions in terms of the numbers of presentations they make. They are all to attend. So, they're forced to do things that they've never done before. I think people have been facilitated to blossom because we've set the standard high, at whatever level they're at. And they don't feel in any way inhibited from reaching any heights that they could, or wish to. We don't say you have to reach that, but we give you all the opportunities, and see what happens. ... And, again, you are talking about having carefully selected people in whom you see that potential. (Alice, Int. 20, p. 290)

Equality is ambiguous. Hegyvary (1990) believes that underlying the collegial attitude is the subtle expectation that total agreement is required. Equality does not exclude debate, although **pluralistic dialogue** is more likely when clinicians respect each other as equals. When individuals value each other differences are more readily explored:

> In this team I think we all have equal roles in so much as without the bit that the others do, we wouldn't function as well. So we are equal in so much as we have separate things to do! Professionally, we're not equal. Academically I'm not equal to them. There's no question there. Is a doctor equal to a nurse? What does it mean? I

> don't see doctors and nurses as equal. I would rather say I am equal to a district nurse. Am I equal to a midwife? It wouldn't enter my head to put myself as equal to them because I am different. I have a completely different role to play. In my eyes a physiotherapist is equal to an OT but they play different parts and come together and they do work well together. If you look at who is equal you have to look at what we do. It starts with your own self-value (Marilyn, Int. 12, p. 169)

Those who did not value themselves and their work appeared to be unusually sensitive to stereotyping based on unchecked assumptions, regardless of competence or professional contribution. However, experienced clinicians do retain power, albeit informally:

> I think it depends on what areas you are working in, I very much feel that we are all equal here On the surgical wards we're not seen to be as important as the surgical teams ... But, the teams don't undermine physio or occupational therapy. They're interested in it. It's just a different focus. And the surgeons weren't very good at asking the occupational therapy and physiotherapy opinion. There wasn't the pressing need there so that [therapy] wasn't in such a high esteem as it is here. But that's not to say that it was negated. We just went and did our thing. We didn't say what we were doing. We just did it. Here, the doctors are very much into therapy. (Carmel, Int. 47, p.553)

The collegial attitude carries rights, obligations, and responsibilities. In the small teams members worked together to meet service needs and made real efforts to dialogue with colleagues about decision making, even if their input was limited by experience. But, in the large ward team, the collegial attitude was harder to establish because there was a fine line between having confidence in colleagues or checking out the validity of their input:

> People have different levels of training and different expertises with that training. My notion of equality is that your opinion is respected and acknowledged. When you get people who are skilled and experienced you feel more comfortable about their opinion and you never question it. ... Or, if you do, it's more a drawing out of the detail. If it's somebody who's inexperienced, I'm always wondering if they've done enough? And there will always be some dissonance in what my opinion might be versus what they are telling me. ... When I've been to see the patient my observations may not have been the same. If it was an experienced person then I would accept the judgement and say, "Well, I was wrong". If it was a junior person then I would feel more anxious because it's going to effect the

> outcome of what we can do with this patient. ... They are not all equal, are they? People's backgrounds, their level of intellect - it's different ... But they all have something to contribute that will help this person. If you've been consistent, and you're reliable, and competent, then you will get respect. And, if you stuff something up, you lose it. (George, Int. 33, p. 342)

Equality and respect build up over time as team members know each other better and learn to trust each other. Respect certainly facilitates **pluralistic dialogue**:

> Respect is a personal thing. People generally respect other people that they know, get on with, and have worked quite a bit with. Or they build it up. ... It's very, very important to have a voice. And that's part of being respected. Being respected is being heard and listened to. ... And it's not just having a voice, it's also having a voice that will be received in a certain way. It's attitudes. It's people's attitudes. (Lee, Int. 45, p. 528)

Respectful attitudes towards colleagues cannot be assumed. Manion et al. (1996) claim that respect means treating people with dignity and fairness unconditionally. They argue that treating team members with consideration is a basic human requisite. Respect is also about regard and value. In this study, clinicians valued highly knowledge and competence. Theoretically, there is no place for practitioners with poorly, developed skills in a specialist team, yet they still appear. Once again, though clinicians who have not kept up with changes in knowledge and technology are a liability, they continue to be tolerated, albeit unsympathetically:

> This specialty is still in the medical model of care. A lot of the registered nurses are not up-skilling here. ... Doctors are very clear about which nurses they'd trust ... Some registered nurses are perceived as experts and then there are those they were wary of to the extent that they don't like them looking after their patients. Opinion is based on the nurse's interaction with the doctor. Nurses would ring the doctor just to give panadol even though we have standing orders to give panadol! It coloured their involvement in the interdisciplinary activity. ... When we all got together some colleagues were embarrassed by what they saw as silly, twittering remarks. ... Perhaps they are not acknowledging overtly the lack of skill. ... You can't manage an interdisciplinary team where people don't have expert knowledge. With some registered nurses - you have this conundrum where they've been trained for thirty years, but they are still novice practitioners. ... (Ann, Int. 3, p. 29)

The *breaking of stereotypical images* thus depends on individuals and whether they enter into the dialogical process whilst exploring thinking collectively. Bohm (1994) argues that, when we do not see the impact of thinking, we take actions and reap intentional consequences. In this study, team members examined difference and diversity further as they grappled with different mind-sets.

Conclusion

Blurred boundaries, pioneering new structures, confirming competency, and the collegial attitude have been discussed in terms of their contribution to the *breaking of stereotypical images.* Generally, team members have moved away from traditional authoritarian relationships towards respectful, collegial interactions where every contribution is valued. Clearly, **pluralistic dialogue** is evident. The tensions and contradictions inherent within deconstructive thinking have been illustrated. Clinicians are slowly letting go of familiar, habitual ways of thinking in a context where health care paradigms are shifting. Team members are learning how to integrate responsibilities for meeting service needs, bringing experience and skill together into an evolutionary form of team practice. The other effects this has on interdisciplinary thinking will be discussed in the next chapter where the other conceptual category of rethinking professional responsibility, *grappling with different mind-sets*, is analysed.

CHAPTER TEN

Grappling with Different Mind-Sets

Introduction

As health professionals working in interdisciplinary teams explore long-standing assumptions, they cannot help but be involved in the *grappling with different mind-sets* required for full engagement in *rethinking professional responsibility.* In this study *grappling with different mind-sets* refers to the individual's examination of professional responsibilities in relation to the other disciplines. Team members continue to alter their familiar patterns of thinking as they work and talk through differences with colleagues from other professional groups. Mind-sets begin to alter as team members scrutinise thinking that is now revealed as being inadequate in the restructuring environment. During dialogue, individual perspectives are examined as understandings change in collective learning encounters. *Grappling with different mind-sets* is another conceptual category that interconnects with *breaking stereotypical images,* as clinicians *rethink professional responsibilities* (See Table 6).

Table 6

The Location of Grappling with Different Mind-Sets within the Theory of Pluralistic Dialogue

PLURALISTIC DIALOGUE	
Rethinking Professional Responsibility	Breaking Stereotypical Images
	Grappling with Different Mind-Sets
Reframing Team Responsibility	Negotiating Service Provision
	Engaging in the Dialogic Culture

In this chapter it is argued that health professionals examine pluralistic world views as they *grapple with different mind-sets*. At the same time team members continue to explore their usual ways of thinking in a context where differentiated commitment affects any potential for change. The team learns to turn disciplinary diversity into positive encounters by practising a team philosophy so that collective practice becomes a reality (See Table 7).

Table 7

The Properties of Grappling with Different Mind-Sets

Grappling with Different Mind-Sets

Coding Family	Properties of Category	Indicators
Causal Conditions	Pluralistic world views	Individual beliefs and value systems, different perspectives and philosophies, learning opportunities
Context	Differentiated commitment	Dedication, vocation, integrity, altruism, moral code
Action/ Interactional Strategy	Practising a team philosophy	Common purpose, direction, shared vision, goals, aim, values, partnership, united front
Consequences	Collective practice	Integration, collaboration, cooperation

Pluralistic World Views

Grappling with different mind-sets originates with the demand for a modern practice model within the pluralistic organisation. Although the hospitals in this study are not predominantly team-based, a new model of professional practice is being sought in some situations in order to manage specialist services better. When health professionals enter a specialist team they discover quickly that familiar disciplinary assumptions require re-

examination. If pluralistic philosophies exist, approaches to the client service are equally differentiated. While divergence en route is permissible, the effective interdisciplinary team eventually must identify a shared mode of thinking that focuses on the client. The indicators of this category are individual beliefs and value systems, different perspectives and philosophies, and the learning opportunities that pervade the teaching hospital environment.

Exposure to pluralistic world views stimulates individual learning that promotes dialogue with colleagues. This is consistent with Senge's (1990) notion that, within dialogue, people are observers of individual action. Participants reported that often, sensitisation to different philosophies and beliefs was uncomfortable, and divergent views were sometimes irreconcilable:

> I worked in a setting where I had very different beliefs and values of how a patient should be treated as opposed to the other staff. I was quite young and I didn't have a lot of experience. I was following my training. Going into a situation where people had different views and different attitudes – it was hard to change those attitudes especially when I was dealing with people who hadn't had much education. They had life experience but they didn't have formal education. And they hadn't learned the reason why we did things like that. The result was that I battled on and that upset me so much I had to leave because I couldn't change. I didn't want to compromise my beliefs and myself so I left the situation. I just couldn't work like that. It would have meant losing what I believed in, just to conform. . (Betty, Int. 80, p. 951)

Conforming to powerful hegemonic influences is often painful, sometimes impracticable. Compromise is fraught with tension if a collective purpose is lacking. For some members of the team, comprehension was seemingly impossible amidst such divergent worldviews. Even when a clinician seeks some common ground polarisation has the potential to prevail when pluralistic world views are apparent. Differences have to be thought through if any sort of cohesive team practice is to eventuate. From time to time though, differences are well beyond the imagination, indeed, defy symbolic expression:

> Well, working in multidisciplinary teams, we're testing each other all the time! We're asking others to "Come and look through my world view!" And that's what I find exciting! It's not that any one world view is wrong. I mean – I don't know where they're at – they're a way out here – in .... in ... a ... critical world of thinking ..... taken to personalised, individualised ..... extremes ..... sort of! That's how I see them. And they're doing some wonderful stuff with people! But I have to have a baseline. I don't believe I put differences aside. You have to have a point where you say "I personally can't support that particular approach". You have to be clear about that. It doesn't mean that what they are doing and saying is wrong. Their heads aren't where I am at. I can't make them change and I wouldn't try to make them change because I'm not the one who is going to have the commitment to making that work in practice. And, I don't understand their culture well enough. (Jade, Int. 8, p. 102)

Strauss (1993) calls the paradoxical understanding-misunderstanding underlying pluralistic world views a "symbolic dispossession" (p. 157). In this study, that occurred when re-interpretation of deep-seated values and beliefs surfaced in social interactions and collective actions:

> Well it would depend on what you're doing together. ... If you're trying to manage an organisation and bringing doctors and nurses and physios together and you're coming from management, well, look through management's eyes. Don't look through medical eyes or nursing eyes! There is a common thing and it depends on what the goal is. If you're trying to manage a ward, well where's management sitting in that? Which perspectives are useful and which arguments do you value in the group? Do you agree on this human resource approach for instance? Yes we do. OK. Then that's how we'll approach it! And there the compromise occurs for the discipline. (Jade, Int. 8, p. 108)

Clearly, compromise and learning are intertwined. Some clinicians do not habitually question current definitions of the situation, while others are being educated to examine the underlying assumptions implicit to alternative interpretations.

Whatever the perspective, many health professionals are beginning to appreciate that team practice is never totally individual. Developing an awareness of the diversity and difference in world views can be an unpleasant learning experience for some. Learning together to change thinking is disquieting, because it requires a person to "work from spaces beyond our habitual bondage" (McWhinney, 1997, p. 60). More often than

not, exploration of pluralistic world views raises complex issues that heighten personal differences:

> That gentle challenging happens all the time. ... If someone comes into the team and they are not clear about their own values – they can't recognise the differences, or express those in a non-judgmental way – – if the other team members see you are criticising their way, rather than presenting an alternative perspective, you're stepping onto very difficult ground. It would be impossible to work in that team. So you've either got to move entirely into their way of thinking, or their value system, or you have to gently introduce your different perspective – certainly being cognisant all the time of not upsetting them. ... Sometimes a lot of work goes into keeping the team happy rather than doing what you think is right for the clients. ... A lot of energy goes into that in a roundabout way. Unless you're accepted as a team member you can't function properly with clients. So you might be doing things that you believe are not in the best interests of the clients because you're trying to be part of that team ... there is discomfort there ... maybe over a long period of time you'd move to the more dominant way of thinking if you were strong enough to hang on to your value system ... I don't know ... I'd like to think I'd be strong enough to hang on to my values and weave them in slowly but my observations are that a lot of teams mould to the one way ... . (Jane, Int. 9, p. 123)

In this study, the full implications of underlying value systems and beliefs were gradually revealed as team members interacted together. Different perspectives have the potential to add depth to collective practice as long as people are prepared to learn from difference. Trofino (1997) believes that learning helps colleagues let go of outdated ideas when change is necessary. Joint interactions stimulate thinking and action, while knowledge deepens:

> We do help to feed into each other's knowledge base. You get to understand the basic level of what other professions do. When you are newly out in the work force you don't have much of a grasp of the furore of the other professionals. Ongoing learning is part of being a professional - that you are motivated to improve your practice. Some of it happens through osmosis – passively absorbing. Part of it is that you are motivated, so you ask. Just being around the team members you pick up bits of knowledge that you weren't actually trained in. You also seek knowledge from your team members. That can be very helpful because we all have different philosophies. I think we all approach the patient from a slightly different way. But you can learn from a different world view. (Kathryn, Int. 71, p. 969)

Definitions of a situation may change although self-interaction[12] depends on a person's willingness to think about new situations:

> It's different value systems, different ways of approaching practice really! It's also a strength thing. I think if you go in and you're easily squashed you would easily merge into how everyone else in the team functions. I think you've got to have enough strength in believing that your perspective, your view, and your approach have something to offer. I think the team assimilates different ways of doing things but I still think it's the dominant person's ways that tend to get assimilated. (Jane, Int. 9, p. 114)

When domination exists, more often than not, assimilation gives way to accommodation. Pluralistic contradiction is emphasised, for *grappling with different mind-sets* involves deconstructive dialogue and the working through of different assumptions and ways of thinking. In all of these teams, imposing world views on colleagues was neither automatically expected nor accepted. Imposition is at odds with professional freedom. Yet, differentiated approaches must be integrated into a common purpose as time goes by. However, value systems and beliefs are primarily affective in origin so the potential for individual philosophical disconnection is high:

> Each health professional was coming from a different perspective. Different knowledge bases, different philosophies, different belief systems! Sometimes, when you expose them all to the interdisciplinary team, there's hurt. There's vulnerability or stubbornness. It takes time. And I've seen nurses hurt in interdisciplinary teams because others are coming from totally different value systems. And each party felt their input was devalued. (Ann, Int. 3, p. 36)

Depreciating disciplinary input is usually unhelpful and may block collective learning. Hewitt (1997) reports that learning together alters self-awareness, which is central to intentional behaviour. The personal capacity for self-consciousness about self-action affects self-controlled responses in relation to joint action.

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[12] Charon (1998) discusses self-communication and how that influences action towards the self. He points out that "talking to the self with symbols is what the symbolic interactionist means by thinking. Self therefore makes possible thinking, the ability to point things out to ourselves, to interpret a situation, to communicate with ourselves in all of the diverse ways we are able to communicate with all other humans" (p. 80).

In turn, self-reflection promotes mutual deconstruction, as everyone *grapples with different mind-sets.* Each interdisciplinary team has to find a worthwhile focus beyond disciplinary differences so that role responsibilities can be integrated. Difference does not have to not be extinguished, simply realigned with the client service:

> If you track a patient through the organisation you have to have a multidisciplinary team that doesn't see turf as being the issue but sees the patient as the focus. So I always talk about stapling yourself to the patient! Then, the interprofessional boundaries disappear. You need to find the commonalities for relating. And so long as there was a common ground on which we were all working, the background that they brought didn't seem to interfere with being able to work together. In our team a respect has developed from the different strengths that people have, and an acknowledgment of their frailties. It's about sharing your perspective so it's transparent. Then we can place our issues and ourselves around it for the best advantage. (Carol, Int. 16, p. 227)

Placing the client central to teamwork is crucial here and assists individuals to understand how professional differences contribute effectively to collective service provision. Several participants observed that self-objectivity stimulated a thinking through of the deeper meanings behind pluralistic world views. Indeed, Blumer (1969) advocates that objectivity is possible only when we see ourselves from the outside, when we self-interact continuously, creating objects of ourselves that are clarified through responses to different roles. This self-reflective ability influences each person's interpersonal responses. The self-objective clinician is much more likely to integrate different perspectives into client care:

> The focus is not on me. I don't really focus on what I feel, but on what I am doing. There is a difference in the types of training we have all had. I knew a different socialisation. I knew that if you took the vision off yourself and got on with the job, you tend to do it better. And you communicate better. So I am not just me. I am a [health professional] working here. And I go into a role that is not necessarily me although I use what's in me. It's a bit like acting except it isn't! I don't act but it is a bit like that. And if somebody is self-conscious all the time they work then they don't do a good job. They are focusing on themselves rather than the job. (Lee, Int. 45, p. 521)

Self-interpretation and self-organisation often help individuals to realign their actions as they interpret the acts of others. Having values and beliefs in common certainly provides a stable, supportive environment so that people can more easily understand role responsibilities. Inevitably there are times when team members *grapple with different mind-sets* but do not grasp the essence of the pluralistic world views informing joint action. Despite this, a deeper appreciation gradually develops amidst diversity, assisting the team to link their separate actions as they work together to meet service needs. May (1996) thinks that diverse values are important for the development of a mature and stable ego, and the clarification of individual and team commitment.

Differentiated Commitment

Manion et al. (1996) state that "commitment and full engagement of all team members is essential for the team to evolve to higher levels of self-direction" (p. 57). However, Barczak (1996) notes that, while a team might have a worthy goal and can enable people to actualize it "without commitment a group could fail miserably" (p. 75). In this study differentiated commitment explains how health professionals accept individual responsibility for professional action and meeting service needs. Commitment is multi-faceted as team members consign themselves to a relevant purpose. That includes the client, the team, the organisational culture, the profession, and colleagues. The indicators of differentiated commitment are personal commitment, dedication, altruism, vocation, integrity, and moral code.

Commitment retains a symbolic component. May (1996) observes that "without the challenge to many of our values that comes from diversity of perspective, our commitments will not be very strong or, more importantly, understood, and reflectively endorsed" (p. 22). In this study, many health professionals respected vocational commitment absolutely and responsibility for action was taken seriously:

> Commitment's not new. People become doctors and nurses, and to a lesser extent, direct caregivers, because they think they can do some good and change the world through good works. In terms of society, it's highly acceptable. You see it a bit with other professionals. But, with those groups, you don't see that absoluteness in terms of the commitment. Some of it is because health people don't get an opportunity not to do something. In an emergency, you don't actually have an opportunity to turn away and not use your skills. (Janeanne, Int. 2, p. 20)

Mansbridge (1990) suggests that, sympathy for other people and commitment to a principle, are two very different things. Even though concern for others may well have activated sympathy, the individual working in a professional capacity is not necessarily altering personal behaviour. Mansbridge believes that, commitment has an actional component that implies personal obligations to change actions and interactions. Even if commitment contains an implicit self-sacrificing element, miscellaneous interpretations abound. In this study, participants noted that understanding did not necessarily modify social interactions with colleagues. If anything, the symbolic devotional aspect of commitment seemed to polarise team members who saw professional commitment as being something that was discipline specific:

> I think somewhere along the line there has to be commitment. One of the problems in an interdisciplinary team is who that commitment is too. Often the nursing commitment was to the organisation. They believed in what we were achieving. We had a common culture and a common goal. Everything they were doing was because they believed in what we were doing and the clients were benefiting. But it was a culture commitment. And in an interdisciplinary team, because the doctors and others were contracted in, they didn't have the same commitment to the culture and the belief systems. The doctors were quite committed to the client. That caused tension. Commitments were in different ways. What we needed was that commitment to the whole ideology of all working together. (Ann, Int. 3, p. 37)

Differentiated commitment did tend to be discipline specific. Disciplinary differences possibly account for the fact that nurses are reported to value caring and sensitivity to patient needs, while doctors are thought to value patients' rights, and the scientific approach to disease and cure (Rodney & Starzomski, 1993). By the same token, in this study, physiotherapists claimed a commitment to mobility while occupational therapists stressed

function. Indeed, a unified ideology was merely a vision. Clearly, commitment is variable, and a fundamental tension between the individual and collective commitments may exist:

> Sometimes that commitment can be for different reasons. A lot of the nurses that go into those interdisciplinary teams are going for a commitment that is altruistic. They know they're going to learn. They feel important. It gives them self-worth. Whereas the doctor's going in because he's committed to the client, or, he's committed to make sure he's still practising safely. With medicine, they want to make sure they know what's going on with that patient because of the medical-legal problems. Their commitment can be partly to the client and partly to their medico-legal role. (Ann, Int. 3, p. 34)

Although some team members redefined the focus of their commitment, others were loath to openly explore deeply held meanings. Most health professionals are trained to be committed to the client. That belief is underpinned by the assumption that commitment is unshakeable (May, 1996) throughout the professional life. That idea is impractical and creates unwarranted tension in a turbulent, discontinuous context. Novices are especially vulnerable while they struggle to manage individual responsibilities in daily activities. Commitment to the client may not be apparent when a team member concentrates on refining skills and competencies in clinical situations. At the same time, a sense of commitment is also connected to the self and bound up with what Zohar (1990, p. 159) calls an intimate sense of "at-homeness" that develops in time:

> I do see my work as a vocation. I see it as a giving of myself. It's a mind-set. Ultimately, my job is a continuation, is an extension of giving, of caring, of helping others to change positively. That is my motivation for being a physio. And it fits in really well with the rest of me as a person - with my value system and me. If someone asked me why I chose to do physio - I wanted to help people. Physio seemed the best. At the time it seemed the way that suited me best. Serving is a good point. I try and have that mind set. Sometimes I get lost there. I may think I'm serving a person but in fact I'm serving my professional physiotherapy goals. If I'm really honest I don't think I'm always totally client focused. I'm more aware of that tussle as I've done more post grad education. And as I've become more informed I've started to see that maybe when I think I'm working for the person I'm possibly not. (Catherine, Int. 76, p. 884)

The effort required to keep the client central in service delivery reflects the dialectic struggle to resolve conflict rationally in a reality that is disorderly and illogical. Individual commitment is reconsidered to include organisational goals and change in the pluralistic context. For some, there is a tug of war between commitment and uncertainty when traditional beliefs are being challenged by business-like actions in the responsibility-based organisation:

> When there's uncertainty around the organisation, you'll often find that staff commitment is all over the place. And that might be because they don't know quite what the future is. So commitment declines and people grumble more. Basically, people are wondering whether they will have a job or not. They link it to security. You can't actually say to everyone that they are secure job-wise because you know that they're not. If beliefs don't fit into the organisation's belief that's when people move on to another organisation where they feel that they can contribute. But job security is important and if people don't think security is there then their commitment to the organisation will be zero. (Lilly, Int. 90, p. 1451)

When commitment to the organisation declines, it is sometimes redefined at the team level where commitment is rethought and expressed within helping relationships among team members. The social embeddedness of empathic feelings combines with a moral commitment to influence the self-interested behaviour driving action (Mansbridge, 1990). Even though it was clear that some individuals interviewed were reluctant to express commitment to the wider organisation, many were quite willing to exercise a personal commitment to colleagues and team goals. Shared commitment was a powerful bond among colleagues in some teams:

> It must go beyond the commonalities that we share. We had to have the same commitment. It wouldn't have worked if we didn't have the same level of commitment to the service we were offering and to each other because we cared for each other. People were extremely committed - extremely committed - to offering something of value to each other as health care professionals, and to the children, and their families. Commitment wasn't altruistic. We were very, very much based in reality. We worked in a dreadful environment. There was a very real potential that you could be bonked over the head at night and no one would find you. But, we cared for each other in a way that we never let that situation be threatening. The learning, and that chance to be involved in something that the parents really endorsed – you know it's like you offered something that they

> wanted. Nurses or health professionals always have something to give but we don't always listen to what people want. There was the common goal. And there are different reasons for people being involved with that. People are involved for different reasons - because it's cost effective or because of their commitment to nursing care. (Louise, Int. 1, p. 9)

In some situations, adversity activated a deep sense of commitment that included a real concern for the welfare of colleagues. Many health professionals certainly redefined commitment in action, according to contextual need. Sometimes, commitment was shaped by moral integrity as well:

> I think commitment for me is that I do the things I do based on my moral code. And it's not that I'm trying to impose that on the people. I offer what I offer because of my own moral code. And people can accept that or not accept that. And that is fine. I am very open and happy about that. I am not trying to impose a moral code. But I can only really go by what I believe in. (Sophia, Int. 79, p. 903)

Personal values and beliefs emerge in attitudes towards commitment to the extent that moral integrity frames behaviour and enables the individual to synthesise roles in conjunction with like-minded colleagues:

> Personal integrity is your reason for being there at all. And if that is shot away you can't be there. It is doing what I say I'm going to do - honesty of purpose. But you have to look at integrity to know what is going on with the commitment! And individualists are never involved because they don't see the need for it. Our team could only change because we knew about the people and we absolutely trusted their personal integrity too. You can't accept collective responsibility unless you've got individuals that are committed first and the whole team realizes that they are personally committed. Then they'll start thinking about actively accepting collective responsibility. (Margaret, Int. 85, p. 1101)

In most teams, accepting collective responsibility for team commitment highlighted the team's insight into how individual actions influenced joint actions. People entered teams with different agendas that perpetuated differentiated commitment. In these situations, deconstructive dialogue emerged as an awkward process, although individual commitment sometimes developed from a vague, indistinct notion:

> My understanding has changed over time. ... I went through a very difficult patch where I didn't understand what a team ethic was. I was an individual in a group. I was outside the team so I didn't have any understanding. From there I went into an odd state where I thought that being in a team was having no conflict at all – everything is happy and joyful! I can remember at the time feeling very dissatisfied with myself because I kept thinking this isn't me, I'm being really unclear myself here, and if I'm being like that, I don't know how I can be in a team. From there I think I've moved again to much more of an understanding that what teams are about is individuals together. So you don't loose your individuality because you are part of a team. If you are committed to a team – actually really committed to the team, and not just paying it lip service – I think that the team achieves far more that ordinary individuals together. I guess that can be quite fragile. It's very dependent on having a whole group of people all of whom are truly committed to the team, and all who have haven't lost their individual sense of self as well. (Caroline, Int. 92, p. 1154)

The team was not responsible for individual understandings of commitment but it was responsible to clarify collective commitment. Team commitment was differentiated clearly in this study. The smaller teams had reached a point of collective commitment while the very large ward team struggled with the implications of the process in a group that was forever changing. When collective commitment was evident it occurred because a team had generally made extraordinary efforts to practise a team philosophy.

Practising a Team Philosophy

The team philosophy helps health professionals focus on team practice by melding diversity into a definitive direction. It determines meaning for their joint action. Alternative world views were widespread in the teams in this study; individual differences were substantial. Meeting service needs was both a focus of divergence and a point of convergence. The indicators of practising team philosophy are the common purpose, goals, aim, the shared vision, direction, partnership, and the united front.

Team practice is progressive when team members are philosophically harmonious. Typically, philosophical similarities are discipline specific. To date, little is written about shared philosophical perspectives originating from interdisciplinary reflection. However, differences in training and

professional socialisation can be overcome once a general direction is set and a congenial purpose is clarified. That is consistent with Manion et al's (1996) argument that "a collective meaningful purpose provides direction and sets the tone and aspirations for the team" (p. 56). It was quite clear that this was easier when a team leader was free to choose colleagues and establish a new team in the organisation:

> Early on we sat down and said these are the aims and this is what we aim to do. We set the goals, and goals and values are interchangeable. Obviously they modify as you go along, what you can and can't do and things change a little bit. But I think we all started with having an idea of what we were all about. This is the direction we're going – at least - and then once we got under way you see if it became clearer or not. We were all doing completely new jobs. There were no guidelines, no boundaries. We could just fit into the system to achieve what we wanted to. (Richard, Int. 13, p. 180)

Fitting into the team was much less hazardous when colleagues shared some beliefs and values. However, both clarity of purpose and vagueness may be present and this signified possible difficulties in formulating a sharp, shared vision as a plan of action in a changing environment. Nonetheless, it was clear that the clarification of a common purpose provided a central focus of agreement although it could mask underlying insecurities and differences:

> Some people are really good at setting the tone in a team. Perhaps it's because they are more experienced, or they just have that personality. In the initial stages of forming a team, people can become quite defensive and threatened and petty really. As time goes on the team settles down. One of the things that overrides just about everything is if you can get commitment to the common purpose. If you do that, then a lot of other ills fall off. So if there is some antagonism towards someone it can be buried by the common purpose. (Kate, Int. 95, p. 1462)

However, those who persist with strong, individualistic behaviours usually initiate antagonism towards others and/or within the team. Some individual differentiation is endured (Larson & LaFasto, 1989) and collectively embraced as long as it operationalises team goals. Participants believed that team members are much more at ease with each other when the team philosophy is generally supported by everyone:

> It's all about shared values. When you are working with colleagues everybody needs to have the same vision for the patient. We all need to know what part we have to play. But, it's not just having the common purpose. It's knowing how to achieve that. It's a partnership thing. (Molly, Int. 78, p. 1017)

Partnership facilitate decision making when team members identify the patient as being the common ground. Some participants interpreted the common purpose as a united front. Different definitions of the work situation did not matter much as the general nature of practising a team philosophy meant that colleagues were free to role make and role take as long as they were heading in the same direction:

> That united front is your philosophical base for the team. And we are fortunate because our team leader was alone at first, and then she got me, so she was able to choose who was coming in. We all have different backgrounds and training but we all have similar ideas about the medical model and health and public health and things like that. That makes it easier as we are moving in a reasonably similar direction. It's easier to provide the team approach when we are like that. (Alec, Int. 37, p. 478)

Disagreement and agreement can sit alongside each other until each is thought about differently and turned outwards, towards meeting service needs. Agreement is always tempered by individual differences. Many participants recognised and valued multiple world views and approaches to practice. As experienced clinicians, they usually respected the uniqueness of people, and automatically sought alternative strategies for providing an integrated model of patient care:

> Working together is interdisciplinary. That is where it is changing. Once upon a time I would never, ever think I could share anything with physiotherapy because they are at their end and I am at this end. But in actual fact, it's a partnership. Now, we are merging. We agree that we share the patient. Change has come with the focus being on the patient, rather than on the task. And we all see now that before, we thought we had a common purpose, but we didn't. We were there for our own disciplines, our own professions. We were there to keep our own way of being. But now we focus on the patient completely and we are working together. (Margaret, Int. 85, p. 1109)

In the small teams, a team philosophy definitely pervaded practice and served as a guideline for collective action. This supported Strauss's (1993) argument that, "shifts of personal or collective identity are likely to turn

around or result in changes in how the person or collectivity conceives of his, her, or its major reasons for acting" (p. 154). Team philosophy was no ethereal entity that was dusted off occasionally for visitors. If it existed, it had to be put into practice:

> We can all accept a token responsibility and be accountable but it is actually more than that. With accepting the collective responsibility you've actually got to participate to get the consequences for the team. Its more than commitment - it's about accepting a collective commitment. (Margaret, Int. 85, p. 1107)

Collective commitment to a team philosophy also shaped social interactions and joint action:

> Because of our disciplines we saw things in different ways but somehow we had the same purpose. We didn't have the same perceptions. But somehow the purpose and the perception were married together to create more insight to achieve the purpose. Without that identified purpose or commonality between the disciplines, we wouldn't be working within the team. The focus of teamwork is the family and the patient. It's about a commonality and a commitment to child health as a whole and a passion for that. The team needs to be seen and it's about you representing the common purpose of the team and their beliefs and their philosophy. And as an individual you don't let the team down. The balance is so fine. You are representing the purpose and everyone else that's with you in that team. They want to make it happen! It's the driving force! And that's a motivating force for everyone who is a part of this huge team. The purpose to the client remains constant. (Louise, Int. 1, p. 6)

The cohesion that surrounds the common purpose is critical for clarification of the team goals, and the structures and strategies necessary to achieve the team outcomes (Bolman & Deal, 1997). Indeed, team effectiveness depends on having a commonality of purpose (Larson & LaFasto, 1989). In this study, while two of the teams took time together to articulate the team philosophy and direction for action, the other two teams merely assumed collective interpretations existed:

> I do feel a sense of responsibility for the direction that things go. But there is an assumption that people in the team work with common goals, which I think we do. Once you've got your team established, you have a pretty clear understanding about whether people in the team are going the same way as you are. Usually they are. (Grace, Int. 93, p. 1201)

The idea that all team members are moving the same way is important when there is a real potential to drift through changes. Some clinicians may simply refuse to role make or role take by ignoring collegial interactions and behaviour altogether. In this study, team leaders were influential in role modelling the team philosophy:

> The shared vision is the goal you are aiming for because if you didn't have something to aim for, you'd drift. People would just go with the status quo and continue moseying along. Nothing much is happening there and you're not actually enhancing the organisation very much either. When you've got a goal you are always planning how do you get to that goal, what are the steps you need to get there and what would really enhance the organisation to meet that goal? And each in our own way does it in a different way. Everyone is working together for a common purpose. And if you didn't value your colleagues you wouldn't actually work together as a team. The team would be going in a different direction and there wouldn't be that collective sense of purpose. (Lilly, Int. 5, p. 69)

Team leaders shape the collective vision. Manion et al. (1996) argue that having a clear vision is not enough. Organisational support structures must be managed to uphold the vision as well. Although it is difficult to be clear in an age of uncertainty and discontinuity, people are generally responsive to an overall plan of action that gives some idea of what the future might be. Senge (1990) states that, a shared vision is vital in the learning organisation because generative learning, creative learning, only occurs when people are committed to something that matters deeply to them. Paradoxically, it is so difficult to give any detail at all about vague, future changes that are in the process of creation:

> We are very lucky to have someone who has quite a clear vision of where she wants us to be. And we also have a vision of where we want to be as well. And it may not be where she wants us to be, but we need her to pull us up to where she wants to be! She has such crystal clear dreams but she doesn't have the problems that we encounter along the way. Things like dealing with staff and implementing change and taking on board all their problems as well as those of the patients and families as well. .... So it's very important that we have that. I think we will go a lot further, than if we didn't have someone in that position. Otherwise we would just get bogged down with what we are doing. (Ann, Int. 53, p. 606)

The collective sense of purpose emerges as collective practice. Once the interdisciplinary team has clarified shared values and beliefs or identified a shared vision it is much easier to make differentiated commitment work to support a philosophy of partnership. Effective interdisciplinary teams are trailblazers operating on the edge of extremely challenging contexts. Somehow values and beliefs must to be integrated within new practice arrangements which are all-inclusive of collective practice.

Collective Practice

Organisational change in the present health care environment has altered traditional work practice. Health professionals are slowly beginning to understand that parallel practice is untenable. Modern-day health care involves a broad range of health professionals. Although colleagues appreciate individualistic expertise, successful collective practice is possible only when everyone recognises the indispensable nature of each other's contribution. The individualistic professional practitioner struggles to blend individuality within the team. Collective practice requires team members to rethink their professional responsibilities for meeting service needs. That happens as clinicians consider and reconsider collaborative action and interaction. In this study, collective practice refers to the way the team identifies professional strengths, and accepts shared responsibility for working together cooperatively as an individual-collective unit. Collective practice is collaborative practice - team practice. The indicators for this category are integration, collaboration, and cooperation.

> Collaboration is just working with the other members of the team and finding the strengths of the other people and building that up with your strengths so you have the best patient outcomes.... I think you do the easy things first! So we collaborate on the easy things and then go on from there. (Alec, Int. 37, p. 475)

Initial collaboration on uncomplicated work establishes a mutual confidence to practise cooperatively. Ostensibly, the mix of people, the purpose of the team, and the time, determine what collective action looks like for any particular team. Collective practice can appear to be indefinable because it is created informally in everyday action. The full

meaning of collective work emerges gradually, and depends on how people understand the interplay between perspectives, experiences, and selective perceptions (Strauss, 1993). In the complex care institution any organisational change has a significant effect on team practice:

> I think change has made the team more dependent on each other. So much of what is going on is integrated with all the different groups and if the team members weren't working together effectively then there would be a certain degree of chaos. ... There is so much more demand on services. There is a pressure on people; there is a faster pace of work in so many more ways that if we weren't working in a more integrated fashion, it would end up in a big me. (Sophia, Int. 82, p. 1051)

It was clear that reflection on traditional modes of practice was not always helpful in the rapidly changing practical world. Understanding the evolution of professional services may not help clinicians to rearrange practice. Team members often struggled to understand the multiplicity of changes across the organisation and how those influenced client care. Many participants spoke of an underlying reluctance to relinquish traditional approaches:

> It's the medical "These are my patients! I will invite other people to consult if I want them!" That's always the way it's been and there are good reasons for doing that. When you keep control you know what's going on. The more people that get involved and interfere, the harder it is to keep control of what's happening. That's the underlying problem. (Richard, Int. 13, p. 174)

Once collective practice is identified as a basic requirement to meet service needs, contrary perspectives may have less impact. Structural reform both demands and allows change to proceed regardless. This means that a new team must establish itself in a work setting, among others who may not work directly in the team, or support its style of service management. As a result, collective practice may have to begin invidiously as small teams of health professionals progressively adjust their roles and boundaries. Initially, collaborative practitioners may not function optimally in a new environment and discretion is usually needed:

> Oh, I think we're past the stage of easing in gently. If we need to stir people up we go in and do it now. That was in the first four or six months when we just worked into it quietly. But now we're at the stage where people know what we're about. Some people recognise us. Most people don't know who we are, I'm sure, or know quite what we do. But, there's still reluctance. The teams aren't referring particular problems to us, yet. The registrars use us because they know what we're about. Referral doesn't often come from consultants … .(Richard, Int. 13, p. 175)

Traditional understandings of teamwork are based on parallel practice. If health professionals believe they personally have full control over patient care it is more difficult to introduce collective practice which requires them to change. Those who are uncomfortable with changing modes of practice may choose to ignore, or try to ignore, innovations. Inevitably, conflict occurs and causes frustration, as cognitive dissonance follows, and changing mind-sets seems impossible. Denial becomes a safe defence and is often activated. Nevertheless, collaborative practitioners are certain that they have to maintain high visibility amidst widespread resistance:

> If you don't go and ask, or be visible, people will not tell you. If you're not there they will ignore you... It takes manoeuvring. I guess the reason it's worked is that all of us had a reason to make the thing work. And, early on, there was a bit of shuffling around working out how things work and what the order was. Earlier on – we knew what we wanted but it was trying to work out how to get information we needed and the most efficient way of doing it. So there was a reasonable amount of trial and error earlier on working out how it was physically going to work. (Richard, Int. 13, p. 178)

Disciplinary differences are barriers to collective practice. In collective practice it is important for colleagues within the organisation to realise that any new team is not internally competitive. However, clinicians engrossed in the urgency of practical life are often uninterested in yet another organisational change, and spare little thought for the position of others creating new roles and responsibilities. In this study, this meant that the new team had work through issues informally, by themselves, and this was much easier in the clinical setting, when the patient was the focus:

> With collaborative practice we are all coming with different experiences and expertise. If that expertise doesn't mean anything to the patient and doesn't get that patient where he wants to go, then we're worth nothing. We've got to come together, see what each one of us is offering. We do this best now in the ward situation rather than in the interdisciplinary team meeting. Colleagues and I work in the same room so we get together informally and in a way that would collaborate in order to achieve the patient's needs, the team goals. It's got to take place where the patient is as opposed to the meeting that is away from the patient. (Bob, Int. 27, p. 583)

Clinical work is complex and requires a multifaceted approach to client management. When the patient is central to teamwork, cooperation often follows, and clinicians are able to retain their individual purpose within the team as well:

> Collaboration would be more about collectivity or cooperative working. Collaboration is collective. You work in a team and you take issues to the team to discuss because you are finding things too difficult to work out by yourself. In our department we have a collective responsibility for others. In the multi-disciplinary teams we're getting better at that collective responsibility. Things are discussed collectively but ultimately we still look back at what your job title is. (Alison, Int. 28, p. 450)

While participants reported that informal dialogue occurred at the team level, the influence of overall organisational change had to be included in due course. Organisational restructuring is all-pervasive and impacts on decision making in the clinical areas. On the surface, collective practice may seem to be a clinical entity, but it inevitably includes the wider organisation as well:

> There are other things at stake here. There's financial remuneration for success. There's the need to be seen to be working collaboratively and with more transparency with the purchasers of the service. I imagine that everyone is acutely aware of being watched in that environment. And we're all dependent on our performances being recognised as we achieve the outcome. Collaboration is the way in which a team works together to that end point. It includes the process - the way you react to get there. And it also probably involves leadership and reciprocity. (Louise, Int. 10, p. 135)

Team members gradually learned to practise together in a more collaborative fashion and, eventually, many discussed how their team efforts could not be isolated from organisational goals and strategies. In the study, most teams encouraged open discussion that served as a forum to work through team issues and their impact at the organisational level. Collective practice was affected by the team dynamics:

> The dynamics are changing too so that the whole group is talking to one another saying, "This is just not working! It's not our fault!" or, "It is our fault! If it's our fault let's change it!" Before, nursing, doctoring and allied health were all just a little bit different. Allied would go up through allied to say, "We were a little bit offended to be accused by such and such". Whereas now, as a team, everybody in the team knows that they all got blasted, or somebody was concerned about whatever, so where was the issue? So, that dynamic seems to be changing very nicely. Team dynamics, for me, seem to be even better when you have a known profession, a known product, and a known outcome. Everybody is part of the one group. They live and breathe together. If the outcomes are bad, it reflects on all of them! (Wayne, Int. 90, p. 1248)

Collective practice evolves when the team cooperates and shares responsibility for the client. The differences between collaboration and cooperation are subtle, indistinct:

> Collaboration is when you get together and plan something together and move it along ... when you feel more that you are on the same team for a particular cause, or issue. Whereas with cooperation you say "Well, this will impact on me so I'll help you!" Collaboration is strategic ... it's set up and planned. Cooperation is the operational level - the process is more an operational level thing. (George, Int. 33, p. 337)

In this study, a sense of cooperative responsibility was mostly directed towards the client service. Despite the fact that individual practitioners were usually committed to the client, integrating individual practice and directing it to enhance total quality management, was a very different challenge, and not one that was always easily embraced:

> It's very easy to focus on your discipline. And I think you need someone to stand back and look at the whole picture. Priorities have to be identified. We need to deal with things in order and stop people trying to take their own particular discipline first. We need to get the overall picture and work out the most appropriate direction to go in.

> And order is important - what you've got to do. And that's hard to do when you're actively involved but when you're able to stand back a little bit and take a bigger picture, its easier (Richard, Int. 13, p. 181).

Generally, the team view of the whole was developing. Many clinicians were learning to work *with* colleagues.. Interdisciplinary practice, collective practice, demanded a *rethinking of professional responsibilities* so that individuals were genuinely working for team goals in a way that enhanced mutual efforts. Practising together is learning together. Both are empowering. Within the team the person who is willing to learn with others may develop in ways that are impossible for individuals practising in isolation.

Conclusion

In this chapter the discussion has focused on how health professionals redefine cooperative relationships in clinical settings. Overall, the cooperative-competitive spirit underlying **pluralistic dialogue** is person dependent. The cognitive struggle underlying deconstructive dialogue is personally and professionally absorbing. Disciplinary diversity may indicate that problems are irresolvable because of entrenched symbolic differences. Familiarity with securely established models of practice often blocks consideration of interdisciplinary teamwork required by structural reforms. There are no clear answers when alternative values, beliefs and perspectives, inherited from the disciplines, collide in a turbulent, changing environment. Progress may be slow. Yet, active involvement of team members is evident, despite uncomfortable and challenging engagements. Problems may well be insoluble but nevertheless, responsive clinicians handle difference by analysing the issues, and formulating new ways of thinking about professional work in a pluralistic environment. Disciplinary integration is therefore possible and constantly evolving within the responsibility-based organisation. In the next chapter the researcher will explain how *grappling with different mind-sets* interlinks with *negotiating service provision.*

CHAPTER ELEVEN

Negotiating Service Provision

Introduction

Negotiating service provision is another conceptual category in this grounded theory of **pluralistic dialogue.** It explains how interdisciplinary teams in acute care organise client care as they *reframe team responsibilities* within restructuring organisations (See Table 8). Teams do not exist independently within an organisation. Individual actions and interactions must be meshed within the team, and also synchronised with the overall purpose and activities of the whole organisation. Under these circumstances, some negotiation of interests is likely. Bolman and Deal (1997) argue that "negotiation is needed whenever two or more parties with some interests in common and others in conflict need to reach agreement" (p. 186).

Table 8

The Location of Negotiating Service Provision within the Theory of Pluralistic Dialogue

PLURALISTIC DIALOGUE	
Rethinking Professional Responsibility	Breaking Stereotypical Images
	Grappling with Different Mind-Sets
Reframing Team Responsibility	Negotiating Service Provision
	Engaging in the Dialogic Culture

Hewitt (1997) recognises that negotiation is a fundamental social process. Coordination and social order are the result of many individuals' self-conscious actions, which are discussed, negotiated, and settled with others. Likewise, *negotiating service provision* is a consultative process occurring in a complex care environment, which is plagued by scarce resources and multiple demands. Health professionals cannot divorce themselves from an

evolving organisational culture that is full of parochial differences. McWhinney (1997) suggests that one way of handling dissension is by reframing, changing the bounds of practice so the issues dissolve.

In this chapter, it is argued that, health professionals do *reframe team responsibilities* and *negotiate service provision,* because the demand for continuous information coordination is unrelenting. Negotiations continue in a context dominated by business-humanitarian clashes. The interdisciplinary team handles difference by deciding together, and negotiation proceeds more easily when collective accountability is the expected outcome (See Table 9).

Table 9

The Properties of Negotiating Service Provision

Negotiating Service Provision

Coding Family	Properties of Category	Indicators
Causal Conditions	Continuous information coordination	Sharing, exchange, withholding, clinical input, client continuity
Context	Business-humanitarian clashes	Economic scarcity, efficiency, bureaucracy, constraints, optimisation
Action/ Interactional Strategy	Deciding together	Discussion, communicating, challenging
Consequences	Collective accountability	Reviewing, abdication, resource management

Continuous Information Coordination

Continuous information coordination is the hub of service provision. Because the conditions of very sick patients moving through the hospital change so rapidly, health professionals must keep in constant touch with each other to deliver up-to-the-minute care. Information coordination is especially important in the hectic environment where potential for discord

exists simply because of the sheer pressure of work. If information is poorly coordinated collective practice may become disjointed. Stott (1995) reports that, as more health professionals are involved with client care the likelihood of discontinuity increases. Although clinicians coordinate their own activities, the complicated nature of collective practice demands total, consistent, information coordination of time-limited episodic care. Pressures are constant amidst the urgency and uncertainty of acute care where very ill people enter a service and are discharged rapidly into the community.

Indeed, Allred, Arford and Michel (1995) claim that coordination decreases uncertainty because "it fosters information exchange among the various patient care experts. When these diverse experts are effectively communicating ... it is likely that patient care problems will be resolved in a *simultaneously* innovative and efficient manner" (p. 23). Continuous information coordination is fundamental to effective negotiation between the disciplines. This category is full of contradictions. The indicators are sharing, exchange, withholding, and clinical input, and the intervening conditions are client continuity.

Today, flattening organisational structures emphasise continuous information coordination and integration at the clinical service level:

> We are looking at the ward to see what's happening there. The person closest to the patient knows better what's happening there. A senior coordinator in every unit helps that now. Management is a lot closer to the bedside. It's more about the efficiency of the ward, or the service, or the patient, rather than the hospital. Now there is one person to ask. In the past there were five options! Today, they have one decision-maker and everyone knows who to call and they can get on with the patients. That decision-maker is the best placed physically day to day. They are not always the most skilled or the most knowledgeable – it's about geographical location. That person has both the geographical location and the managerial responsibility to make something happen. (Wayne, Int. 4, p. 45)

Participants reported that efficient client management depended on continuous information coordination. Schaffner, Ludwig-Beymer and Wiggins (1995) claim that advanced nurse practitioners are most effective in reducing service costs by coordinating collaborative efforts and communication in patient-focused care. The quality of the interprofessional

linkages is crucial (Allred et al. 1995). Those views were supported in this study. Information coordinators were central reference points for colleagues:

> The teams that have the nurse practitioners with them function better than those that don't because you've got a person who has the skills and experience and is able to work in that coordinated way across the disciplines. Things do get done and organised. But others – outside the team, other disciplines - often see that coordinator as being the next point of contact. If they can't get hold of the consultant, get hold of the nurse practitioner because that person is around and knows the process. Here we have a lot of experience and we are well recognised. If teams don't have those practitioners you notice the difference. It's not as well organised, and things don't flow, and the meetings aren't so good. (Alec, Int. 15, p. 212)

Disorganisation slows client care. Tension builds when the pace of life seldom slows, and patients enter and leave services rather too rapidly. Paradoxically, continuous information coordination very often depends on individual attempts to make sincere efforts to keep colleagues informed. In acute care, official documentation certainly exists but informal networks are often more effective providers of current data:

> We have to be communicating all the time - with one another in a formal way but also the informal. You walk into a room, "What's going on with Mr so and so?" "Have you heard what the family have said?" Always there's a constant sharing of information. (Kathryn. Int. 71, p. 976)

Sharing information is important for consistent communication by the team with the client and family. Information coordination was more complicated in the large ward team. There, client care required contributions from many clinicians if a satisfactory conclusion was to eventuate. Clinicians usually knew what they should have been doing but so often, other priorities intruded. Coordination facilitates joint action. Charon (1997) believes that coordination is a linking together of the separate acts of others. It helps people interpret and redefine situations so that respective actions can be integrated. Yet, continuous information coordination is seldom straightforward, despite the best intentions of individuals:

> One issue is around capturing enough information to make a decision about all sorts of discharge plans. We need accurate information about the client and their level of performance and function. In the multi-disciplinary team you've got six or seven people

> doing that. And you all have a lot of information. It's the sharing of that information frequently enough. (George. Int. 62, p. 920)

Information coordination tends to happen informally. So much information is exchanged casually as clinicians interact in clinical spaces. Conversely, much information remains in people's heads and is not documented, particularly if a team member under-rates personal-professional contributions or has poor communication skills. Decisions on whether or not to exchange information are generally individual. However, continuous information coordination became complicated when team members exercised professional judgment and decided to share or withhold information, in the stated interest of patient privacy. Failure to exchange information was interpreted as withholding:

> If information is not shared with all team members you start getting into suspicion. And it's all to do with understanding as well. And maybe it's a piece of information the team needs and people can understand why they shouldn't know it and somebody else should, and that's fine! (George, Int. 62, p. 929)

On the whole, information coordination in the large ward team appeared to be haphazard. There was an underlying assumption that information would be passed backwards and forwards in the interests of client safety. While the team relied on open interchange, definitions of what was important varied. The three smaller teams were affected as well. Even though team members made every effort to coordinate information efficiently, they had to depend on liaisons with people from many organisational departments. Health professionals are less used to looking at information and evaluating choices from the perspective of colleagues and what they might regard as important. It is challenging to take the role of another and consider information value from an alternative point of view:

> It also very much depends on the people around you and how they give you information. And the sorts of questions you ask. And maybe, if you also assume their world view, they show you how something works. I guess it depends on what their ultimate plan is. And the culture is part of what the organisation is about. Whether you actually keep a wider view, or whether you are quite narrow. (Mark, Int. 46, p. 634)

World views certainly influence the flow of information. Clearly, interdisciplinary team members define situations according to their disciplinary criteria. However, in a team they also need to reframe issues broadly, to look at the whole. That is very difficult when colleagues carry entirely contrasting, even conflicting, perspectives. But, individual issues *are* collective issues:

> When you don't trust you respond by not giving enough information to others. If I'm in a situation where I know all this information about somebody I might give one little piece to somebody else whereas any information is important information for the whole team. That person had a totally different way of looking at things. I really didn't trust her input. She didn't have any experience in our area at all. She shouldn't have been here. I got very sneaky! I held back on a couple of things. I was defensive as well. I got the team around me as they had a very similar sort of attitude. I had to have people say they were behind me because I kept questioning, "Was it me?" (Molly, Int. 78, p. 1030)

Individuals choose what information to pass on to others, but patient outcomes are jeopardised if **pluralistic dialogue** does not take place. A lack of collegial trust becomes a barrier to the reframing process. At best, information management is problematic and overwhelmingly time consuming. Problems are recognised although the complexity of issues may prevent reframing:

> You're right about information exchange. Perhaps its because we are in an acute setting and things happen much faster. I've been really wondering about that. I find it extremely frustrating. Information about individual children is really difficult to obtain. It just drives me mad! Because its acute, we are not used to having regular meetings about particular children, so when we do have them not everybody comes, including me, because I don't even think they might be having one about one of my kids. Either way, they don't ask me, and I don't know. I find that extremely difficult. And trying to find out the actual truth is really difficult ... You hear from one person that it's this, and then you read the notes, and it doesn't tell you anything. It's very frustrating. (Caroline, Int. 92, p. 1154)

Frustration is common if coordination is absent. Quandaries are prevalent in the uncertain environment and may be perpetuated by team size too. Stott (1995) suggests that there are "staggering increases in time required for communication as team size rises" (p. 97). One of the major issues with continuous information coordination was that teams assumed that

information was manageable. The information mismanagement seen in this study indicated that organisational structures blocked efficient information flow as well. The new-style interdisciplinary teams constantly challenged the traditional channels of communication, and when allied support staff were not trained to redefine situations or to consider the roles of others, problems emerged:

> The clerks here hold a wealth of information. They know all the patients, they know where everything goes but they work to a system. They don't deviate from the system because that's not what you do. So trying to get the patient three outpatients appointments on one day was a major event! But we succeeded! And we didn't succeed because the clerk helped us. We succeeded because we kept saying "Well, I'm very sorry but he's not coming on three different days. He's coming on Monday. Shall I ring the consultant?" "Oh, I think you should!" So you ring the consultant and he says, "Yeah that's fine!" "Will you just tell the clerk?" So he tells the clerk," Yes, sure, you just book them in!" (Marilyn, Int. 7, p. 98)

Using authority figures to facilitate information coordination is time consuming. Yet, organisational workers competing for scarce organisational resources are maybe less inclined to cooperate with health professionals until traditional authoritarian interactions are introduced. However, the experienced clinician, familiar with organisational traditions, is prepared to use such strategies. They automatically seek alternative solutions to problematic situations. Taking on the role of the other, they predict actions, and reframe social interaction so that the issue is resolved:

> The clerks think the patient can't have an appointment before they leave but they can, if you pick up the phone and ask, "Tell me why you can't give the patient an appointment today?" "Oh, I don't have the book". "Why don't you have the book?" "It's in another room". "Well would you go and get it please". And you find out why. Everyone should have an appointment when they leave. How will I know that she changed it? I will because I saw her do it! I saw her change it on the computer and she had two pieces of paper being shown to her and she understood immediately what I was saying. (Marilyn, Int. 7, p. 97)

Understanding the fundamental issues of information coordination is vitally dependent on the individual integrity of each person. So many health professionals interact orally with each other, forgetting that individual communications of this kind affect collective responsibilities as well:

> They don't read anything. The ambulance officers write down what they see. They are taught to write what they see. Not what you think you saw but what you see. If you see the passenger in the car in this position - now you may assume they were the driver but just because they are in the driver's seat doesn't mean they were the driver. They draw everything. This is what they saw. They don't write down anything else. They might tell you this is what I think but they write what they saw. The patient comes into hospital and their run sheet comes with them. If I don't want to read the run sheet I'll ask the ambulance driver, "What happened?" "Oh. The patient fell down some concrete steps. There's some alcohol involved. They've got a fractured hip". He moves away. The next one comes, "What happened?" "Oh, the patient was pissed and fell over!" They say that because there's some alcohol involved. And then you get, "The patient was walking up the concrete steps and fell off them!" I get so frustrated and the story gets bigger and bigger as it goes along. And you can do this with three doctors who come along. It's like that "parachuting accident". He wasn't parachuting! He had finished and he tripped over his cords! (Marilyn. Int. 4, p. 95)

Inaccuracies in human interactions abound. Yet, it's so much easier to exchange information orally. Interactions are often complex and it is difficult to document everything. At the same time, continuous information coordination may be made even more difficult when written exchanges cover mainly objective data. Participants reported that sometimes it was impossible to document the finer details of care or decision making exchanges:

> There is that issue of time. It's easier to tell things to people rather than writing fifty lines in the notes. It's also harder to document what you've told the patient and the patient's relatives. And people say there are legal things so you must do it. But it's an exchange. It's not just you doing the talking. It's not straightforward quite often in that exchange. (Grace. Int. 93, p. 1227)

Continuous information coordination is affected by the often ambiguous, complicated nature of information. A wealth of data is contained in the patient notes but so often it is not considered relevant by a team member searching for specific evidence. Team members reported that finding out changes in patient management was a challenge. There may be contradictions between information documented in the notes and that held in people's heads. This situation illustrates well what McWhinney (1997) calls the dialect struggle between values and facts that are logically

incompatible. In this study, it was not clear that the team accepted a collective responsibility for information exchange:

> I'm wondering if sharing information is a collective responsibility? Sharing information to me almost sounds like it's an option. It's an optional extra. It isn't. (Laura, Int. 74, p. 530)

Information exchange is always problematic. When team members were observed in action the full nature of the problem emerged. Individuals did not comprehend the full scope of information management-mismanagement. While sharing information was discussed vociferously, busy team members fully engrossed in clinical activities did not notice the total impact of information mismanagement with clients and colleagues. The pace of practical life is such that information exchange is influenced by business-humanitarian clashes.

Business-Humanitarian Clashes

Business-humanitarian clashes refer to the disagreements caused by the operational and strategic responses to economic change, and the traditional altruistic concerns of being a health professional. One strategy for cost containment is to run health services in a business-like manner. Spiralling costs turn service provision into an economic equation. As health care access seems to decrease and primary prevention seems to decline, health professionals are constantly challenged to negotiate for resources that are increasingly scarce. The indicators of the category are economic scarcity, efficiency, bureaucracy, constraints, and optimisation.

It was evident in the study that, the contradictions underpinning business-humanitarian clashes were culturally embedded:

> Health management is not like business world management. If you applied business world management and tried to pull them together that would suit a couple of the disciplines. But it would be entirely inappropriate because you're not running the Warehouse. You are running a hospital and the issue is about the culture and the values there. It's a provider of a *service,* which has taxpayer funding, so it's different. (Jade, Int. 28, p. 108)

The changing nature of service provision underpins the business-humanitarian clashes. Handy (1990) believes that reframing works best when there is a stimulus external to the organisation and/or the team. Declining resources pressure all team members to *reframe team responsibilities* and *negotiate service provision* in structures that impose strict controls on organisational resources:

> Hospitals have been able to run unchecked for some time now. They took no responsibility for spending. They've soaked up the loot and never really had to be accountable for everything they used. Now, health care is so expensive that we've got check it. ... That's why organisations are putting in business managers to run the place like a business. ... That clashes with the doctors who want multiple choices when they can work equally well with less. So we are saying to the health groups, "Money doesn't grow on trees! You've got to get the best value for money. And you can use very good products for the care that you give your patients. ... But, you don't always need the Rolls Royce!" That's where the clashes come because they think they need the Rolls Royce all the time and money is no option. ... The business side of health care recognises we only have a certain amount of money. Of course, in the past the government has always bailed them out. If you went over budget by twenty million every year that was all right because the government bailed out. They don't now. It's about accountability. (Lilly, Int. 85, p. 1443)

Participants reported that accountability clashed with idealism as service provision was reframed. Clinicians had to look at situations and problems differently; to observe different perspectives; to take the role of the organisation; and to consider the wider goals influencing team decision-making. The long-held view of the altruistic health professional controlling a responsive service indefinitely, was fading fast:

> We had more idealistic goals before. There are major pressures to get people out of hospital fast. Time pressures are significant. ... In our team I am fairly protective of the patients because I understand more of what's going on. Once I've found out about a disastrous home situation, it's hard to get people home without trying to optimise the situation. ... I don't know what running the hospital like a business means really, but I feel cynical about all that. ... In some ways it hasn't touched me a lot, but in other ways it has, because we've had to become more efficient and we have altered our goals. It's hard to resist the pressure to get people out of hospitals. You do still try and do your best for people, but you can't be all things to all people. ... I feel cynical about the commercial goals of the system. I don't know the answers for health, because there isn't a bottomless pit of money, and so it's reasonable that we get as efficient as possible, and that we give good cares. (Grace, Int. 93, p. 1218)

Many participants understood that, when client management was optimised to the fullest, the patient and family were the recipients of a form of care that balanced organisational and service needs. Business-humanitarian clashes have to be melded within an integrated delivery system that acknowledges resource management, time pressures, complexity, and uncertainty. Many clinicians were troubled by this when their concept of quality was at odds with the notion of ideal care. Often the disciplinary culture socialises novices to maximise patient care to the highest possible standards, rather than manage client care effectively and efficiently. Although most participants did accept that care should be efficient and effective, Bowie and Shirley (1994) observe that health professionals are commonly less accustomed to evaluating clinical practice in relation to efficacy and cost-effectiveness. The interdisciplinary teams in this study were learning that perfection was negotiable and a little less than perfect was quite acceptable:

> I have a responsibility to give the individual patient the best care that I can. But I have to balance out that ideal for a patient who might stay for months to get into an optimum condition. There's an economic reality that we all have to deal with and accept. There are often people waiting to get into the unit. That's the bigger picture of how the patient's care fits in to the overall health system. That's the social and economic picture. You have a definite responsibility for the patient and often a conflict within as this person could make further gains if they stayed longer. But does it change the discharge location and does it then place a burden on society? You have to balance that out because you simply can't give the time you want to everybody. And you become incredibly stressed and guilt ridden that some poor person is sitting there for so many weeks and maybe it's time for them to go. And you have to argue that because our service wasn't able to provide enough when they deserved longer. You get torn in all directions. (Kathryn, Int. 71, p. 978)

Being torn in many different ways forced clinicians to *reframe team responsibilities* in order to be able to provide any service at all. Many participants spoke of their struggle to make sense of the tension between the ideals of the past and the possibilities for the future. These people were able to explain their actions in terms of shifting goals and redefining the situation. That supports the symbolic interactionist view that individuals are goal directed and constantly determine lines of action towards objects

by changing goals as required (Charon, 1998). Sometimes personal motivation helps individuals verbalise collegial action and interaction so they are freer to make sense of many complex acts. Resynthesis[13] is imaginable, indeed possible, when the wider implications of service provision are considered:

> In our department we feel that we are offering a worthwhile service. It's a caring attitude really. You take problems to a satisfactory end. You don't fob people off. We take a problem on and we fix it, or direct people to where it can be fixed. We offer that good service not only to the public, but also to the consultants, and other people coming into the office. It's not just doing the job – it's making people feel good. We are a service department so we offer rapid, expert services to a broad range of people. (Jean, Int. 29, p. 367)

Service provision occurs in a competitive environment that is required to emphasise efficiency and monitor outcomes. Bureaucratic structures are both constraining and facilitating:

> I've worked in small bureaucracies where you couldn't do things because you just couldn't! And bureaucracy has always been like that. Here, there are constraints on me. They're almost always financial. I accept that because we live in a world where that's so. There's never going to be enough money for health – whatever we put in they will always need more. But I don't feel very constrained here. I feel as though if there is something I want to try, and take on, I'm given this huge support to do it. And I'm almost dropped in and told, "Off you go! And if you fall over we'll help you but we'll let you go until you fall over!" (Caroline, Int. 92, p. 1164)

Although enthusiastic organisational support does facilitate individual reframing, it is debatable whether improved bureaucratic organisation necessarily furthers joint action that is beneficial to the client. Negotiating bureaucratic constraints was often time-consuming:

> Economic constraints have had major effects in two ways. Firstly, there are many services that we would like to have access to that simply don't exist or access is restricted. And the second is that those caring for the patients spend a considerable amount of their time manipulating the existing system to get what it will provide for the patient's benefit. And, arguably - there always has to be some work done in that regard - but many would think that there's far too

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[13] The concept of resynthesis was explained in detail Chapter 7 (p. 128). Bohm and Peat (1987) argue that "when the rigid tacit infrastruture is loosened, the mind begins to shift to a new order" (p. 244).

> much paper-work and bureaucracy required to get things done for patients who need it. (Ian, Int. 17, p. 247)

Unquestionably, bureaucratic constraints do affect business-humanitarian clashes. When services are rationalised teams may reframe their responsibilities by labelling patients as demanding. Blank (1994) argues that heightened public anticipation of technological advances has created an increased demand for scarce societal resources. Also, Blank claims that the political determination behind public decision making is likely at odds with local, individualised needs. This was evident as some clinicians simply could not resynthesise economic arguments to be compatible with humanitarian need. Resynthesised thinking is often impossible if **pluralistic dialogue** between differing parties does not take place:

> Well it isn't health management. When bureaucracy sees beds they see money and they see time - like a length of stay. Clinicians see people with needs. And they don't see people as beds. Management comes in and questions that patient who has been in that ward for four weeks when the normal length of stay here is three weeks. They want an explanation. And if you can't give them the perfect explanation, the patient is out the door. So there is that constant challenge of money over quantities and time and people. Management is not about people. They try and tell you that they are but they aren't. I am actually employed to be humanitarian about those people in those beds. (Margaret, Int. 82, p. 1119)

Business-humanitarian clashes definitely stimulated **pluralistic dialogue**. Clinicians frequently discussed the strengths and weaknesses of new organisational propositions for providing a quality service for clients. Such dialogue loosened up thinking about the familiar infrastructures. Morgan (1997) claims that taken for granted practices and assumptions must be re-examined if new capacities are to be created. If service provision is to be negotiated differently thinking has to change, and individual self-interests redefined in conjunction with others. Although logical, rational thinking may be constraining for some, clinicians searching for creative role making, role taking alternatives must integrate pluralistic perspectives as they negotiate services:

> Today, the key attributes of an organisation are customer focus and excellence for clinical and administrative systems. The other thing is measurement. One thing that comes through the quality stuff is if you can't measure it, you can't manage it. There is so much uncertainty and we can't measure it. So I think we need to start talking in teams about what we could measure, and then discuss what would help team function. We also need a team appraisal system - key accountabilities and sets of goals. The team needs to be managed like that. We need to look at team function, what productivity is, what outcomes are, and how they compare with other people. (George, Int. 62, p. 933)

Comparing team performance with other teams in the organisation emphasised the efficient and effective management of resources. Offering an optimum service to a specific group of people meant that team members had to take into account future service needs. Charon (1998) suggests that, "we are planners. We consider what our present acts will lead to. We are problem solvers. We imagine the consequences of the alternatives we choose. We are social beings. We imagine the effects our acts will have on others" (p. 142). Those notions were clearly evident in this study, as so many clinicians were expert at considering diverse points of view:

> I have a problem wanting more staff. It's not about whether we have a service but whether we can have an optimal one. Health is like a big bucket but how big is the bucket? However many staff we had the work would always expand to fit that. We do need more staffing but I have a feeling that it doesn't even matter if I hit on the right argument or not, that won't help anyway. (Caroline, Int. 87, p. 1141)

Whether arguments affected resource management or not, clinicians were left managing the specialist service as best they could. The organisation expected all services to be well-managed contributors to organisational functioning. Business-humanitarian clashes may well have pervaded the workplace but collective effort is critical for the optimisation of client care. When a cooperative spirit was present the professional orientation of individuals was blended into mutual problem solving efforts so team activities were synchronised to meet service needs:

> You have to keep remembering that there is a person at the end of this. It's easy to get sidetracked when you've got all these facts and figures and pieces of paper. You have to have an idea of the wider picture of what is involved. You have to be conscious all the time of

> following up. We always think that is somebody else's job. I've done my bit and her job is to type it and it was my job to put it away and it was nobody else's job to do anything else! It's not straightforward usually. It's not just a question of somebody doing something wrong and falling down. It's usually much more complicated than that. The hospital system is pretty complex. It's hard to explain how busy it is sometimes. So you take the rough with the smooth, as usually there are lots of things happening all around you all the time. You have to see clearly where you are going. (Sue, Int. 30, p. 306)

The central focus on patients enabled health professionals to *reframe team responsibilities* in order to benefit the client as best they could, albeit perhaps with some limitations. Structural reforms forced clinicians to *negotiate service provision* that took into account the pressures on the public purse. It was difficult for individual team members to *reframe team responsibilities.* All members of the team needed to support each other as they worked through the issues, and made decisions together.

Deciding Together

Deciding together is the team decision making process that is essential for *negotiating service provision.* Traditional, authoritarian modes of decision making rely on bounded rationality, and work well in bureaucracies where patterns of power and influence are stable, and clearly definable. Morgan (1997) suggests that such styles are less useful in the technocratic organisation where the turbulent environment, power and accountability are directly linked to technical knowledge and expertise. Because the acute-care hospital depends on technical contributions and expertise that change rapidly according to patient progress, time, and space, a flexible means of decision making is required in order to optimise client care. The indicators of this category, discussing, communicating, and challenging, shape the team approach to decision making:

> There are still groups who want to make decisions for all the other professionals. Particularly for things like occupational therapy and physiotherapy, which, until quite recent times, were on prescription. It's only from the mid-80s onwards that physios and OTs have made independent decisions for treatment based on their own assessment of patients. The medical groups aren't finding that transition easy. I have only ever worked with one group where the consultant knew how to take information, use what he wanted to make his medical

> decision, and leave the rest to good communication so everybody knew what they were doing. He never pretended to make decisions on behalf of others. (Janeanne, Int. 2, p.21)

In this study, most physicians had learned how to *reframe team responsibilities,* and they were willing to delegate decision making to competent colleagues. Competent colleagues were encouraged to make situational decisions autonomously. However, the complex nature of client care required team discussion in many situations:

> You have different ranges of decisions. You have the everyday decisions that you just decide yourself. Then you have the more complex things that we discuss with the team. It's not necessarily a matter of having to ask the boss about everything. We'll talk things through together. So there's a range of levels. And then there are the more political decisions - about a group of clients we might have. The team might decide that we are not going to see some people because we have not been resourced for that. (Alec, Int. 69, p. 854)

Making choices about resource management is seldom easy. In this respect Larson and LaFasto (1989) believe that effective leaders create a decision making environment that "unleash[es] people's willingness to exhibit a bias for action, which in turn create[s] an enthusiasm and commitment to the team's objective" (p. 125). Free, open discussion is fundamental to encourage new definitions of a situation as fresh interpretations for new actions and behaviour evolve from social interaction. Leadership style appears to be vital here as it sets the tone for open, honest communication:

> It's communication! If there is a team involved then you need to talk not just to the nurses who are there most of the time, but to the OTs and physios who are in and out. So that is a responsibility to try not to make too many unilateral decisions. There are certainly unilateral decisions about medication changes, which aren't a problem, but in terms of the overall aim for the person who needs to get people on board, there needs to be an opportunity for discussion. Ideally I would like to talk to people, and agree where we're going as a group and make sure that the team was happy about that. (Grace, Int. 93, p. 1210)

Pluralistic dialogue facilitates team agreement as the clinicians work through different points of view. The symbolic interactionist perspective suggests that decision making is ongoing (Charon, 1998). Decision-making

is never isolated from environmental interactions and actions. So often, decisions must alter in an unfolding reality:

> Sometimes we have real dilemmas with decisions about our patients. I know what's best for them but I also know what they want. So how do you balance things up? And even when it's against your judgement you are powerless to change a decision. And you know that in a months time it could all fall apart and the patient could end up back here anyway. Some patients are very hard to manage! Communicating together is important. It's deciding in the team that the decisions made are the right decisions. And that takes a lot of discussion. It's a discussion rather than passing on information. There's a debate. If you are going to make decisions you need to debate the issues. There is an expectation that everybody will have input in decision making. (Molly, Int. 78, p. 1038).

In the four teams, team input into deciding together was regarded as being imperative if influence across the professions was to be negotiated into a cohesive outcome for the client. Once full discussion took place it was much easier to understand each other's concerns for meeting service needs. Interestingly, Rodney and Starzomski (1993) note that, when teams discuss issues at a team conference in such a way that the reasoning of others is easily understood, nurses and physicians discover that they share the same understandings and opinions. While that may be so, some participants recognised that, vital differences affecting decision-making were often more the result of poor communication between colleagues:

> There are different ways of making decisions. The consultant may make the decision and we might think it's right or wrong. That is autonomous. So we work to that decision which is normally a discharge date. Or, the OT makes a decision about discharge after the home visit. That decision is autonomous as well. Or, the decision is a collective one around the client's progress. Decisions then are based on outcome measures. The person will have achieved those or not. Decisions are outcome dependent or, made when outcomes are unknown. The problem is that you have the two types of decision-making going on at the same time. When decisions are autonomous, that is very disempowering. Collective decision-making is more empowering. The way those autonomous decisions are made is not clear. So it leads to conflict. It leads to professional and time conflict. And the consultants who make those decisions don't realise that. When the pressure is on, when the social side comes onto them, they review and think "Right! This person can go". Some decisions are made like that. At other times there doesn't seem to be any rationale behind decisions to keep patients for another week. Sometimes decisions are client-centred, goal orientated, and outcome measured. On the other hand, it seems to be the consultant who makes our

> decision and there is no way that I can negotiate on that decision. So I have to work to a time constraint, which is artificial for the client. I have no recourse because I feel unable to negotiate my responsibilities to that client and with the team. If a decision is made and if I can't get to that date I am then the one that's at fault! But in fact the client actually isn't ready because that's an artificial date. There doesn't seem to be any clinical rationale. It becomes more inconsistent the busier the beds are. I don't know what their thinking is behind making those decisions. It's not my thinking. (Laura, Int. 74, p. 826)

Trying to understand a colleague's thinking when **pluralistic dialogue** was absent made deciding together very difficult. Although most interdisciplinary team members expected a constant stream of action throughout each day, too many unilateral decisions that were inconsistent with the team goal could undermine the concept of teamwork and threaten joint action. Decision-making was contextual:

> There may be disagreements about how best to manage a situation with a family. And the person that made the decision that the child should be in hospital very often isn't there! So the process around how decisions are made and who carries the burden of care within the hospital system, are unclear. It requires a two-way acknowledgment or talking about the different burdens and responsibilities that people in the team carry when decisions are made. I carry the medico-legal responsibility for discharge. But I'm not the person who is going to be punched in the middle of the night. So there's ample opportunity for enormous splitting of the team and resentment around that. It is very easy for someone to decide but I know I'm going to end up in the manslaughter court if I send the child home. I know he is difficult but it is not my job to manage him. Team members need to listen to each other without being personally threatened. (Emily, Int. 96, p. 1526)

Listening with the intent of understanding the deeper meanings of each situation is important for deciding together if the team is to negotiate service provision effectively. Creative action emerges from a supportive, encouraging climate that invites the open exploration of options. This must be integrated with fact-based decision-making that is absolutely critical as a base-line determinant for action (Manion et al. 1996). Although differences are inevitable these can be managed positively when interactions remain informal:

> There are other agendas. Someone told me that the doctors make decisions at the morning meeting and then the nurses take the decisions away and change them! I wouldn't challenge another doctor in that type of context. I would try to do it informally. I try to do things differently. I think that's a female way of doing things. So things would be challenged outside of the meeting. There's not much that is controversial but it does happen. If I disagreed with someone I'd talk to that person individually so it wasn't public that we disagreed. It depends how serious the challenge is. I prefer to talk to someone on my own rather than in the group but it depends what it is about. If you want to change someone's behaviour it is less threatening and you will get a better exchange by talking individually. In public you are more likely to defend your actions rather than change behaviour! (Grace, Int. 93, p. 1214)

Changing actions or behaviour is fundamental to the negotiation process. If joint decisions are to be activated, team members must support the notion of interdisciplinary cooperation. Shifting the focus onto the client service facilitates the process of deciding together in ways that are congruent with the competitive, distributive demands of health care organisations where there is a new emphasis on accountability.

Collective Accountability

Collective accountability occurs as a consequence of team members negotiating their mutual responsibilities and obligations together. The indicators of this category are reviewing, resource management, and abdication. Manion et al. (1996) claim that mutual accountability "means that there is a review process for the accepted responsibilities" (p. 76). In this study, collective accountability varied somewhat. Thoroughly established in the three small teams, in the large ward team it occurred more by individual effort. Although individual responsibilities are well understood, collective accountability can be a nebulous term that is readily assumed, but practised less often. Indeed, if it actually directed team practice consistently, that influence was implicit.

In the specialist teams in this study experienced clinicians assumed clear, individual professional responsibility for their practice. Manion et al. (1996) contend that any successful team effort is founded on "mutual accountability that differentiates a real team from a working group" (p. 76).

When collective accountability exists, every team member is responsible for team outcomes and results. That means that a team is only as good as its weakest member. Therefore, if collective accountability is a desired team goal, team performance must be reviewed in relation to the clinical input. This process is quite different from traditional team practice whereby individuals were accountable for their separate input:

> We collect information so we have a feel for what's going on. It's not collected for political reasons. It's collected for clinical reasons. And we have control over the information as to who gets what and where. It's a slightly unusual situation. In most medical fields you deal with your own patients. You don't get involved or review other patients unless there's a specific problem, which you are responsible for, or are on call for. It's unusual to do rounds on other people's patients. So people get very sensitive about others assessing their quality of care. We started in very gently to make sure we didn't upset people, by having a general look around, and not being judgmental. When you're collecting information and assessing patients you can use it as an audit tool and you can start hammering people over the head with their problems. We tried to stay away from that and tried to use it to improve the care for the patient. Many services collect information and beat people with it rather than use it usefully. And that's not what we want to do. So, you're always greeted with a fair bit of suspicion when you start reviewing other peoples' patients. We had to make it clear that we're not auditing. We're just collecting information, finding out what's going on. And part of that review process is finding things that haven't been dealt with. (Richard, Int. 13, p. 173)

Reviewing the collective accountability of specialist teams is fundamental when a focused, integrated structure is required for quality service provision. It is not particularly unusual that members of high-performance teams hold themselves collectively accountable for mutual professional input (Bolman & Deal, 1997). Nevertheless, Larson and LaFasto (1989) believe that the need for review is more likely in teams when efforts are random and haphazard because clear roles and accountabilities are absent. Hierarchical patterns of accountability no longer provide the flexibility required by interdisciplinary teams operating in institutions that are focusing on function, rather than political power (Greenwell, 1995). Health professionals, though, are known for their ability to think, and to take control of changing situations. Equally, managers seeking improved organisational functioning expect that professionals will automatically extend their thinking beyond the boundaries of immediate service provision to include the wider environment. Accepting mutual accountability for

clients' recovery includes negotiations that incorporate organisational demands as well:

> Accountability is not just accountability of the outcomes it's accountability for what you do. But you must increase control. Otherwise you're giving them the accountability but none of the responsibility nor the control to achieve it. And that's ridiculous. And in management we always do it! We constantly do it! Get that right! OK! Well, wait a minute. How can you say get it right! That's impossible! So the collective responsibility I think is grown rather than given. What you do is give them collective accountability. And be serious about it. (Wayne, Int. 90, p. 1243)

In this study, collective accountability was negotiated internally in the team at the clinical level, and externally between the service and the organisation. Throughout the process, one of the key responsibilities for managerial leadership is to establish conditions that support accountability (Krantz, 1989). When that happens, all team members should be able to be mutually accountable for following through with joint actions:

> We can all accept token responsibility and be accountable but it is actually more than that. When we accept the collective responsibility we also accept the consequences. The whole team has got to participate to get the consequences. Anybody can agree and sign across the dotted line but if you are not doing any work and everybody else is doing the work the team won't work. Collective responsibility is not to the patients. It's to the team goals and everyone is accepting that they have to work equally and participate together.(Margaret, Int. 85, p. 1108)

Accepting mutual accountability for both participation and achievement did not occur unthinkingly, just because practitioners were professional people. In some situations collective accountability was seemingly ignored:

> There is some abdication of responsibilities. You see individuals around who don't do what they should. Then someone else has to do it for them. So work gets missed. If it happens in a team with different disciplines, if one falls down for some reason then the others may be able to take up some of that - but not all of it. So it certainly happens (Alec, Int. 69, p. 847).

More often than not abdication results when a team member cannot deal with a situation for some reason. Continuous change may blur a team member's interpretations of reality and their definition of a situation can

narrow, so they become selective, thus blocking their ability or willingness to act:

> I don't see people abdicate responsibility much. They don't do it a tremendous amount. I think it's come from an inability to deal with something, rather than a lack of acknowledgment of roles or their responsibilities. It's the, "I'm not going to deal with that!" It's more a stress thing. (Laura, Int. 74, p. 832)

When change is continuous often any single, isolated action to maintain the status quo will stand out in a team that is constantly adjusting collective actions and directions. From the symbolic interactionist perspective, Charon (1998) notes that "we watch others and we label their acts; we look at our own action and we label those acts" (p. 127). Labelling shapes decisions and enables control over the general direction of mutual actions. Relabelling helped some participants to reframe issues:

> I can identify with that abdication of responsibility myself. Currently, there is a lot of pressure within the system. When we've got so many varied responsibilities that we are accountable for, overload occurs. I can understand that sometimes you just have to make a stand and say, "Well, I am just not able to meet this or to achieve that - at least for now anyway. It's the constant change and I've felt there have been so many things to try and achieve at once, it is unrealistic. Sometimes I just have to say "I can't do that or be responsible for that right now" (Sophia, Int. 79, p. 909)

Choosing not to take on responsibility for work roles defined by others may not be intended to block cooperative action but may be used deliberately to allow time to think through potential responses and actions. Although deliberative thinking extends individual understanding, it does not necessarily enhance mutual accountability. It is possible that abdication has evolved from disciplinary isolation and the traditional fragmentation of services:

> Abdication is a very interesting concept. Basically you withdraw from a situation and say, "It is no longer something to do with me. It's not my responsibility". You see that more often in the surgical wards where the style of the teamwork is quite different. The doctor assesses the operation he has to do and the nurses look to what their roles will be. Then, the surgeon will say, "I've done my bit!" And they abdicate! They just say, "Send the patient home!" That is irrespective of whether it is appropriate or inappropriate. What they are saying is, "It's over to you!" And similarly, with physiotherapists, if you are

> dealing with a really difficult patient - they have tried some sort of interventions and the patient is not interested. The physio has done their best, exhausted their resources of trying to inveigle or entice the patient to participate. And they don't! And they say, "Well, that's it. We can't do any more!" and they just withdraw. So that leaves it with the doctor or somebody else to try and negotiate it. And they're very difficult situations! And invariably, it comes down to one or two people to try and work out, or negotiate outcomes. (George, Int. 38, p. 432)

Constraints have the potential to restrict innovation when a team negotiates new ways of practising in this type of environment. Moreover, Morgan (1997) argues that redesigned organisations call for different types of action and response when "flexibility and capacities for creative action are more important than narrow efficiency" (p. 28). In this study, negotiation was challenging:

> In the wider picture of health reforms, our profession has had to alter. The atmosphere is changing and we have to be a lot more accountable for outcomes and a lot clearer about what we do. And probably here, we are in the forefront of our professional development in health reforms. We are different to the rest of the profession in that we are keeping statistics. We have started to use outcome measures and we have best practice guidelines. We are trying to be clear about what we do, and how we do it. But health reforms impinge on professional freedom. (Catherine, Int. 76, p. 888)

The perception of a gradual erosion of professional freedom was unsettling as interdisciplinary team members shifted thinking from individual professional accountability towards a collective responsibility that included the profession, the client, and the organisation:

> There's an element of it's not part of our role to worry about paper work, to worry about administrative decisions. We treat the patients and help them and that's not part of our role to worry about where we are going to be working or what forms we have to fill out. We have to be responsible with our allocation resources and we know that we have limited resources for both ourselves as people and in the service as a whole. We recognise that and are trying to be fair about that. That's uncomfortable but I think most of us would feel happy enough with that, in theory. Just working out in practice is hard. But it's the other stuff, which most often doesn't affect us, but every now and again comes at us. We have to code statistics at the moment. We've got into that now and that's OK. That's a paperwork thing. Then there is the bedspace issue. We are getting more pressure to get people out. We are told by managers to make sure we aren't keeping people for the last 5% of getting better. (Catherine, Int. 76, p. 883)

When it was difficult to see the vision clearly in time-limited care episodes, collective accountability was likely to decline. In fact, collective accountability embraces individual action that has to be moulded with collegial activity at both the team and organisational level. Teams are challenged to remain centred on the core product and the core process of health care provision – caring for patients. Indeed, Doerge and Hagenow (1996) argue that the health professionals "must strive for integration at three levels: within ourselves, between persons, and within our organisation" (p. 42).

Negotiating outcomes and collective accountability when some team members concede responsibility to colleagues is awkward. A partial explanation is provided by Katzenbach (1998) who argues that mutual accountability threatens "the simplicity and security of individual control" (p. 50). In this study, the absence of mutual accountability left willing team members negotiating extra responsibilities among themselves. Manion et al. (1996) observe that it is impossible for the team to hold itself responsible for team achievement when individuals are not accountable to themselves or mutually accountable for the team outcomes. Responsibility without performance control fosters a false accountability and effects the extent to which client care is optimised. On the other hand, answerable responsibility may lead to partnership:

> Responsibility is about achieving and being part of the team that provides health care for the client. My responsibility involves me being part of a team that offers care in partnership. And to do that I assume an approach that the buck stops with me. I have a responsibility to value input from my colleagues and the client. I have a responsibility to ensure that process is as smooth as it can be - that it's coordinated, explicit, constant, dynamic, and reflexive. I have an ability to move in, and I might not make decisions, but I respond to cues to let you know it's your time to move in, to do some work, and share information – at the right time in the right part of the team. At the end of the day responsibility means we are providing quality service in health care for the people we work for, the team, and the client. (Louise, Int. 59, p. 869)

Cooperation and constructive controversy sit beside each other comfortably in **pluralistic dialogue** when the client is the focus of care. In this study,

actions, interpretations, and choices are melded together interdependently, as interdisciplinary team members respond to environmental change, think through potential actions, and move to provide a responsive service in an ever-changing context for a constantly changing patient population.

Conclusion

In this chapter the negotiation of service provision has been discussed. **Pluralistic dialogue** replaces the confrontational interactions of yesteryear. Health professionals are redefining independent approaches to client care, assuming that interdependent actions are necessary for the optimisation of client care. Negotiations are no longer confined to parallel professional interactions but are now inclusive of wider organisational functioning. The negotiating process is transitional. Some causal, conditional, or consequential factors are well developed while in other situations, change is occurring more slowly. While services are generally well coordinated, information exchange is precarious and dependent on individual effort to ensure success. Furthermore, collective accountability is implicit but not overtly discussed, so it effects decision-making and the extent to which client care is optimised. The plurality of actions is emphasised in a context shaped by complexity, ambiguity and paradox. That setting supports **pluralistic dialogue** that opens up a paradoxical pathway for clinicians to *engage in the dialogical culture*. That conceptual category will be examined in the next chapter.

CHAPTER TWELVE

Engaging in the Dialogic Culture

Introduction

In the previous chapter *negotiating service provision* was examined. That conceptual category combined with one more, *engaging in the dialogic culture,* to generate the theoretical code *reframing team responsibility* See Table 10). Many health professionals *engage in the dialogic culture* when they share suppositions and inspirations freely and frankly, at the same time conferring intentionally over the most effective means of fulfilling functional responsibility for meeting service needs. *Engaging in the dialogic culture* is a conceptual category that explains how members of interdisciplinary teams generate shared meaning, as they are involved in resynthesising their thinking.

Table 10

The Location of Engaging in the Dialogic Culture within the Theory of Pluralistic Dialogue

PLURALISTIC DIALOGUE	
Rethinking Professional Responsibility	Breaking Stereotypical Images
	Grappling with Different Mind-Sets
Reframing Team Responsibility	Negotiating Service Provision
	Engaging in the Dialogic Culture

In the Chambers Dictionary, Schwarz et al. (1994) define engage as being "committed to a point of view or to social or political action" (p. 556). In this study, interdisciplinary team members share a common concern for meeting service needs. No one clinician can meet the client's needs individually. Hence, most people are deeply committed to a team culture that values meaningful interactions and above all, the best care for the

patient. **Pluralistic dialogue** facilitates the collective interpretation of team predicaments. Discourse is important in order for the team to be able to engage in joint ways of thinking about interdisciplinary practice. Engaging is a dynamic exploratory process in which colleagues examine all sorts of probabilities in a supportive environment.

In this last chapter presenting the emerging grounded theory, it is argued that team members *reframe team responsibilities* and *engage in the dialogic culture* because they work together in conditions that support some measure of interprofessional safety. Engagement in dialogue proceeds better in a context where pluralistic leadership exists. In order to handle the individuality that emerges in the dialogic process, the team becomes involved in tolerating personality differences. Effective interdisciplinary interactions result in a sense of community (See Table 11). These categories are analysed next.

Table 11

The Properties of Engaging in the Dialogic Culture

Engaging in the Dialogic Culture

Coding Family	Properties of Conceptual Category	Indicators
Causal Conditions	Interprofessional safety	Openness, honesty, trust, listening, confidentiality, subversion
Context	Pluralistic leadership	Facilitation, people management, encouraging, communication
Action/ Interactional Strategy	Tolerating personality differences	Self-awareness, sensitivity
Consequences	Sense of community	Willingness, team person, support

Interprofessional Safety

Individual thinking pervades team actions and interactions. In this study, new disciplinary alignments may threaten psychosocial safety within teams. Close alliances are unfamiliar and potentially risky when professional groups have a long history of authoritarian approaches towards semi-professionals[14]. Semi-professionals are less used to seeing themselves as true partners in practice. Indeed, Hirschhorn and Young (1993) suggest that "powerful psychosocial dynamics shape people's capacity to work safely in groups" (p. 143). The call for security between professional groups working together is crucial if all colleagues are to resynthesise their assumptions and focus intentions into collective inquiry and action. Effectual teamwork flows within a safe communication climate.

Interprofessional safety refers to the shared communication that ensures the efficient, collective connections needed for *engaging in the dialogic culture*. When individuals are open and honest with each other, trusting interaction enriches the whole group. Once team members feel safe among the represented disciplines they are comfortable challenging assumptions and trying out new ideas to meet team outcomes. The indicators of interprofessional safety are honesty, openness, trust, and listening. Confidentiality and subversion comprise the intervening conditions, the constraints that support or constrain how members of the team are able to interact together.

Today, closer working relationships between health professionals are seen by some as dangerous liaisons that are eroding the traditional disciplinary roles and responsibilities. Although every discipline articulates standards of professional safety and competency for its members, emotional safety in team interactions – across disciplines - is less well defined. In this study, many participants were unaware, insensitive, or over-sensitive to safety issues in interdisciplinary team dynamics as professional boundaries were merging. Tensions were subtle:

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[14] More explanation of the term semi-professional is located in Chapter 3, p. 43. For further reading on the topic see Etzioni (1969).

> Safety in the team is knowing that you can say anything you like in the team and they won't be mortally offended. That it will stay within the team. They actually won't go out and repeat everything you've passed on in confidence and create scurrilous innuendoes or rumours ... .Safety is understanding the attributes of the others so that you feel that you can express what it is you want to express and you know you will get support from the others. You know that you'll get the help ... .you'll get support from your mates and that you can be open with them. You can't be open anywhere else. And you can't even talk openly with your immediate managers. (Lilly, Int. 85, p. 1412)

Many participants were clear that freedom of expression precedes safety and is grounded in trusting interactions. Preconceived assumptions about disciplinary differences are alterable, as long as practitioners trust each other enough to examine personal thinking, feeling, acting, and interacting. Trust is not transferred automatically but must be earned in due time. Learning requires trust and trust promotes learning, but both take time (Hackman, 1990; Katzenbach, 1998). Paradoxically, interprofessional safety and trust are generated in a context where time is at a premium. The intensity of professional work means most health professionals are accustomed to forming intimate, safe, trusting relationships, quickly, with strangers. By contrast, time-dependent safe interactions with colleagues are ongoing and affected, in part, by the sort of people who are health professionals:

> Essentially health people are fairly honest. Because that's the way you do things in health. You share as honestly as possible because you know that if the next person doesn't get the information an inappropriate decision could be made. There's responsibility there. That's ingrained in all of us but because of that we're all a bit too honest and open and transparent. We're not good managers of the political process, which means that when you're doing that collective group management it won't get together if you haven't got the attributes of leadership and actually understand. (Janeanne, Int. 2, p. 9)

Team leaders are influential in interprofessional safety. They are well positioned to set the tone, and to encourage the staff to create a reliable, secure interactional space. Openness, honesty, and trust foster a cooperative climate (Barczak, 1996), and also improve the quality of collaborative outcomes (Larson & LaFasto, 1989). Similarly, open-mindedness implies a tolerance of pluralistic difference as well as a certain

flexibility of thought essential for the enhancement of **pluralistic dialogue**. Although all this begins with self-interpretation within each team member, self-evaluation may contribute to *engagement in the dialogic culture*. Many participants spoke of the need for every individual to take the role of others and define situations from alternative points of view if shared responsibility for interprofessional safety was to be actualised. Perception of emotional safety was always individual and influenced by personal attitudes:

> I think you need to find commonalities of relating. With some disciplines you have to look at your own insecurities about what you feel about that discipline. There is potential there to assume power hierarchy with a discipline, depending on the level of knowledge they have. So respect develops with the different strengths that people have and an acknowledgment of their frailties. But that minimises people's putting down of others because the strengths are what you have them there for. ... The common purpose is critical and until you see and own that – that the patient is the pivotal reason for all our existence – then you get caught up in turf battles. ... And when you talk about the capacity for a team to be open and honest, for me, that's when creativity can happen. When people can't be open and honest there is more potential to defend and to close up. And when people can honestly share, and have a bit of fun, and not be picked on because they're not politically correct all the time but they're politically correct most of the time. Once those things are out of the way you can start working together! (Carol, Int. 16, p. 229)

Working together cooperatively proceeds when people feel safe to make frank expressions. Freedom of expression interconnects with collective action. Strauss (1993) thinks that "individual action, whether overt or covert, is complexly linked with collective interaction. Also, since we are languaged beings, our thought processes can scarcely occur without connections with collective contexts" (p. 133). Therefore, when health professionals are emotionally secure with colleagues, they offer and receive input readily and candidly, putting personal defensiveness and value judgements aside in the interests of the client. Interactions are direct and to the point:

> You get straight into the issues. You haven't got to be worried about whether you are saying the right thing. You don't have to worry about approaching the subject in the right way. I would be quite happy now to go into a meeting with a physio and an OT and a doctor and say, "Well the nurses are not doing this!" And I know that they would listen, they would respect what I had to say. They might totally disagree with me but I could go in and say that. I wouldn't

> have to spend three weeks thinking about it and wondering if perhaps I should say this or not. I will just go straight in. I feel safe that they're not going to laugh at me because they know where I am coming from because they know me. I can speak up and not be frightened that people will ridicule me. (Margaret, Int. 56, p. 408)

Evidently, team safety nurtured engagement and nourished a sense of belonging. Sharing honestly seemed to vitalise flexible thinking so that the capacity for creative action was possible. Informal discussion often assisted the team exploring multiple options and initiatives. This sharing of information "can be a source of creativity, shared understanding, trust, and commitment" (Morgan, 1997, p. 110). Such interactions are very different from historically situated authoritarian relationships that have limited **pluralistic dialogue**. Some team members were highly sensitive to interactions that seemingly created a sense of mistrust:

> I feel with some team members that I work with that I don't completely trust them. If I was to say something I'm not always sure that they're going to listen to what I say and to value it. They might say, "Well yes but we're going to do this anyway". I don't mean that I don't respect them or anything like that. It's just that I feel cautious about how they're going to react to me. But I think it's really important with trust that something is going to get done or that you can value what they are saying. You have to be honest but sometimes they're not listening. (Carmel, Int. 47, p. 560)

Sometimes it is a challenge establishing a conducive listening environment (Gage, 1998). The positive spirit of mutuality inherent within listening cannot be assumed. Culbert (1996) believes careful listening is just as important to ensure people get on and solve problems without making mistakes. Deep empathic listening sensitises colleagues to others' thinking. But, when valuing is absent, people listen selectively, furthering individual interests at the expense of participative interaction. Indeed, the dialogic culture emanates from respectful listening that involves putting aside the self and self-interests, and taking the role of the other:

> He listens a lot more and I think he is clearer about roles. He bites the bullet with some difficult decisions. He acknowledges and supports his team members. He listens but he also thanks you and he doesn't leave you. I feel secure. We have some highly complex cases where we have been left wafting in the breeze. To try and get somewhere is impossible individually. I wouldn't mind taking collective responsibility because I do feel secure. Some of the people I

> work with are excellent but he has a real handle on everything that is happening with his patients. He allows them to take risks and he acknowledges the risks we take with them too. We are supported in taking risks with those patients that we wouldn't otherwise. He allows people to take a chance with his team. So his style is comprehensive and inclusive and secure. (Laura, Int. 52, p. 724)

Clearly, the extent of interprofessional safety in the team was also affected by the attitude of the team leader. The colleague who took time to understand others was highly valued in an environment where such actions were rare. Without doubt, the regularly changing team personnel in the large ward team affected the quality of team interactions. Safety is seldom settled in those work groups, for new people enter the team all the time, disturbing the existing safety zones. New people generally bring different thinking and approach new experiences with fresh eyes. If they are anxious about the unknown, unpredictable environment they might resort to social defence mechanisms, inadvertently blocking team action, as they try to regain control in an environment seemingly out of control.

Yet, it is so easy to *engage in the dialogic culture* when people are willing to support each other. But, overall, it seems that emotional safety is not well understood across the disciplines. Often, members of disciplines take common understandings for granted, making unwarranted assumptions about who understands what. The possibility of deeper power issues dominating here cannot be underestimated. Trist (1993) suggests that the untenability of unwarranted assumptions and the persistence of certain behaviours is indicative that team members are using non-understanding of each other as a psychological defence in situations they are forced to recognise or resist. In this research, nurses and occupational therapists, traditionally undervalued in service delivery, discussed interprofessional safety freely while other professional groups were quite puzzled by the idea:

> As a physio I had no idea what safety was. I said, "What's this safety thing?" As a physio, people are safe if you don't drop them! We don't actually have any concept of being emotionally safe. That's not in our way of thinking. It is probably in our way of relating, but we don't talk about it. When nurses talk about safety it is a core thing. I realise nurses think of safety in terms of physical safety and emotional safety and now I can understand it. But before that it was a foreign word to me, a foreign language. (Catherine, Int. 76, p. 894)

Multiple meanings pervaded **pluralistic dialogue**. Discrepant interpretations of language and behaviour spilled over into interdisciplinary practice affecting those who were more used to subordinate roles in the health service. Semi-professionals wanted to be treated as professionals yet some presented confusing signals to peers:

> The therapists feel they can be trodden on, and other things take priority, and their opinion gets overlooked. In some instances that's professional safety - that they get dumped on as individuals. I think a responsible team could acknowledge that would be a difficult thing and that would be the team leader's job to sort of say, "Well, OK we haven't dumped on you". But is it appropriate to go through all the lengthy discussion about what we would do here in this meeting? But we could meet afterward and talk about it. (George, Int. 63, p. 935)

Discussion, formal or informal, certainly influences interprofessional safety. So often, team discussions reveal credibility or vulnerability that is uncovered when patient management is scrutinised. A few participants spoke of vulnerable team members who may respond by projecting anxiety onto others via subversive interactions. From a psychodynamic perspective those people may try to exert control of situations out of control, by dividing the team. Those actions are consistent with Hirschhorn and Young's (1993) idea of splitting that is a defensive mechanism, which helps members of a group control and contain feelings of anxiety when facing difficulties in their work. Hiding professional incompetence is likely to be energy sapping, as so much effort is required to defend narrow, reflexive thinking that is untenable in a complex environment:

> We can't ignore personalities in the team. People scuttle a team by subversive manipulation of people. And I've seen that happen. I've seen one or two in a team stabbing others quietly in the back. They do it in the team, and outside it. They set members of the team against each other. So there's no safety. I think they do that because they've felt unsafe in a team, and because they aren't competent. The way these people function in the team is to become destructive. When safety is undermined, there is no way to survive it, because it's not being dealt with. It's happening in an underhand way, and often takes people quite a while to see what's happening. Then, there's mistrust in the team. Because of that, the goal is misty. ... Those personalities undermine inter-professional safety and then you've got a difficult time ahead. Even if you've got competence, commitment to the goal is undermined. If you're not feeling safe, you think, "I'm not going to lay my cards on the table because I'll get stabbed in the

> back, so I'll stay back". That is about safety. It's not just rapport. But, it goes back to competence. (Kate, Int. 95, p. 1609)

Clearly, interprofessional safety is affected by competence as well. Safety grows and is simplified when the team accepts that no one has all the answers. Some teams are more supportive of each other than others. Although responsibility begins individually, the team must actively share a commitment to safety. Indeed, Hirschhorn and Young (1993) believe that, when team support is absent, a threatened individual is more likely to project the sense of danger and feelings of safety and security onto another. That action undermines the potential for team action. Even though individuals sustain each other, collective action is also required:

> He acknowledges what I do and is more overt with it. But, it's more than that because we are talking about professional safety. What is it that makes me feel safe? He stands alongside me in allowing risk and because he is alongside me there is his presence. And that's what I mean about his sense of warmth is there. So I feel supported because he endorses what we do and he doesn't do it one over one he does it by standing alongside me and he shares my problem. So I feel supported because I can talk to him and he shares my problem rather than leaving the problem with me. It is my job to do that and I do that but he makes me feel more secure in doing it. I am clear about my role and my boundary. But when a problem is left with an individual when it should have been a collective responsibility – that "over to you" is a most unsupportive thing. (Laura, Int. 52, p. 721)

Of course, client problems are team problems, even though it is perhaps inevitable that, in larger teams, some individuals will always try to absolve themselves from responsibility for team action. In contrast, many more participants spoke of a sincere commitment to develop the self personally and professionally. However, while individuals made significant efforts for themselves, and the team, the leader had a major influence on the total process.

Pluralistic Leadership

Attitudes to working together are strongly influenced by the context, and also by the actions of those at the top - how they encourage, or discourage, new ways of practising and participating together in times of change. Mazaney (1995) is quite clear that the most important predictor of success in change programs lies with the "attitude, commitment, understanding, and involvement of the leader" (p. 18). Furthermore, success is more likely when team members trust themselves, "their leadership and their systems, and the nature of their motivation. Values-based leadership nurtures and develops this trust" (p. 17). In this study, pluralistic leadership is the way the person who has overall responsibility and authority in the team guides the group. The key to this style of leadership is that the person constantly models a quintessential valuing of people that transcends all boundaries.

The shared responsibility underpinning **pluralistic dialogue** is very different from the individualistic responsibility typical of professional groups. In this study, leadership and management often appeared as separate entities supporting the notion that "all managers should be leaders, but not all leaders need to be managers" (Mazaney, 1995, p. 93). Leadership emerged clearly as both team leadership and team management. The roles and responsibilities for each are quite different. The team leader and the team manager are not necessarily the same person. In this section, pluralistic leadership is addressed, while specific leadership-management issues are examined in the discussion chapter. The indicators of pluralistic leadership are facilitation, people management, encouraging, and communicating.

Mostly, pluralistic leadership is consultative. Understandings of how to behave in a team in the 1990s are different from those of yesteryear. There is a new awareness that the climate of team interaction should be one of cooperation, rather than direction. While every team has an appointed leader, many have learned that leadership style must be modified to the circumstances and the team characteristics. Today, leadership direction must be adaptable; it has to be appropriate for the circumstances. In a highly complex context, a shared style of leadership is important as so

many team leaders hold an invidious position in the clinical setting. They assume the ultimate responsibility for the client but have little control over those who carry out activities associated with the person's care. Leadership is positional, status-directed, and shaped by the legal parameters of practical life. Although leaders cannot accept absolute responsibility for everything that is done to the client, they assume responsibility for the general team direction. It was evident that the nature of team interaction affected the quality of team practice:

> It is about fostering relationships really. You do need to give people power for the thing to improve. I'm not sure how you do that but it does relate to not just saying how you think things should or must go. Trying to invite input. ... People work together problem solving. I think it's still important in the group to have people working together and taking responsibility for what they do. It's encouraging problem solving. ... If you do it in a non-threatening way people want to tell you what they think and you get a range of responses. (Grace, Int. 92, p. 1215)

Encouraging team interactions is fundamental to values-based leadership. The way the team responds to problematic situations depends on how interaction evolves according to various interpretations of situations. Team interactions benefit from management by a central person who has team authority and an overview of what is happening for the patient and the team. That person takes a pivotal role ensuring that team practice is synchronised towards meeting service needs. The pluralistic leader welcomes different contributions and works with the group as they redefine situations in line with the team purpose. Those findings are consistent with McWhinney (1997) who argues that "the dominant quality of the pluralistic leadership styles is recognising other people and valuing their opinions and data. The skills integrate these values and data into coherent arguments for action and adapting people and resources to their intended functions" (p. 196). Communication is vital in **pluralistic dialogue,** but someone has to accept the overall responsibility for facilitating teamwork:

> I have a different communication style for different groups. With some I am very, very direct. In other groups I let the group do a lot of the deciding and then pull it all together. With others I encourage interaction. It's facilitating. The facilitation is important to get the outcome that you want. That involves different communication styles. You don't always use the same style all the time because it

> won't work all of the time. ... Facilitation has a whole range of things attached to it and communication is one thing that is important. Facilitation could be silence or saying, "Well what do you think about this?" and then stopping and letting the team chat and carry on and talk. Facilitation could be listening to what the group is saying. It might be pulling together what you're hearing or, pulling together what you're not hearing. ... It's how you chat and work with the group. I ask a lot of questions. It provokes a reaction. What they want me to do is cut to the heart of the whole thing. (Lilly, Int. 90, p. 1431)

McWhinney (1997) believes that that ability to be other centred and to focus on the development of others is at the heart of integrative leadership that encompasses exploring, confronting, balancing, encouraging, and valuing. In this study, it was clear that, as social interaction developed, this type of values-based leadership became more fluid. In this sense, leadership in the day to day routines revolves around client need and which clinician is better placed to facilitate team practice. The values-based leader calls for a general direction in routines that are known to block or make possible creative action (Strauss, 1993). Flexibility and willingness facilitate the process and are the keys as responsibility is shared among the team.

Participants related that, when the leader had a clear understanding of each team member's ability, she confidently relied on each colleague's professional expertise and judgment. Valuing of individual expertise created the conditions for emergence, independence, and self-organisation that were expected to benefit the team as a whole:

> We all have equal status and our leaders are incredibly supportive of each member of the team. They see that each member of the team is utterly vital to the life of the team. You feel appreciated and you have a lot of backup from them. The main players in our team are women, and because of the leadership, things are decided on a democratic basis. Nobody is jostling for power. ... Women are our bosses but only really in a very loose way. I think if you look at teams lead by men that is not the case. There is a very definite hierarchical structure there and that is not the case in our team. We have the two bosses and it's very hard to say who comes next. You can look at it one day and think you've got it sorted and then the next day it looks different! I think women are better group players. ... I think women work better as a group. Women are used to relying on each other whereas men do not. (Sarah, Int. 18, p. 257)

Women valued participative management styles that included all team members in decision making. When power was shared among colleagues, clinicians willingly accepted responsibility for individual and collective actions. Women leaders seem to be comfortable passing control to competent colleagues. This is consistent with Zohar's (1997) ideas of quantum leadership. That style of leadership recognises the subtle, intuitive aspects of indeterminate and ambiguous situations, but relies on trusting interactions and the skills of others. It is easy to encourage each other when the leader openly acknowledges colleagues' strengths and skills to others. Pluralistic leadership fosters mutually encouraging interactions:

> Well I do see my role as being a leadership role. It's very much as partnership with the people I lead, rather than a boss. So I facilitate the group but I have to take responsibility for what goes on. So, I facilitate generally, on the whole, an excellent group of people to work together for the common outcomes. I am fortunate that everyone in my team is excellent in their field - nationally and internationally. Partnership is that we make decisions together. Everyone has equal rights really. And we plan things together, which is important too. So we all own the situation. ... We have had a terribly busy winter and had some very difficult things to deal with at all sorts of levels. At times I've felt very discouraged and at other times I have had the most delightful feedback from other members of the team - encouraging me. And likewise I have given that encouragement to them when situations have arisen for them. So it's that encouragement we can give each other. (Alice, Int. 20, p. 303)

Encouraging *engagement in the dialogic culture* is pivotal in the values-based leadership team. In this study, negotiation of shared responsibility for team practice was not always discussed openly in team meetings. When collective action was required some individuals often needed more time to reconsider actions. Once large numbers of people participate in collective decision making it takes time to redefine situations as roles are taken and made. The pluralistic leader plays a significant part here. A knowledge of individual and collective modes of engagement seems to be useful as people talk through options, as new meanings emerge:

> My role in the team is facilitating communication. Even though nursing and the therapists communicate really well, a lot of people still come to the boss, which is me. My role is to make sure that the communication flows. You have to be available to communicate with people. ... To find out what's going on with everybody, to know what they are on about. And you might be in a meeting and someone is

> saying they can't do this and that but once you go out and find out what is going on you can see what else they might be able to do. So we talk about things. (Margaret, Int. 22, p. 486)

Talking through options in a safe team environment is a prerequisite to the dialogic culture. Cognitive dissonance may surface when people reconsider the options. Many participants spoke of situations where team members agreed to disagree. But, **pluralistic dialogue** clearly shaped collective practice when the legitimacy of diverse perspectives was respected. Engagement is a complicated process:

> People agree with the leader to maintain peace and harmony. But there isn't really peace and harmony, because if the team don't agree underneath, resentment builds up. They're a bit bloody minded by the sound of it! ... My main concern is achieving a positive outcome - by a collaborative approach. I look at us as providing a service and I look at us having expertise that is different from our partners - in a professional sense. And it's melding those two together. It's to value what they do and to provide some leadership in that and also be responsive to the leadership moves they're making. ... It's not just about survival. It's about being adaptable in the new environment. And to ensure that clients are offered the best deal. We wouldn't have a nurse if we didn't have a client! You can't shut yourself off from the other contextual issues. You are part of the whole. We can't isolate ourselves. Otherwise we will get swallowed up. You can't isolate yourself from the whole and therefore, how strong a part of the whole are you? And that's the whole issue really. (Diane, Int. 11, p.153)

The individual's position within the collective is the crux here. In this research, members of some professional groups seemed to prefer an isolated stance within the interdisciplinary team. While the pluralistic leader is in a position to either encourage or discourage such activity, the success of the team depends on individuals making a genuine effort to change their behaviour. This challenges many on a personal level:

> I think you've got to be an individual to be part of the team. You've got to think if you have anything of value to bring to this team to be a good team member. You've also got to realise that other people in the team have got equal values and equal strengths and you've got to try and understand where they're coming from. You've got to be aware that you've got something to give this team. (Bob, Int. 27, p. 580)

Individual awareness is so important because it contributes to the depth of *engagement in the dialogic culture*. Hewitt (1997) claims that the self is

shaped by ideal conceptions of what the person should be, and this is influenced by all sorts of social differentiation. The large number of women in the health services may account for the gradual change to behaviour in bureaucratic organisations that maintain patriarchal values and the subservient role of semi-professionals. Symbolic dependency behaviour is recurrent. Despite this though, those claiming professional status have little choice about acting professionally. For many, that requires a deep level of self-reflection and a shift in thinking:

> I think that you can't have a team if people won't change. You can't have a relationship if you are not prepared to concede something. With any kind of working together or partnership people have to modify a bit of what they do. For the individuals within a team to do the team work they have to mesh with each other to a certain extent. Each person has to do that; for a team to work well they have to decide, "Is this team's approach and this team's business something that I can endorse and go along with?" Now if they don't, then they've got a choice of trying to change it and that may be a really productive thing. If it doesn't change and they are still unhappy then they either leave or they can stay there and end up with split teams and quite destructive processes. And I think that impacts badly on good patient care. ... It's always a bit of an uneasy balancing between individual integrity and that sort of lateral thinking - and how much people mesh together. (Emily, Int. 96, p. 1518)

In this study, *reframing team responsibility* and the extent to which the team resynthesised thinking and actions was both individual and collective. Actualisation of responsibilities depended on how people tolerated personality differences.

Tolerating Personality Differences

Throughout this study there was convincing discussion about personality and how individuality affected teamwork. Generally, discussion focused on the disruptive, subversive, negative attributes that health professionals reported from multiple dealings with clinicians over the years. Personal idiosyncrasies tend to be tolerated alongside disruptive behaviour. The indicators of the category **tolerating personality differences** are self-awareness and sensitivity.

Personality differences have an enormous impact on successful team functioning, or otherwise. Much energy goes into handling those dysfunctional team members seemingly bent on destruction. While most participants accepted personality differences as a normal part of working with people, they were much less comfortable managing colleagues intent on sabotaging effectual teamwork. Many spoke of learning to appreciate the full extent of personal control that overlaps with professional identity:

> There are obviously dominant personalities but I also think particular disciplines are not good at making their voice heard. And I think they do merge together. It's personality but I also think there's another factor there too. ... It's a lack of clarity about your particular discipline's focus, or potential, or values. (Jane, Int. 9, p. 115)

Ambiguous understandings unsettle those people who are vague about individual contributions to the collective action. Some people simply do not appreciate that a normal part of team integration requires the mutual negotiation of role responsibility. Indeed, professional practitioners are expected to balance the professional voice and individual personality. Self-knowledge is influential. Every participatory team seemed to assume that all professionals were engaged in professional development, although this was rarely discussed openly:

> If someone is unable to do their share then the team may still function competently – because others are doing extra. Individuality is important. You need to be comfortable with your own professional boundaries and what you need to do, and how you need to do it. ... And knowing what your failings are. Motivation is important. So you have to work at it. And if you are aware of those things, I think it helps. (Alec, Int. 69, p. 856)

Somehow, the team approach presumes that all health professionals are self-aware. This positive approach is often apparent in a context where people are outstanding as practitioners. Paradoxically, professional talent is in high demand and the nature of the work, combined with the pace of life in acute care, means there is a tendency to relegate personality issues to the trivial basket. This attitude is functional for a busy hierarchical bureaucracy but is less helpful in a more collaborative business culture. Personality disruption affects team efficiency and effectiveness:

> The saddest issue is when some people as a part of their personality development, somehow aren't sensitive to the environment. So they operate out of a set of values that they think is right and good, and they are not sensitive to how people perceive them. It's self-awareness. If people don't have a degree of self-awareness and are not sensitive about how they are perceived by others, it's a big problem. If you think of the relationship between senior and junior doctors, you don't want somebody who's bright necessarily. But you want someone you can talk to, and who is responsive to change and guidance. They need to be competent, willing, and industrious. And if you give them instructions about what needs to be done and it is done, then they will make progress. Then you get a relationship and you give more. (George, Int. 38, p. 341)

Giving of the self affects *engagement in the dialogic culture*. The self-centred team person is supposedly unable to redefine their contributions in relation to those of colleagues. In many instances, those personalities appear to externalise problems beyond the self, rather than assuming personal responsibility for their own thought processes. Participants sometimes attributed that behaviour to a lack of professional education. Perhaps it is perpetuated further by the long-standing history of authoritarian, competitive relationships that have stifled cooperative interaction. The overall situation is not helped either by the old-fashioned assumption of compromise (Gage, 1998). Nonetheless, in **pluralistic dialogue** conflict appears as a normal part of learning to think differently:

> We don't really realise what important skills are needed in a team, to function as a team. The team is just a buzzword – the way we work now. And few of us have ever been given much guidance – we've learned by being there, and by taking on board what is happening there. And that of course depends very much on how sensitive you are to the cues. ... As professionals, we all have pretty strong personalities – some of us are stronger than others. Over time, we learn to temper those things. And we learn to let others take their positions, and think it through, before jumping in and thinking that you might know better. That's quite a learning curve in a team – learning to respect the other people. That doesn't always happen. (Kate, Int. 95, p. 1472)

Participants talked of tolerating personality differences by removing the self altogether. Withdrawal, or total team exit, was a frequently used conflict resolution strategy. While it diffused the immediate conflict, in the long-term it served to deny deeper problems. Conflict tended to be ignored as long as the team was output-productive. Many participants considered that

some team leaders did not deal with the issues at all. Although they understood that, for the team to function effectively, conflict issues had to be addressed, they seemed to be paralysed from enacting a resolution. Paradox exists here. More often than not, health professionals, who are skilled in working with dysfunctional families, refuse to use that training with colleagues:

> In the health care industry what we are facing more and more is that we have people who know all this! They know the academic jargon, the counter transference, transference, and projection! And they all know how to be assertive. We have this wonderful up-skilling of supposed communication. The words are there but the bottom line is - if you choose to take me in the wrong way you will do that no matter how kindly, how gently, how quietly, I say it. You really, truly cannot cope with what I am saying. You do not want to hear that. There comes a point of being human or just being busy. And again, it comes down to your basic optimism about humanity. If you are living life believing that everyone else is trying to screw you, and you are a victim extraordinaire, then that's the way you will perceive many of the interactions you have with others. (Carol, Int. 16, p. 236)

Many team members discussed their self-interested colleagues who were so engrossed in personal problems that they lacked awareness of their individual impact on the team. It is not particularly unusual that people find it difficult to absorb negative feedback that does not support their self-perception (Kerfoot, 1997). But, what is less easily understood is the seemingly complete team acceptance of dysfunctional behaviour that may impact on meeting service needs. However, there comes a time when differences are significant, and avoidance is unreasonable:

> I see and wonder what the currents are there - it's to do with the communication within that group. There are communication problems everywhere! That might just be personality driven there, I don't know. The group was saying they didn't really want to talk about it because it would be too sensitive to see what was wrong with it, which is really dodging things. They don't want to address the issue at all. (Mark, Int. 48, p. 653)

Participants also spoke at some length of those personalities who had a reputation for being appallingly rude. Some people were well recognised for consistent power-coercive tactics and for individual aberrations. Nonetheless, such personality differences were still accepted. Confrontation was carefully avoided, even though some personalities were capable of

blocking productive positive engagement in professional interactions (Adams & Renfro, 1991). Although team acceptance may be interpreted as a tolerance of human nature, passive-aggressive intolerance may also explain why colleagues were allowed to continue to behave in a way that was obviously disruptive.

Paradoxically, although some individuals plainly had poor interpersonal skills, the teams were not without blame either, as they seemed unable to address the issue at all. Poor peer communication skills are not particularly unusual when conflict situations must be addressed, but the collegial interactions described, suggested avoidance was a popular defence mechanism when team members were unwilling to face conflict together. Ironically, emotional distancing is safer. The personality who was an excellent clinician was excused from reasonable interactions with anyone on the grounds that the team chose, apparently deliberately, to cover the consistently unfortunate lapses. The team put enormous energy into circumventing and covering such people. Team members, professionals by definition, were highly tolerant of intolerance. Tolerance of personal idiosyncrasy enabled the team to establish a sense of community.

Sense of Community

In this study most interdisciplinary teams had a strong community spirit. The sense of community refers to the collective spirit required for the disciplines to gel together into a team. Trained to work as individuals many professionals are more comfortable resisting group life (Hirschhorn & Young, 1993). However, a concern for meeting service needs creates a common bond and facilitates *engagement in the dialogic culture.* In most instances individuality is redefined as clinicians forge mutuality within the group. The indicators for this category are willingness, support, and the team person.

In this study, team connections provided stability in the changing environment, nurturing engagement in indeterminate, ambiguous problem-

solving situations. The team person who was inclined to try new things was valued:

> It depends on which aspect of the department or profession you are in. The person who fits best is the 'can do'. That's the person who is willing to be creative or take on things rather than sit by and let other people do it all. Just trying to get a customer service approach both internally and externally is quite important. ... It's quite amazing how many people feel that certain things aren't their job. Yet in the bigger picture, everything is their job. ... Work is ultimately about growing through learning relationships with other people. Ideally your team member has got to be someone who is open and honest with colleagues. ... And be willing to discuss issues rather than let them slip or whatever. That doesn't help the team ultimately. (Mark, Int. 48, p. 464)

That willingness to be involved with the team was central to the sense of community. Indeed, it is more usual for clinicians to support the notion of professional individualism. Individualism that perpetuates independence, and being a team person, are often perceived as separate, contradictory notions. That logical positivistic attitude emphasises either-or choices that are at odds with the paradoxical context that demands wide-ranging convergent and divergent thinking at one and the same time. In some cases, the individualist may be the one who develops the sense of community most. The important point is the interplay between individual actions, the team, and meeting service needs:

> To me support seems like such an innate practice. You should support your fellow team members. Support certainly becomes more apparent when you get individuals who don't have that attitude. And disruption occurs through that. It depends on the willingness of the team as a whole to be open to that situation. It isn't necessarily a negative thing. It can be a positive thing. I think some people who perhaps don't fit into the group model or the team model could in fact be an innovator in some fashion. They have come from a different model in a different place and may have different ideas to offer. It can be a positive thing because it can help broaden the spectrum of the team. (Sophia, Int. 81, p. 1008)

Sometimes the individual approach persists because clinicians cannot see where the team is going and how collective practice can come together into a significant whole. Independence though, does not preclude the interdependence necessary for the successfully functioning team. Team members who are slower to appreciate the sense of community tend to see

individual actions as discrete from the whole. However, power and energy co-exist within collective action:

> I am a team person so being in a team is easy for me. I'm also the only one who does this job so there's no one to threaten me which makes me very comfortable – obviously! I'm not a threat to them and they are not a threat to me! But we want to expand and get another person in here. That person has to have something they hold on to – "this is mine and this is what I do in this team". Then we will all flow better. I can work by myself but I work better if I'm part of a group. It doesn't necessarily mean I need the group to motivate me but I get a lot of pluses from being in the group. I get a lot of energy. I'll very quickly slot into a team and do a part but I won't want to do your bit! I'm happy to do my bit! And I'll be very aware of what you do so that when someone says to me, "Could you do this?" and I'll say, "No! [Someone] does it better". Teams are more powerful than one person is. (Marilyn, (Int. 12, p. 158)

That willingness to join together with the others is fundamental to developing an effectual sense of community. Many people enter the health service because they are committed to helping other people but that does not necessarily make them a good team person. Most have to learn how to integrate professional work with others when they are all involved in creating an interdisciplinary team in a challenging context. Participants found this easier when people liked each other and when colleagues had a good sense of humour – a useful attribute to break the tension in a tense, stressful environment:

> You have to be careful. I won't have anyone I don't really like. Like might be too strong a word. I feel it's important that we have someone so we can have fun with each other. When we were choosing between two staff members we just had this intuition that the one we have chosen was more flexible. It's something about your personality. It's intuition and it is important if you're working together all the time. It's hard work with these complex, chronic diseases. Some of it is difficult and quite taxing and very hard work. We all work very hard so we have to be able to feel we can have that relaxation in the environment. (Alice, Int. 20, p. 372)

As health professionals work together, synergistic relationships are more likely to be created when a team engenders a sense of fun (Gage, 1998). Being able to laugh together is essential for stress release, and helps teams avoid "blow-ups and burnout" (Mazaney, 1995, p. 31). The sense of community however, engenders a spirit of cooperation among the health

professionals working with very sick patients who usually present with multiple, complex problems. Cooperation occurs more readily when team members have a genuine interest in others' roles and responsibilities and are willing to commit the self to ensure the team is heading in the same direction. When a team accepts responsibility collectively they make the effort to keep in touch with each other, to pass on information informally, and over time, and the sense of community deepens:

> But when you look at the collective responsibility here - one of the things that the team has is a very strong feeling of responsibility for is making sure that I know if somebody is not having a good day. If I'm not having a good day then someone will bring me a cup of coffee. If someone else isn't having a good day someone will turn up and say to me, "Oh! You'll need to know that such in such this has happened!" And so I am always on top of things. I think that is one of the reasons it is because it's cyclic thing because they have such a strong sense of community; they want to make sure the information is passed on. Because they pass it on all the time it fosters again their sense of community. The team will protect each other but that is a very well functioning team. I've worked places where I've known that if something bad happened that would be my responsibility – alone. I've certainly seen teams, in situations where I feel people got picked on, if you like. And no one moved a finger to stop that. (Caroline, Int. 87, p. 1139)

The underlying conflict inherent in **pluralistic dialogue** always seems to be lurking quietly beneath the still waters of team life. Cooperation across the disciplines was evident in this study because the majority of participants focused on the client. Yet, underneath, an implicit tension exists between the disciplines, and attitudes that have been passed on in disciplinary socialisation constrain clinicians responding to a complicated context. Health professionals who insist on retaining already socialised attitudes may block the sense of community because they are often unable to change their communication style:

> We are talking about interpersonal skills and being a team person, or not. It largely boils down to communication skills. It's also to do with their willingness to buy into the concept of trying to help this person. But it won't necessarily make them a good team person. When you are talking individual patients, it may not be clear exactly what is happening. People put forward their views and maybe there is a difference in views and it's teasing that out. ... And seeing it all as an objective and non- personal issue. It's very easy, by saying a couple of wrong words, to destroy a whole process. It's harder to keep it

> going than to kill it dead when you are going through a process where everybody's professional competence is being put on the table in front of other health professionals who may or may not know what they are supposed to be doing. ... None of us have been trained in this. We've been trained in our discipline but not in how to work together. If you look at medical students, they may be taught something about communication skills as students, but that is socialised out of them when they become junior doctors - by the role models and the apprenticeship system and the pressure of work. (George, Int. 33, p. 343)

Although the old hierarchical ways of working together are seen to be unhelpful (Tjosvold & Tjosvold, 1994), options in the turbulent, pluralistic environment are less clear. Certainly, alternative ways of practising are facilitated by integrative communication that involves a real desire to understand colleagues. In this study, the team person who accepted responsibility for a personal place in the team outcome, was apparently motivated to interact with the self, and with others, to create a new form of team practice that supported effective client care and a sense of community at one and the same time:

> Communication is what it is all about. It's someone being clear about what they do, so it's clarity of roles. The person who fits into the team talks about what they are doing with other team members being discursive, being flexible, and being a good listener. It's the person who's even in their mood, who has a sense of humour, and can keep their sights clearly focused on what we are really about. Someone who appreciates what people do. So someone who is reflective – someone who talks! When it comes down to it, it doesn't matter what they say as long as they will talk and be open and not get upset when they are challenged – that is part of learning. So, what makes a good team member? Someone who is willing to put forward their ideas, talk about it, reflect on it, focus on what the client requires the team to do for them, and listen to what others have to say. (Laura, Int. 55, p. 719)

The enthusiastic team person was prized. In many ways the sense of community seemed to be created more because particular personalities come together at a certain time and place, rather than through deliberate acts on the part of team members, to encourage the same. Whatever the cause, though, the community spirit altered whenever there were changes in the team membership. The team then had to rebuild relationships, all over again. The cycle is ongoing, never-ending, representing a web of interconnections in the constantly changing environment of hospital life.

Conclusion

Engaging in the dialogic culture appears to occur more by good luck than by good management. Health professionals certainly seem to understand effective team behaviour. However, although very small, new teams deliberately set about making positive team behaviours a reality, other teams tend to merely acknowledge what is needed to create an effective team culture. If intentions are acted upon it is because individuals are committed to team processes. The dialogic culture seldom evolves because the team takes a deliberate responsibility for the consequences of their behaviour with each other. Teams work effectively because particular personalities gel at a certain point in time, not because group action makes attitude change possible. Communication is crucial throughout the process and emerges in the reframing and rethinking processes in the form of **pluralistic dialogue.** In the next chapter the research findings will be summarised.

CHAPTER THIRTEEN
Overview of the Research Findings

Introduction

At the beginning of this study the researcher set out to use the grounded theory approach to discover the main concerns of health professionals working within interdisciplinary teams, and to explain the processes that members of the teams use to continually resolve practice problems in a restructuring workplace. An initial literature review had indicated that little was understood about the concepts of interdisciplinary practice, interprofessional practice, and multidisciplinary practice, and that these concepts were ill-defined and poorly researched. Existing knowledge continually emphasises the tensions and conflicts created when changes in professional territory generate new interdisciplinary responsibilities. Yet, little seems to be understood about the processes that health professionals use in their day-to-day interactions as they negotiate new forms of practice in hospitals implementing reform.

The purpose of the research was to develop a substantive theory of interdisciplinary teamwork in the acute care hospital. One of the guiding assumptions behind this project was that health professionals are able to develop different working styles when practising within an interdisciplinary team. That assumption is supported. It has been shown that clinicians *can* and *do* work together. Many actively participate in mutually beneficial interdisciplinary relationships that are facilitated by the process of **pluralistic dialogue**.

In this chapter a summary of the grounded theory of pluralistic dialogue is presented. The findings are discussed and the implications of the

research for practice, education and further research are considered. The limitations of the research are reviewed, and the chapter closes with a personal reflection on the research experience.

Pluralistic Dialogue: A Summary of the Grounded Theory

Widespread change has intensified the call for new collaborative relationships that are being renegotiated by specialist teams in clinical service areas. In this grounded theory study four teams from three specialist services from two acute care hospitals were studied in their practical world as they went about their daily business. Various clinicians from across the disciplines were interviewed and many participants were also observed when they interacted with colleagues.

Although team members usually held a position in a primary team, many clinicians also had responsibilities to other teams. Therefore, the concerns illustrated, and the continual resolving of those concerns, were all-encompassing because participants described team practice in broad terms, which moved beyond the original team, and certainly extended across other specialist services. For example, even if a practitioner worked mainly in one team it was not uncommon for that person to be invited to consult elsewhere. Eventually, forty-four participants contributed to eighty hours of interviews; and there were eighty hours of participant observation.

It became evident in the study that, the drive towards the integration of effective, efficient, quality health services, was politically driven. Interdisciplinary teams were working in a context that may best be described as an organised disorganisation. That is not particularly unusual, and may even be said to be typical of any large city hospital serving a metropolitan community. Paradox pervaded this study, so perhaps it was hardly surprising to find that one hallmark of a

successful interdisciplinary practitioner was someone who demonstrated a flexibility of attitude. Effective interdisciplinary team members were recognisable for their ability to organise the predictable, and their competence at simultaneously handling the unpredictable. However, those skills were merely a part of a wider pattern of behaviour.

It was very clear from the data that interdisciplinary team clinicians developed professional and team responsibility for the client service by changing their conventional modes of thinking. In this study, it was found that members of the interdisciplinary team processed differences by using the basic social structural process of **pluralistic dialogue**. This is a means for discussing differences that supports team members who are thinking through and constructing new ways of working together. It emerges as various health professionals integrate multiple perspectives, which contribute to the clinical and organisational management of the client service.

Pluralistic dialogue has two complementary phases. These are *rethinking professional responsibilities* and *reframing team responsibilities*. Rethinking and reframing are theoretical processes that are underpinned by team learning, and, by new ways of managing changing service structures. Therefore, it is suggested that, in an interdisciplinary team, health professionals must *break stereotypical images* in order to meet service needs in a context where teams are constantly *grappling with different mind-sets*. Team members continually resolve their concern for meeting service needs by *negotiating service provision*. As a result, the health professionals are free to *engage in the dialogic culture*.

The process of **pluralistic dialogue** has the potential to challenge, to empower, to transform; or it can perpetuate mediocrity. The decision to dialogue mindfully with others is essentially individual. A person may choose a non-involved response at any time, although someone must

fulfil functional responsibilities in the team. Any variation in an individual's commitment is covered by disciplinary associates but seldom challenged by colleagues from a different professional group.

This study also highlighted several significant categories impacting on effective interdisciplinary practice. Competency, alternative world views, information exchange, accountability, personality differences, and leadership, all affected team processes and **pluralistic dialogue.** Team success is dependent on the individual's courage to challenge the self and the humility to cooperate in collective learning experiences.

This substantive theory presents just a glimpse of the practical life of interprofessional people working in two busy city hospitals. The teams studied were unusual in that they each offered specialist care to a select group of clients. Perhaps they were unique and are non-representative of the average person who is a health professional today. So many of the health professionals were highly educated, well-respected specialist practitioners who stand out for their individual investment and dedication to improving the client's pathway through acute care. The study participants' patterns of behaviour would suggest that, when interdisciplinary practice is well established, an attitude of cooperative inquiry pervades joint actions and interactions that focus on meeting service needs.

Pluralistic Dialogue: A Discussion

As the grounded theory introduced in Chapters Seven to Twelve has shown, the quality and tone of **pluralistic dialogue** is very much dependent on each team members' response to changing professional responsibilities in an unsettled context. Chapter Nine indicated that many participants were free to *break stereotypical images* simply because they were evaluated by colleagues as being competent practitioners. Competence was expected to be team specific and, because all the teams covered specialist areas, it was rather more than

a basic skill and knowledge mix, and included expertise and a well-rounded specialist knowledge base as well. Colleagues were less interested in which discipline a person belonged to, and were rather more interested in their knowledge and skill and how that contributed to team function.

Effective team function is dependent on clinical competence that should not be taken for granted in a world where knowledge is constantly changing and developing. Although there is an implicit understanding that all professional people will be motivated sufficiently, and be able to keep their knowledge updated, that assumption needs to be checked out carefully as knowledge generation is developing at such a rapid rate. Currency and application should not be presumed. While disciplines are not in the habit of checking out each other's knowledge bases openly, surreptitious monitoring always takes place in practice, and it is usually acceptable for members of the same discipline to be involved in peer review. However, it is suggested that peer review needs to be occurring prior to problems developing, rather than after a problem has emerged within the team. Limitations in knowledge in an individual are not necessarily negative, but the team that understands each person's ability is in a better position to arrange cover and teaching as required, and is less likely to compromise the quality of client care. The participants in this study did not expect colleagues to know everything but they certainly expected every member of the team to be willing to learn.

Another aspect of the findings that stood out was that it is wiser not to assume that an experienced practitioner will automatically transfer specialist skills into a new setting, with a different team of people. It was evident that most of the participants in the study had extensive experience in New Zealand and overseas, and were used to practising with a wide variety of people in changing workplaces. Almost half of the participants had undertaken, or were involved in post-graduate study. It is possible that the practitioner who has not extended educational

experiences beyond the basic qualifications, or who has not had exposure to broad clinical experiences in other institutions, may have more difficulty fitting in with the interdisciplinary team.

The participants also revealed that, once competence was proven to be at an acceptable standard, respect followed automatically, and the practitioner was trusted, albeit in a simplistic way. Competence, respect and trust were linked together although trust, which is established in the early stages of collegial interactions, tends to be naīve. It was evident that the initial trust and respect associated with clinical competence were also connected with the notion of credibility. Many participants were invited to join teams because they had a strong clinical profile, which outwardly generated a sense of trustworthiness. Nevertheless, credibility had to be maintained. Participants were allowed to make some mistakes clinically – they did not have to be perfect – but such experiences were watched with great interest by colleagues who expected behaviour to change, reasonably rapidly, to indicate that learning had taken place.

It was noted, too, that learning was likely to be uncomfortable, and fraught with tension and conflict, as clinicians challenged the self, both personally and professionally. The data that generated the conceptual category of *breaking stereotypical images* suggested that, these health professionals were learning to let go of familiar, habitual ways of thinking in a context where the health care paradigms are shifting. Professional development was indeed intertwined with a demand for changing modes of practice whereby team members had to learn how to bring experience and skill together into an evolutionary form of team practice. It was very clear that, as team members were exposed to different approaches with their colleagues, they were very much involved in a collective learning experience that was rather different from the separate disciplinary learning encounters of the past.

In Chapter Ten it was noted that participants found learning together to be a challenge as they *grappled with different mind-sets*. Paradoxically,

specific disciplinary differences had to be put aside, although they were never lost, because they were an intrinsic part of each person's special contribution in a successful team approach. Interdisciplinary teams rely on people who bring a wealth of knowledge and skill as contributions to the particular expertise that is invaluable in the remarkably complex patient management process. So many participants had *grappled with different mind-sets,* and had learned how to blend their unique experiences with those of their colleagues, to meet service needs.

Nevertheless, differences in world views were deep-seated and likely to cause problems if a team member was particularly inflexible in their thinking. Examination of difference was intrinsic to the process of **pluralistic dialogue**, so it was important that the team was reasonably willing to talk through inconsistencies, in the interest of meeting service needs. Those who were ready to talk with others stood out because they had a strong professional identity that had helped them clarify their role as a professional person. By contrast, those people who were unclear about their professional identity struggled to take their place beside colleagues, and were more likely to retreat to an entrenched disciplinary position that had the potential to block effectual collective action.

It was evident, too, that a deeply ingrained understanding of the securely established models of practice, like the medical model, sometimes blocked a fair consideration of interdisciplinary teamwork. Unequivocal answers were rare when alternative disciplinary values and beliefs clashed. It took time to work through predetermined beliefs that supported unsubstantiated myths and assumptions. Progressive understanding was slow. Nonetheless, many team members were prepared to enter into uncomfortable and challenging engagements. While problems may well be insoluble, responsive clinicians handled difference by analysing the issues, and finding new ways to move forward as they considered more creative responses to their professional work. Disciplinary integration was constantly evolving. Team members did not always have to agree, but team practice was so much easier if

every individual understood the team values that may have been non-negotiable.

In Chapter Eleven it was evident that negotiations were no longer confined to parallel professional interactions but were all-inclusive of wider organisational functioning. *Negotiating service provision* was a communal effort. Several things stood out in this conceptual category. While services were generally well coordinated, information exchange was precarious and dependent on individual effort to ensure success. In particular, the interdisciplinary teams relied on informal networking to keep abreast of many of the changes in client management. That networking took place around the organisation. In other words, members of the team gathered much significant information about their clients as they physically moved across geographical spaces. The need for physical movement to find out what was happening with a client was essential, especially when clinicians were crossing over many service boundaries where they often had little control. Much was written in the patient notes, but whether that was up to the minute information was a moot point. According to participants, it was not. Daily reporting on patient progress was certainly the norm but, more often than not, interdisciplinary teams relied on minute to minute information, delivered orally, in order to make the most informed decisions.

The problems of continuous information exchange were complicated. Passing on information frequently, and to the people who needed to know, was quite a challenge when so many clinicians spent their days moving around clinical spaces, sometimes across floors. The nature of being a therapist, doctor, social worker, or dietician meant that that person had to cover patients who were scattered all over the hospital. While electronic paging systems helped to some degree, a lot of information was described as small but significant, and some practitioners were reluctant to disturb colleagues with seemingly minor information, although they knew that it was seldom insignificant when considered in terms of the total quality management of the client. So, it

seemed that, if team members did not move around the hospital, they were unlikely to keep updated on the latest information about the client's care.

Information exchange was essentially time dependent. The fast pace of hospital life meant that decisions were made rapidly, patients moved in and out quickly, and the bureaucratic information systems appeared to be inadequate to deal with the demand for a rapid turn-around. As a result, staff had learned to use their informal networks. Many relied on the face-to-face communication, which was generally effective for finding out what was happening. The team coordinator played a significant role here because that person was more likely to be the one person who had a grasp of the whole picture. Regardless of team size, the teams that had a coordinator were better managed than the ones that did not. Efficient continuous information coordination was fundamental to the team approach, although there was much room for improvement in the restructuring organisations.

The participants revealed that restructuring is a highly complicated process. *Negotiating service provision* was seldom straightforward and, generally, the negotiating process was observed as being transitional as the health reforms proceeded. The political nature of health care delivery stressed the business-humanitarian clashes created by economic scarcity, and the call for optimisation of care. **Pluralistic dialogue** was vital in these circumstances because every team had to become involved in making decisions together. Decision making very often encompassed the resource dimensions of care, an issue that, traditionally, has been ignored at the clinical service level.

It was clear that decision making was interconnected with collective accountability as the teams *negotiated service provision*. Members of the three small teams expected to be collectively accountable to their colleagues, and the organisation, as it was more difficult to avoid answerability for actions, or non-actions, in a small group. But, the

meaning of collective accountability was tenuous in the large ward team where, declining resources in a changing organisation, challenged individuals in relation to their professional position and their role as a public service employee.

Although workplace controls of service delivery were evident, many participants continued to resist any managerial influence over clinical service provision. Some clinicians, usually women who were nurses or allied health workers, stood out because they appeared to make little effort at all to understand the organisational resource position, and seemed to have minimal understanding, or interest in, the government policies driving health reforms. Mostly, people who took that position had had no exposure to further education. As a result, some team members opted out of any involvement in collective accountability, and, generally, the team did not seem to object to such a stance. Others, who had different attitudes to accountability, stepped in and completed the work that needed to be done.

This meant that collective accountability was managed more by individual effort than by any combined effort on the part of the whole team. Consequently, anyone in a management position was necessarily involved in persuading less responsive team members of the need to be responsible for professional decisions in an economically restrictive environment. Most managers reacted by requesting rationalisation of the decisions made, and this often emphasised the business constraints, and polarised those team members who wanted health care to remain the same as it always had been. The teams that discussed the issues appeared to cope better as they supported each other, even though they may have struggled to understand the wider organisational picture.

In Chapter Twelve it was evident that *engaging in the dialogic culture* seemed to occur more by good luck than by good management. Health professionals were able to identify effective team behaviour even though

the time and effort needed to achieve that was simply not available. The very small, new team, deliberately set about making positive team behaviours a reality, and was most successful. The long-established small team had refined the meaning of effective team function over a period of about ten years. The other small team seemed to understand each other well after being together for about four years. However, the team dynamics always changed when people moved in and out, and the process had to begin all over again. The large ward team knew what they should be doing to create an effective team culture, but everyone was so involved in their daily activities that it was very difficult to get any time at all to get together when they were not discussing patients.

In this study, leadership in the large ward team was not clear. As long as each discipline had appointed leaders there was no one person who had the overall authority as a team leader to try to change interdisciplinary behaviours. The senior medical consultant was regarded as the ward leader of the team but, often, there were two medical consultants, each with their own team. They seemed to have minimal influence over any other team or discipline. While shared leadership worked well in the three smaller teams, it posed a very different challenge in the larger ward team where many clinicians rotated through the service on short-term learning assignments.

Therefore, if a team has problems with function and process, no individual has the responsibility to manage the whole team, or to ask colleagues to address possible issues. In the past, the ward sister assumed an overall leadership role in ward situations and now that role has been lost, charge nurse managers see themselves as being responsible for nursing personnel only. In this research, it was evident that, if good intentions to improve teamwork were acted upon, it was because individuals were committed to team processes. Teams worked effectively because particular personalities gelled at a certain point in time, not because group action made attitude change possible.

Another aspect of the emerging theory that was significant here concerned the toleration of personality differences that was discussed at some length. Enormous energy seemed to be put into working with people who were often described as being dysfunctional personalities. That situation created a dilemma for many health professionals who were health workers because they wanted to help people. As a result, the awkward personalities were seldom confronted and continued to move around the organisation until they outstayed their welcome. Generally, those people had a long history, twenty years or more, of such behaviour patterns. They were well known across the organisation, and yet they reportedly continued to behave in an unacceptable way because no one person challenged them.

When team leaders spoke of those situations it was noted that their tolerance was based on team need. Thus, the so-called dysfunctional personality had a certain skill that was valuable to the team. If they did not, the team leader would take immediate action to remove the person. Otherwise, they remained. Therefore, it is suggested that, if teams have such people in their midst, they will need to address the issue as a team. Leaders seem to see teamwork from a different perspective, and probably do not experience the full force of the awkward personality because of the positional status they hold. The impact of team leadership was in fact significant, as these people set the tone for the team. Investment in the individual has emerged as being a significant factor in the successful realisation of interdisciplinary practice. This has implications for practice.

Implications of the Research for Practice

Team leadership is critical for team effectiveness. This research has shown that interdisciplinary teams require effective team leadership *and* the efficient coordination of collective activities. While most teams have leaders, few have interdisciplinary coordinators. This role is central if effective team function is desired. An interdisciplinary team coordinator

can come from any discipline, as the main prerequisites are professional competence, extensive experience, and people management skills. It is suggested that, in the current environment the organisations may invest in charge nurse managers to act as team coordinators. These people are still the best placed to coordinate team function and process, as long as they have been suitably trained in group facilitation skills, and have the clinical credibility to be respected by their colleagues across the disciplines.

This study has also shown how very important individual attitude is when a group of health professionals work together in an interdisciplinary team. Many individuals are willing to practise differently but are unsure about how best to proceed in an uncertain environment. Investing in individual development is suggested as being an important option for managers restructuring the team-based organisation. Clearly, individual investment carries an educational component and the organisation is likely to benefit more if specialist practitioners are educated at least to the masters level.

It also seems to be important to include some form of mentoring as a part of individual investment. That could be set up as either a formal or an informal process. A formal process would follow the traditional pathways for mentoring that offer guidance by senior practitioners in a specialist service. Or, alternatively, the organisation could ask for professional supervisors who could declare their special professional interests via a special web page on the Internet. That way, any team member would be free to approach another practitioner who would be prepared to professionally supervise a colleague with particular professional development needs.

The need for professional supervision is seemingly important. It has especial implications in relation to professional competence. Organisations must look for ways to assess professional competence from the interdisciplinary perspective. Now may be the time to consider

the setting up of an interdisciplinary peer review system. Successful teamwork requires some evaluation of team processes. The need for assessment has been shown to be critical in the areas of competence, accountability, and personality differences. Interdisciplinary teams require organisational support to assist them to manage team practice that is very different to the traditional forms of disciplinary practice.

If a clinical sector or a specialist service is genuinely interested in creating a team-based philosophy it will have to invest time to effect the change. Organisations moving from hierarchical to team-based structures often presume that people automatically know how to be effectual. Realisation is unlikely without resources, time and effort. Any success is jeopardised when teams are expected to alter approaches without any training in how to manage change. The alternative is trial and error learning that is so time-consuming. Ironically, time is of the essence in the acute care environment. There is never enough time for professionals to do all they want to do with patients, let alone with colleagues. No doubt this will continue to be problematic. But surely gifted clinicians can find new and better ways to manage time, if they are given the chance to work in partnership with managers as well as each other.

Organisational managers might also encourage specialist service groups to create dialogue groups that would meet weekly for say two hours over the period of a year. The setting up of dialogue groups would go some way to assist team members to explore their values, beliefs, and world views in an informal setting. Initially, those groups may require an outside facilitator to maintain the focus and encourage participation. An informal monthly discussion group incorporating socialisation over a meal may also provide informal familiarisation by way of a variety of topics unrelated to everyday team practice. The exploration of wide-ranging issues in an informal setting away from the workplace may help colleagues to discover the underlying value systems that affect others involved in team practice.

Intra-organisational dialogue might also be encouraged by interprofessional seminars, which include the whole organisation. Hospitals often hold regular grand round meetings to discuss the clinical management of patients. These are generally open to everyone. Management could to set up a similar forum for discussion of general organisational issues. Issues such as the post-industrial society, moral responsibility, the health reforms, the meaning of transformational leadership, and the responsibility-based organisation, could be presented by individuals and discussed by everyone. Such sessions have the potential to encourage all members of the organisation to understand their place within an organisation that values learning.

Several other factors that have also emerged from this research and have implications for the practice setting. The problems of information exchange will be addressed later in the chapter. General issues surrounding leadership in the pluralistic era, team agency, and attitudes towards the responsibility-based organisation will be integrated into discussion in the next chapter.

Implications of the Research for Education

Clearly, if social change of the kind identified in this research project is to be taken seriously professional education must be reviewed. New social perspectives, major sociopolitical reforms, require new modes of education. Professional socialisation within specific disciplines is no longer helpful to prepare practitioners for an environment that is being radically restructured. Traditional education programs are more likely to perpetuate disciplinary division. It is very difficult to teach the art of cooperative inquiry within any one discipline that is educating its students in isolation from the very practitioners those students must work with. Interdisciplinary socialisation begins in the educational setting. If social values are to be changed to support the health reforms, any change that supports an interdisciplinary culture must begin as

soon as students enter the learning environment. Interprofessional education programs are essential to changing attitudes and beliefs, and facilitating a new form of interdisciplinary practice.

Educators must consider the benefits of generic education programs for interprofessional practitioners. If organisational managers are convinced of the value of a team-based organisation, and teams are perceived as the management tool for the future, there is a need to prepare people for that expectation. Interprofessional curricula need to be established to create opportunities to study professional practice in an environment that also recognises the importance of health management practice, health politics, and interprofessional communication. Only then will education provide better professional preparation for practitioners entering the new millennium.

There is also an urgent need to review curricula to ensure that professional practitioners are prepared better for the world in which they are working, and the one that cannot yet be envisaged. This means teaching chaos-complexity theories of change and quantum thinking. Frequently, innovative ideas for the health professions are already well trialed by other disciplines such as physics and management. While many health professionals are engaged in tertiary study, it is debatable whether modern-day programs have altered to the extent of preparing people for tomorrow's practice. Certainly critical analysis is well documented in most curricula but educators generally appreciate that only the most gifted student will ever achieve the suggested outcome. Placing thinking central to the professional education program seems a little bizarre because it is so obvious. At present, thinking is implicit yet it needs to be taught so that the graduates can work effectively in a changing health care work environment.

Implications for Further Research

As mentioned previously, one major issue that emerged from this study concerns information exchange. This area was fraught with difficulties. In particular, many team members reported significant problems with the recording of information in the patient notes. This problem is so critical that it requires immediate attention. It is suggested that a participatory action research project be set up with an interdisciplinary team to find some solution to what appears to be something that affects quality management of the client service.

The influence of team travellers on successful team function also demands further investigation. So many teams have practitioners passing in and out for three month learning secondments that these people must affect the team dynamics and the way the team is able to meet service needs. It is important to gather more information in this area.

The issue of successful interdisciplinary team leadership warrants further research. Although leadership has been well researched over the years, research related to transformational leadership seems to be sparse. In this study, several leaders stood out for their outstanding leadership qualities. Mainly women, they managed interdisciplinary groups with a style that was both successful and elusive at one and the same time. They were also talented managers of complex, chaotic situations in a time-limited environment. It would be worthwhile to try to document some the determinants that shape this type of leadership behaviour in order to improve leadership per se, and to circumvent constantly recurring problems that are frequently perpetuated by trial and error learning.

Limitations of the Research

This research has addressed interdisciplinary practice from the point of view of the health professional working therein. Originally, the project was designed to cover the patients and families receiving care from these teams as well. The size of the project precluded that investigation. However, it is important to follow through whether the patients and families being looked after by these teams benefit in any way at all, and whether they recover better, or more quickly when they are the recipients of what appears to be, quality team processes.

This research is limited, as the design did not link quality team processes to the outcomes of care. Even though many interdisciplinary team members have displayed a unique ability to respond to the restructuring environment, to find new ways of thinking and working together, those processes can never stand alone and, in today's health environment, must be connected specifically to the outcomes of care. As the twentieth century draws to a close, it is evident that the nature of health service delivery has become a political activity. Research, to be effective, must include sociopolitical issues that impact on interdisciplinary practice and efficient, effective service delivery.

Personal Reflections on the Research

The completion of a research project is a time for weaving together the many complex reflections that have emerged during the research experience. One point that stands out concerns the lack of understanding that so many people have about social transformation within a post-industrial society, and how that affects professional practice. Generally, health professionals struggle with change that is often perceived as being imposed by politico-economic reform. They selectively resist social change on moral grounds, and often have only a

partial understanding of the wider issues of a society that is passing through an continuous cultural movement.

History may label this period similarly to the enlightenment. It is certainly a period of evolution that is influencing ways of knowing, thinking, acting, and interacting. Society may well be enacting a paradigm shift. If that is so, it is perhaps inevitable that health professionals will eventually have to change their behaviours. Although social reform and restructuring are politically directed, any political mandate reflects wider social values and beliefs. This means that every individual has a social responsibility to other members of society. Health professionals have dual responsibilities here, and they cannot avoid the moral responsibilities that are attached to the professional role. Society has awarded professional people a social mandate to practice in a particular way. This cannot be ignored; it must not be abused; health professionals must be accountable for delivering health services in a way that integrates the needs of society as a whole.

Perhaps the popular professional rejection of broader social changes may be due to a state of not knowing. Not knowing is a powerful contextual determinant that gains ascendancy when there is any knowledge explosion. The transmission of professional knowledge begins in educational institutions. Education is inextricably implicated. Interdisciplinary programs are indeed imperative. Health professionals must be prepared better to deliver efficient, effective quality care in a society that must change and reform itself if it is to survive.

Conclusion

The grounded theory findings presented illustrate the complexity of team practice in a context that is undergoing structural reform. The teams observed in this study may come across as being privileged, in that they had set up conditions that were supportive of autonomous

practice in bureaucratic institutions. However, team success, or otherwise, was more the result of individual effort, and because those in positions of power, at either the clinical or the organisational level, were prepared to invest in expert practitioners, in the interests of quality management. In the final chapter the grounded theory of pluralistic dialogue will be situated in the general literature that relates to leadership, team agency, and attitudes towards the responsibility-based organisation.

CHAPTER FOURTEEN
DISCUSSION

Introduction

So far, the grounded theory of pluralistic dialogue that emerged from interdisciplinary teamwork in the acute care setting has been presented. A final stage of emergent theory development is to locate the findings in the professional literature. This step completes the circle of knowledge and draws theory development, practice, and research together. While theory development will never be complete because knowledge generation is always ongoing, some attempt to link research findings to existing knowledge is required. In this final chapter, the research findings are situated within the broader body of knowledge. Findings are integrated into a discussion about leadership in the pluralistic era, team agency, and the responsibility-based organisation.

Leadership in the Pluralistic Era

Acute care hospitals are pluralistic organisations that cannot help but be influenced by the social reforms taking place in society. McWhinney (1997) argues that pluralism is now a major pathway to social change, and Kane (1996) notes that pluralism is about melding diverse approaches. In a changing context, pluralism is interconnected with uncertainty that often increases, if the resisting individualist assumes that one perspective must be right when there are competing viewpoints.

Uncertainty emerges when diverse health professionals are asked to deliver an integrated service to a specialist client population. New forms of interprofessional practice will always challenge the status quo. Although the problems associated with interdisciplinary practice may heighten ambiguity in a paradoxical context, **pluralistic dialogue** facilitates the

discussion of difference so that service needs are met. However, leadership also affects the process.

When a health care environment is destabilised by change, leadership is critical if a team is to progress. There is no one best method and indeed, the optimum leadership style is context dependent. Pointer and Sanchez (1994) believe that leadership is a multidimensional, all-inclusive process that is affected by the person, focus, influence, goal accomplishment, and intention. Like most organisations, the health services have a history of deterministic leadership in dominant cultures. Medical professionals have assumed authority over semi-professionals in a reductive bureaucratic structure. Interactions have tended to be hierarchical, controlling, and reactive under the transactional leadership style. Pointer and Sanchez argue that the transactional leader focuses on roles, tasks, and rule compliance. Personal benefits, individual incentives, mutual dependence, and ordinary performance are all important. The leader values everyday operations, and recognises exceptional work with conditional rewards (Dunham-Taylor & Klafehn, 1995). That style is not typical of the pluralistic leadership uncovered in this study, although some components were certainly incorporated into the participative style of leadership.

More recent commentators have examined leadership in relation to participation and process management. For example, Zohar (1997) examines leadership in relation to quantum thinking. Bradford and Cohen (1998) explore the post-heroic mind-set, while Greenleaf (1995) discusses servant leadership. Hammer (1996) analyses leadership in the process-centred organisation; and Morgan (1997) discusses leadership in the corporate culture. Bolman and Deal (1997) take a very different view of leadership that is explained in terms of personal artistry and choice. Similarly, Vaill (1996) focuses on leaderly learning, while Markam (1996) looks at leadership and spiritlinking. McWhinney (1997) examines the pluralistic leadership style, while Senge (1990, 1995) concentrates on leadership and facilitating learning. Each writer emphasises particular

aspects of leadership, and recognises the importance of creating a common focus when pluralistic interests prevail.

This participatory leadership style is consistent within transformational leadership that is concerned with changing the rules, upsetting the status quo, optimising systems benefits, interdependence, working for the greater good, higher level personal actualisation, and extraordinary performance (Pointer & Sanchez, 1994). Kent, Johnson, and Graber (1996) argue that leadership success is dependent on mutual interactional processes. Effective processes include visioning, sharing meaning, creating possibilities, developing stakeholders, building spirit and will, and sustaining focus. When transformational leadership includes elements of transactional leadership, the integrated style certainly seems to facilitate **pluralistic dialogue.**

However, the transactional and transformational leadership models have emerged from distinctly different paradigms. The former subscribes to Newtonian thinking, which determines the absolute whole as a sum of discrete parts. The latter embraces the simultaneous synthesis of segments, which become more than, and greater than the sum of the parts. Senge (1995) believes that, although many people think divisively, organisations benefit most from those that think collectively. In this grounded theory of pluralistic dialogue, because collective thinking promotes cooperative action, a new style of leadership for the pluralistic era is necessary.

The dialogue process is central to interdisciplinary teamwork that also requires managerial and clinical leadership. Leadership must be flexible in an interdisciplinary team. Fluid leadership supports a wide range of responses that are defined according to a constantly changing clinical context. Even though all health professionals must rely on the doctor's medico-legal leadership, other clinicians lead the team at different times when they work with patients and colleagues. In this research, although medical consultants formally led teams as clinical service directors,

leadership had to be informally adaptable, depending on the specific team activities.

Leadership is certainly changing in the pluralistic era. McWhinney (1997) argues that pluralistic leadership values individual contributions. It may be integrative, participative, or consultative. An integrative style is supportive and encouraging, confronting, yet accommodating, in times of radical change. McWhinney believes the style is rare, although participation improves when expertise is added. However, participative leaders risk managing resources and people at the expense of the organisation's interests.

In many organisations, executive managers commonly espouse consultative leadership. Consultative leaders seek opinions and information to validate decision-making (McWhinney, 1997). Consultative leadership can be problematic though, if the followers are not informed about where the leader is coming from, why data is needed, or for what purpose. Fear and distrust of the consequences of consultation may block dialogue. For example, Kent et al. (1996) argue that managers may try to minimise the effects of restructuring on employees by hiding change until the impact is inevitable. Thus, leadership becomes a double bind event in that employees are led, even though they do not see the way (Hennestad, 1990). Sometimes, managers, apparently leading the way and giving directions, can assume that the staff knows where to go. When authentic dialogue is missing, misunderstanding follows if open information exchange is delayed or avoided. **Pluralistic dialogue** can guide the consultative leader to create an environment that eases the team into *rethinking professional responsibilities* and *reframing team responsibilities* amidst change.

In this study, participative and consultative styles of leadership were evident, and changed according to the team context. In the three small teams, the leadership altered according to the client service needs. The clinicians expected to take a participative role, and to guide colleagues as required, according to the dictates of their expert knowledge. Although the

team leader retained the overall team leadership position, shared leadership was facilitated by **pluralistic dialogue**. However, that style of leadership tended to focus on the patient, perhaps at the expense of the organisation. Some clinicians were more inclined to argue that the organisational managers did not understand the clinical implications of the resource dimensions of care as fully as they might. McWhinney (1997) argues that participative leadership is ineffectual in the pluralistic organisation, which manages limited resources for the wider community. However, in this study, team leaders were in direct contact with organisational management so they could not avoid change completely. Most, though, reserved the right to debate differences of opinion about proposals for restructuring that disadvantaged the clients and the quality of the specialist service.

Nevertheless, change was ongoing, and had to be dealt with eventually, despite misgivings expressed by the clinicians. Senge (1995) contends that change is revolutionary rather than evolutionary. Perhaps this explains why many clinicians are cautious in their engagement in the change process. Expert clinicians are knowledge workers in action (Drucker, 1992) and are suspicious of change that is seen to exert any control over their use of knowledge in clinical practice. As a result, proposals for consultative leadership are often resisted by apolitical health professionals, who may be wary of the political impact of reform and the organisation's power to structure positions, and people, out of existence. In these situations, **pluralistic dialogue** certainly facilitated the discussion of difference, and helped team members to rethink their professional responsibilities, while they reframed their team responsibilities.

Hunter et al. (1997) argue that when people work together cooperatively, teamwork is likely more effective if the team chooses the preferred leader. In fact, healthy teams encourage the development of leadership in each other. It was evident in this study that, many health professionals welcomed the opportunity to develop joint understandings, which helped everyone to meet service needs and become immersed in the full meaning of

teamwork. This was more difficult if leadership was poorly developed. While inadequate leadership is likely to be the cause of team problems (Ovretveit, 1993), rotating staff also influence team effectiveness. Both factors impacted on how the team managed collective accountability, and how the team eventually managed, or mismanaged, team function. In the study, none of the teams appeared to evaluate their own team performance.

However, core groups have the potential to assume strong leadership, in order to develop what Bradford and Cohen (1998) describe as, a mature, cohesive, shared responsibility team. In this research, it was evident that any core group was well placed to articulate and recruit commitment to a team vision. The majority of core group clinicians were able people managers, who were skilled at encouraging staff on learning rotations. Core groups comprised the senior members of the disciplines that worked together simultaneously. These people had the potential to influence each other better, and to be responsible by being "influential without being influenceable" (p. 54). Kent et al. (1996) suggest that positive, thoughtful, purposeful leadership can improve the team's motivation, commitment, trust, and the sense of direction. Although the three smaller teams demonstrated well-developed styles of shared leadership, the murkiness of the clinical leadership role meant much team potential remained under-developed.

Whatever the level of clinical or managerial leadership health professionals find themselves to be in, leadership requires learning. Katzenbach (1998) and Katzenbach and Smith (1993) suggest that real leaders constantly attend to the role, build individual and collective confidence and commitment, create opportunities, balance and strengthen the skill mix, manage external relationships, eliminate obstacles, and do the real work. On the other hand "there are two critical things real team leaders *never* do: *they do not blame or allow specific individuals to fail, and they never excuse away any shortfalls in team performance*" (p. 144). In this study, those principles were idealistic challenges for leaders carrying high workloads. Over-commitment made it difficult to manage self, patients, staff, and the

team. Drucker (1992) is not surprised that people become ineffective managers when they try to do too many things. When leadership is reduced to management, team effectiveness declines.

As organisations are restructured, Handy (1990) believes that leadership, not management, is required. In times of discontinuity leaders transcend problems by "leading change, not managing it" (Kent et al. 1996, p. 29). Many writers support the shared leadership philosophy (Bradford & Cohen, 1998; Hammer, 1996; Maister, 1997; Zohar, 1997). In this study, the several outstanding leaders were women who motivated colleagues as they encouraged cooperation and creative interactions, and fostered flexibility, open-mindedness, and freedom of thought. Perhaps they were similar to Bradford and Cohen's (1998) classification of a post-heroic leader, a person who sees everyone as a leader. The seemingly effective leaders were able to create a commitment to a tangible vision, and enhance power through mutual influence. Ultimately, they understood the value of partnerships. Those leaders expected team members to act as partners who shared a joint responsibility for interdisciplinary practice. They certainly set a climate that supported Bolman and Deal's (1997) argument that the best leaders create and sustain a tension-filled balance between the vision and the core ideology, combining durable values with elastic strategies.

Team Agency

The concept of agency is abstract. When it is labelled as team agency it reflects the individual-collective attitude that pervades team practice. Williams (1994) suggests that agency refers to the integration of action and interaction that makes meaning possible. Fine (1992) argues that agency is linked to structure in that it both includes and excludes structural boundaries. This agency-structure connection is fundamental to symbolic interactionist thinking. Symbolic interactionists strive to understand how people create interpretations together so that, in the final analysis, meanings are responsive to contexts beyond the self:

> The core of this debate is the range of actions that are possible (agency) and the systemic limitations of that action (structure). Action and actors, and the limitations on them, have been prime concerns of interactionist writing .... The minuet between the agent who is "free", and the constraints and structures that limit this freedom is critical to any interactionist or pragmatic model of social order. (Fine, 1992, p. 89)

In this grounded theory of pluralistic dialogue, it is evident that a new interprofessional social order is being created. Health professional "agents" are becoming team agents who are redefining professional work within changing structures. Because restructuring organisations challenge clinicians to find new forms of interdisciplinary practice, team agency emerges when individuals *rethink their professional responsibilities* for action and *reframe their team responsibilities.* **Pluralistic dialogue** facilitates this process.

Without doubt, the context shapes team agency in the knowledge-based organisation (Drucker, 1994). In acute care work, all team members contribute significant specialist knowledge, which would amount to little if it was to stand alone. Freidson (1994) believes that professional workers are trained to perform distinct work that focuses on specialist tasks. Yet, interdisciplinary teams must also work in organisations that usually have many problems with process issues (Hammer, 1996). This means that most professional people need to become involved with **pluralistic dialogue** if knowledge is to be coordinated at all.

Because they can no longer act alone within a complex health care delivery system, interdisciplinary teams have little choice but to embrace team agency that concedes collective responsibility to the team *and* the organisation. Herein lies the contradiction for health professionals who traditionally view themselves as acting as individual agents for the patient. Many health professionals welcome professional accountability but are less willing to admit accountability to the organisation. Medical people tend to value peer opinion of clinical performance more than they do any input from an organisational manager (Rasa, 1998). While collaboration within a

discipline is the norm, and partnerships between disciplines are developing, organisational cooperation seems to be advancing more slowly. Engagement in **pluralistic dialogue** becomes essential when social structures are changing.

Pluralistic dialogue helps managers to coordinate collective action, although "the capacity of managers to control productive workers is open to serious question in ways that have not really existed in industrial society" (Freidson, 1994, p. 98). Freidson concludes that the key issue is how the knowledge inherent in professional work is managed when specialisation presupposes the expectation that expert knowledge will benefit organisational function and performance. Specialised knowledge is isolated until it is connected with task and function in a responsibility-based organisation (Drucker, 1995). Dialogue about productivity, output and performance in relation to the knowledge based organisation is important (Rasa, 1998). The grounded theory of pluralistic dialogue goes some way to explain the processes that help that integration. Keeping the lines of communication open is critical so that differences can be discussed freely in a constantly changing context. Contextual ambiguities emphasise the potential contradictions between individual agency that aims to improve life for sick people, and the collective component of team agency that encompasses broader social structural change. Contradictions become matters of value when new management practices impose supposed constraint on clinical work. If economic scarcity and reduced resources reduce clinical freedom, professional knowledge workers tend to respond by resisting managerial authority and control.

Equally problematic is the issue of the professional development of individuals *in relation to the collective* that may pass unrealised in large, bureaucratic organisations. In this study, the hospitals did not have an unconditional commitment to a team-based organisation, in contrast to its popularity as a restructuring strategy in North America (Manion et al. 1996). While many assume that interdisciplinary teamwork ensures a smoother transition in redesigned organisations, health professionals are

accustomed to being managed by their discipline. Maister (1993) observes that it is tempting to assume that, in professional practice, people "can be relied upon to be autonomous, self-starting professionals, with no need to be managed" (p. 207-208). The reality may be rather different. Maister (1997) explains that most autonomous professionals do not want to be "either led *or* managed, and are highly resistant to *anyone's* making suggestions about how they practise, or commenting on their performance" (p. 65). Team agency depends on professionals agreeing to be led, as well as managed.

Team agency can be aligned to the culture of consent. Handy (1990) agrees that "intelligent people prefer to agree rather than to obey" (p. 162). Team agency is underpinned by the collegiate principle of communitarianism that operates using principles that are very similar to **pluralistic dialogue.** Freidson (1994) emphasises that all professional groups are communities. They comprise individuals who have a common commitment to disciplinary knowledge, and a different commitment to special interests. Although professionals have been trained in the art of disciplinary allegiance, learning to extend professional support to colleagues, who have their own specialised interests in the other disciplines, is quite different. Agreement amongst independent professionals may be especially fraught with misconceptions about the meanings of autonomy and accountability. At the same time, health professionals working for bureaucratic administrations tend to lose professional autonomy when technical work predominates. Nevertheless, if professionals expect an organisation to create conditions conducive to the full expression of specialist knowledge, they cannot avoid some consideration of the organisational position in relation to the wider society. Every individual may well carry diverse disciplinary values and beliefs, but, in the end, different perspectives need to be fused with the collective perspective through **pluralistic dialogue.**

While that may be so, the notion of team agency in a responsibility-based organisation is at odds with the inherently prescriptive notion of professionalism. Professionals are often viewed as self-interested

practitioners who pursue individual interests at the expense of clients and the community. Many professionals find it difficult to cast-off their powerful heritage and move in new directions (Schneller, 1997). When new forms of interprofessional responsibility are developing, a collective vision and a strong sense of commitment drive team agency. As collective practice emerges May (1996) suggests that "exposure to a plurality of values and a plurality of life contexts will make it easier to be able to place oneself into the shoes of another person who is very different from oneself" (p. 41). Understanding others is not always easy. Recently, Morgan (1998) issued a public challenge to health professionals who protect self-interests at the expense of macro-economic interest. Morgan recognises that, as agents of the patient, doctors exercise their duty to care by utilising all available resources even though individual patient obligations may conflict with the overall public interest.

When professional practice is evaluated against the public interest, all sorts of problems are evident. For example, the management of salaried professionals represents the conflict between the corporate management culture and the professional culture that socialises professionals (Raelin, 1991). Specialisation has the potential to induce narrow, parochial thinking, and selective inattention that arise from years of intensive learning in a specialised field (Schon, 1992). Raelin (1991) suggests that specialisation is problematic when it develops into overspecialisation and overprofessionalisation. Both conditions signify "the professional's inclination to practise his or her specialised competencies and to serve professional interests without consideration of the corporate goals" (p. 169). Generally, professionals are willing to support organisational commitments as long as they do not interfere with personal or professional values. Neither is that straightforward. "As experience accumulates, the professional is expected to devote more and more energy to the resolution of organisational problems" (p. 170).

Despite the move towards administrative rationalisation, Freidson (1994) reasons that control over work content is not necessarily weakened if

knowledge and skill are integrated into effective organisational functioning. Specialisation is threatened only if it lacks cohesion with the social responsibilities of the wider community. Although managers may not control institutionalised expertise, organisational leaders do set the vision and organise supportive services. They are well able to create a context whereby clinicians manage colleagues across the disciplines. Occupational authority can replace managerial authority in an integrated management system that is founded on clinical cooperation and the collaborative spirit (Crowell, 1996). Partnership is possible when equal status interactions are developed according to theory of **pluralistic dialogue**.

Team agency flourishes in teams where organisational leaders create partnerships with clinicians who are empowered to manage clinical services. Clinical process management implies an accountability for health care which "promotes management as a partnership activity among a large number of individuals and organisations that never before defined management as a part of their skill set or mission and many that are thoroughly uncomfortable with management" (Schneller, 1997, p. 46). As leadership and management roles are redefined in new service structures, roles change and merge, as responsibility for the healing mission and the business ethic are shared. Team agency is interconnected with leadership in the pluralistic era and cannot be divided out from the responsibility-based organisation either. It is vital that organisations take social responsibility, and this begins with expressions of responsibility from each person in the team.

The Responsibility-Based Organisation

In this pluralistic era the responsibility-based organisation accepts social responsibility for organisational function and competence which meets broader sociopolitical needs. New pluralisms evolve because "the society of organisations, the knowledge society, demands a *responsibility-based organisation*" (Drucker, 1994, p. 97). The theory of pluralistic dialogue

illustrates well the social structural processes required to support widespread social change in society.

Interdisciplinary practice in a responsibility-based organisation challenges the Western view of the professional person that values a knowledgeable, autonomous, self-reliant person interacting alongside others with similar goals. Such a perspective exaggerates individualism by detaching the individual from relationships and interactions (Zohar, 1990). It is an approach that is increasingly outdated in the acute care context where many variables obscure clear-cut answers.

Today, as social structures are changing, *all* professional work is being scrutinised carefully. The ethical and moral dilemmas of decision making are open to question by a public that is more knowledgeable about its entitlements, and has a heightened awareness of human rights. Society is also much more ready to criticise health professionals who supposedly have a responsibility to provide a service to society. Health professionals working in the responsibility-based organisation can no longer ignore their social responsibilities in the wider community. Organisations in general, hospitals in particular, cannot pursue the organisational mission, function, or interests if they "encroach on the public domain or violate public policy" (Drucker, 1995, p. 265). Everyone working in the public arena is challenged to exercise more control over professional work that is now evaluated according to its social function.

Health professionals are less used to evaluating themselves in relation to the difference they make to the public good. They are, however, well accustomed to evaluating patient progress as they manage client situations. Experienced clinicians manage clients whose health circumstances are dynamic and unstable. Situations that were once defined become undefined as complications replace stability; and situations that were defined can become defined less so (Hewitt, 1997). While many are talented managers of the unstable situation, they seem to be less

inclined to use those skills to assist social change agents to make sense of a constantly changing reform-based environment.

Clearly, health service delivery is problematic. Advancing and managing organisational priorities and policies and favourably positioning the organisation within the wider society while remaining true to the organisational vision, mission and strategic plan, is indeed challenging (Schneller, 1997). While every organisation holds social power, many are restrained by political power. The hospital is no exception. Hospitals have the authority to deliver health services to a particular population in accordance with the political mandate of the day. Hospitals are in an invidious position. Although they may feel as if they are constrained by political policy, health professionals working in the public sector have a duty to recognise the pressures on the public purse, and to integrate professional responsibility with the wider public interests. Morgan (1998) notes that "the medical fraternity is being required directly to allocate the tax-payer's limited health resources across the limitless demand of the patient population' (p. 11). Some appear to be slow to accept the challenge.

Many health professionals are well practised at dealing with discontinuity and change. These resourceful people work in hospitals that can be likened to the "enacting organisation [that] is proactive and highly interpretive... Enacting is a process of interpretive sense making and controlled change" (Brown & Duguid, 1994, p. 179). An enacting organisation not only responds to the external environment, it also helps create the conditions to which organisational response is required. Parallels can be drawn with the theory of pluralistic dialogue. Although the enacting organisation is not completely typical of the hospitals observed in this study, several teams did exhibit patterns of interaction and behaviour that support 'enacting teamwork'.

> Enacting organisations regard both their environment and themselves as in some sense unanalysed and therefore malleable. They do not assume that there is an ineluctable structure, a "right" answer, or a universal view to be discovered; rather, they continually

> look for innovative ways to impose new structure, ask new questions, develop a new view, become a new organisation. By asking different questions, by seeking different *sorts* of explanations, and by looking from different points of view, different answers emerge - indeed different environments and different organisations mutually reconstitute each other dialectically or reciprocally. (Brown & Duguid, 1994, p. 181)

This means that anyone who works in an interdisciplinary team should be assuming an implicit responsibility to be an active interpreter and shaper of the environment. While some refuse this responsibility, many team members readily accept this position without waiting for change to be imposed. Rather, they anticipate possibilities and respond accordingly. Experienced health professionals have learned to develop thinking in action, drawing on the key process of **pluralistic dialogue** to talk through possibilities with colleagues who share a common purpose. Accepting a place in the responsibility-based organisation is facilitated by mutually reflective conversations that help everyone to accept their responsibility for the collective performance of the team (Schon, 1992).

Collective practice evolves from discourse with colleagues. Once differences have been discovered and discussed, highly experienced clinicians are ready to rearrange the existing social order into new patterns of practice. Mintzberg and Waters (1994) liken this to the consensus strategy for action that is generated when different people make a mutual adjustment to each other, as they learn together in a dynamic environment, "thereby finding a common, and probably unexpected pattern that works for them" (p. 200). In this context, convergence is not driven by a central, or a shared prior intention. Instead, convergence simply evolves as the result of a host of individual actions. Knowledge workers contribute as individuals, who integrate knowledge so that it enhances joint action for the team and the organisation (Drucker, 1989).

This integration of knowledge is not always straightforward, as some fundamental social and moral issues that everyone brings into the workplace can affect it as well. Conflicting role responsibilities are inherent

in a bureaucracy, and these may also create social and moral conflicts for apolitical professional practitioners. If **pluralistic dialogue** is less well established in a team clinicians are more likely to experience the conflicting pulls of moral conscience and self-interest in the responsibility-based organisation, which is actualising broad sociopolitical interests. The nature of their role responsibilities means that clinicians are expected to be readily responsive to political policy change. This is difficult when they have few opportunities to discuss concerns or their resolution. Many perceive the expectation to change responsibilities as an added pressure that is less important when weighed up against the day-to-day challenges of saving lives and managing very sick people. However, negative attitudes can be overcome if individuals are willing to talk the issues through together. **Pluralistic dialogue** helps teams to change their conventional modes of thinking:

> A novel expectation has become pervasive in our awareness: whether a more rationalised organisation of society or, briefly, a mastery of society by reason and by more practical social relationships may not be brought about by *intentional* planning. This is the ideal in the technocratic society, in which one has recourse to the expert and looks to him for the discharging of the practical, political, and economic decisions one needs to make. Now the expert is the indispensable figure in the technical mastery of processes. He has replaced the old-time craftsman. But this expert is also supposed to substitute for practical and political experience. This is the expectation that society places on him and which he, in the light of sober and methodical self-appraisal and an honest heightening of awareness, cannot fulfil. (Gadamer, 1981, p. 72)

When conflicting responsibilities emerge, moral responsibility tends to be emphasised. Moral agency seemingly underpins traditional professional roles that are changing in a more competitive, business-like environment. It is hardly surprising that many people find it impossible to reconcile the dictates of personal conscience with organisational policy (Shaw & Barry, 1992), unless they can talk through the differences. Shaw and Barry believe that many honest, responsible people, who readily recognise moral principles in their private life, struggle to integrate that same moral sensitivity when personal and organisational values collide. Sometimes,

professional freedom and judgment must be renounced in order to meet the goals of the responsibility-based organisation. When individual moral integrity is compromised by organisational demands to move patients through the system in ever-shorter time frames, **pluralistic dialogue** goes some way to easing the associated cognitive dissonance.

At the same time, the issue of organisational moral agency is intertwined with sociopolitical obligations for economic efficiency. In this study, so many participants spoke of a strong personal commitment to the client. Even if the hospital environment does not sustain the moral duty to care in an ideal sense, individuals act as moral agents, actualising their personal obligations to vulnerable humans. **Pluralistic dialogue** helps team members to further altruism and self-interests that must be blended in an unselfish motivation to serve others and meet service needs. These patterns of behaviour are consistent with the notion that a person becomes an agent in the world because of their socially contextualised sense of self (May, 1992). As social constructions of reality change, dialogical encounters further understanding in the postmodern society that can be confusing and uncomfortable.

The tolerance for wide-ranging ideas held by many diverse interest groups in the postmodern society challenges most people. However, health professionals are especially vulnerable because they are expected to respond professionally to biculturalism, multiculturalism, various human rights groups, and the consumer voice. Biggs (1997) notes that, while postmodernism increases diversity and generates new-found opportunities for shared decision-making, it may perpetuate uncertainty, abandonment and the avoidance of social issues altogether. Awareness of diversity "sometimes verges on fragmentation and a sense of riskiness and uncertainty pervading social life" (p. 195). When health professionals are challenged by the plurality of values in which a respect for anything and everything perpetuates an unqualified openness that paves the way for neutrality, they create their own opportunities to think through issues and reconstruct reality.

The grounded theory of pluralistic dialogue illustrates well that, when people are engaged in action and interaction in a postmodern society, they do change their thinking so that they can continually resolve their concerns. Actions support the increasing permeability of boundaries, which reflect a new openness, an interconnectedness and movement that impacts on values and belief systems, altering all human interactions. But, in the end, members of the interdisciplinary team are still individual agents working within a collective sphere.

Rychlak (1988) believes than an agent is an actively contributing being who is always involved with self-interaction, self-reflection, and self-evaluation. Constant interaction with the self and others may shape the collective nature of agency, but action is essentially individual. In this sense, agency is about the socially responsive self. That point is central to this study. Interdisciplinary teams are effective because *individuals* are committed to the collective success of others. In other words, individuals willingly *rethink professional responsibility* and *reframe team responsibility* because they choose to invest in sharing responsibility with others. As May (1992) states "in the end we must act on our own; but our actions should respect the dignity of others" (p. 170).

The participants that contributed to the theory of pluralistic dialogue were unusual and presented a different picture from the generalised health professional population described in the literature. Many of the practitioners are respected internationally. Perhaps the people interviewed are unique. So many are exceptionally gifted human beings working with the very old and the very young, and everybody in between, in an environment where they face suffering, dying, and loss of dignity every day. Health professionals may facilitate healing and comforting but they never escape dying. By making choices they take risks in order to make a difference. Perhaps, the ever-present potential for death of individuals trivialises issues related to the wider society. Genuine professionals seem to want to help individuals, and, it is as individuals that they make the

collective work. These people choose to invest their energy in others. They turn possibilities into reality, because they have the courage to step out onto new pathways with others, to forge a new way of working together. **Pluralistic dialogue** supports interdisciplinary teamwork in the responsibility-based organisation.

Concluding Statement

This substantive grounded theory presents a glimpse, a slice of the practical life of health professionals working in interdisciplinary teams in a restructuring environment. Individuals stand out for their commitment, dedication, and sense of responsibility to others. They are motivated to make the client's hospital experience better. Being a researcher among such people has been humbling and inspirational. It has been a privileged learning position, both renewing and freeing. The freedom lies in the eternal reminder that people *do* care about others, they *are* open and honest, they *are* willing to share unconditionally, they *are* tolerant of difference, and they *will* stand up and be counted as one among the many. Individuals interpret and shape their environment amidst rickety structures that metamorphose from barriers into opportunities when the client is placed central. When practitioners focus on improving the human condition, anything is possible and everything is simple. It is all a matter of attitude.

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APPENDICES

Appendix A

INFORMATION SHEET

WORKING IN INTERDISCIPLINARY TEAMS

1. Who is the researcher and who will be the supervisors?

My name is Antoinette McCallin and I am a nursing lecturer working at the Auckland Institute of Technology. I am enrolled in the doctoral program at Massey University. This research is the fieldwork associated with a PhD thesis. It should be completed in 1999. In this research I have two supervisors. The first one is Dr Judith Christensen who is a Senior Lecturer in the Department of Nursing and Midwifery at Massey University. Judith is recognised in New Zealand and internationally for her grounded theory research on partnership. She can be contacted on 443 9700 Ext. 4332.

2. What is the aim of this study?

As you will be aware I am seeking voluntary participation in this research study. The aim of this research is to investigate how health professionals work in interdisciplinary teams in a radically changing health service. I want to talk to health professionals and some patients and their families. My intention is to develop a substantive theory of interdisciplinary practice.

3. What will be your involvement in this study?

I invite you to participate in my research by volunteering to be interviewed. If you decide to join this study you will be asked to take part in several interviews with me. These interviews could take place either at your workplace or in a location that is convenient to each of us. In the interview I would like us to begin by discussing your ideas and experiences related to working in a interdisciplinary team. For example:

> *I am looking at how teams operate in the health service and would value talking with you about your experiences. Perhaps we could begin with you telling me a little about the work you do.........*

The interviews, which I would like your permission to tape, will be conducted as focused conversations. You have the right to ask for the tape-recorder to be turned off at any time. The interviews would last for about an hour to an hour and a half. As the research progresses and more information is collected I would expect to ask you specific questions related to insights I have from analysing the ideas that have been shared by other people in this research. (*Any ideas shared will always be confidential - see over to 4*). I will want to clarify things you have said and will probably ask you to describe particular situations you have referred to.

The number of times I might interview you will depend on your willingness to talk with me that will always be re-negotiated between us. Some people

may be interviewed once whereas others may be interviewed two or three times over a period of six months. I do not anticipate that anyone would be interviewed more than four times in total.

If you agree to join this research project you would also be asked to read over the transcript that comes from your interview. Some participants read their transcripts. Others do not. The choice is yours. The main point here is to ensure that you agree with what has been said. At this time you will always have the right to withdraw any detail which you prefer not to be included in the data.

I am also keen to observe some interdisciplinary teams during a team meeting and/or as you go about your everyday work activities. This may be possible for your team or it may not. Observation could occur only if it was negotiated and *agreed on by all members of the team* present. I would need to be absolutely clear that if any member of the team was uncomfortable being observed while patients are discussed and decisions for care are made the observation would not happen. The purpose of this observation would be to look at how you interact as you work at assessing, planning, and evaluating care for the patient. Information about patients and their care is not the focus of the observation. The team's decision to allow me to observe them would be discussed in private at the time. A general consent form would need to be signed either by every team member or by your elected representative.

4. Will you be able to be identified in the study?

To ensure you remain anonymous I would not visit you in your workplace unless you specifically chose that place for our meetings. To further protect your privacy your name will not be used in the research. I will ask you to choose a pseudonym that you will be known by.

The information shared between us will be strictly confidential. The only people who will have access to data will be my thesis supervisors, the confidential typist, and myself. All taped interviews and transcripts will be kept safely in my home during the research. Once the research is complete I will offer to return your interview tape to you. Otherwise, the remaining tapes will be presented to the Social Science Archives at Massey University for storage. Transcripts and computer discs will be stored safely for a period of three years. Then transcripts will be shredded and computer discs wiped clear of all material.

5. How will this study affect you?

The aim of this research is to describe and explain how health professionals work in interdisciplinary teams. Taking part in this study will not change your working relationships and situations. When some people discuss their situations they can find themselves considering concerns more than they would have done if the discussion had not taken place at all. There is always the potential that this may be uncomfortable. Experiences may be pleasant or unpleasant for different people. If any distressing situations were to occur for you I can listen and support you at the time. We would then discuss how best to proceed if you needed ongoing support.

6. Can you withdraw from the study at any time?

Yes. Your involvement in this research is based on you willingness to participate. This means you are free to ask for further information or explanations about the research at any time. You are also free to decline participation or to withdraw anytime.

7. Are you able to contact the researcher?

Yes. If you would like to ask any questions about the research and/or have decided you would like to be a participant in this research you are welcome to contact me

Antoinette McCallin
Senior Lecturer
c/- Faculty of Health Studies
Auckland Institute of Technology
Private Bag 92006
Auckland 1020
Telephone 307 9999 Extension 7179

Should you have any concerns regarding the research that you do not wish to address to me, please contact either of my supervisors whose telephone contact numbers are at the beginning of this information sheet.

It is important that you realise that you have the right to decline to participate in this research.

Summary

If you agree to be in this research you need to be clear about the following points:

- You have had the details of the study explained to you. Your questions have been answered to your satisfaction. You know you can ask further questions at any time.
- You have the right to withdraw from the study at any time and to decline to answer any questions.
- Your name will not be used and any discussion that occurs in interview will be labelled with a pseudonym of your choice. The information will be used only for this research and publications and presentations arising from this research project.
- You will be given access to a summary of the research findings once the study is concluded.
- You will decide if the interview/s will be audiotaped.
- You will have the right to ask for the tape recorder to be turned off at any stage during the interview.
- You also understand there is a possibility for observation of a interdisciplinary team meeting and/or you in your everyday activities in your workplace. This would be negotiated and need to be agreed to by the whole team.

Thank you for taking the time to read this.

Antoinette McCallin

Appendix B

CONSENT FORM

WORKING IN INTERDISCIPLINARY TEAMS

I have read the information sheet and have had the details of this study explained to me. I have had time to consider all the information. My questions have been answered to my satisfaction. I understand that I may ask further questions at any time during participation.

I understand I have the right to withdraw from the study at any time and to decline to answer any questions.

I agree to provide information to Antoinette McCallin on the understanding that my name will not be used without my permission. The information will be used only for this research and publications and presentations arising from this research project.

I understand that I will be given access to a summary of the research findings when the study is completed.

I agree/do not agree to the interview being audiotaped.

I also understand that I have the right to ask for the tape recorder to be turned off at any stage during the interview.

I also understand there is a possibility that I may be observed as I work with others in several interdisciplinary team meetings and/or in the workplace but that this would be negotiated between Antoinette and the team.

I agree to participate in this study under the conditions set out in the information Sheet.

Signed: ....

Name: ....

Date: ....

Appendix C

PARTICIPANT OBSERVATION INFORMATION SHEET

WORKING IN INTERDISCIPLINARY TEAMS

As you know I am keen to observe some interdisciplinary teams during a series of team meetings. This observation can occur only if it is *negotiated and agreed on by all members of the team* who will be present. Your team will not be able to be identified in any way. I must be absolutely clear that if any member of your team is uncomfortable being observed while patients are discussed and decisions for care are made the observation cannot happen.

If the observation is agreed to I would expect to sit in the same room as you and to write notes of what I see and hear. Information about patients and their care is not the focus of the observation.

The purpose of the observation is to look at the different roles and responsibilities that each of you takes as you work at assessing, planning, and evaluating care for patient and their families. Because this research is grounded theory I need to look at how you interact together. Some possible things I might be looking at may include:

- how you make decisions
- roles and responsibilities
- verbal and non-verbal behaviours
- attitudes and views

The team's decision to allow me to observe would be discussed in private. If you all agree to the observation a general consent form would need to be signed either by each of you or by your elected representative.

You will always have the right to stop my observation of you at any time.

Thank you for taking the time to read this form.

Antoinette McCallin

Appendix D

PARTICIPANT TEAM CONSENT

WORKING IN INTERDISCIPLINARY TEAMS

Group Agreement for Team Observation:

This team acknowledges that:

- We have had the details of the observation explained clearly to us. Our questions have been answered to our satisfaction. We understand we can ask further questions at any time.
- We understand any one of us can stop the observation at any time.
- Our names will not be used. In the research our team will be referred to as "Team A" (B, or C) or by a name of our choice. The information noted will be used only for this research and publications and presentations coming from this research project.

SIGNATURES:

Appendix E

FIELDNOTES FOR TEAM OBSERVATION

WORKING IN INTERDISCIPLINARY TEAMS

Team Code Name:

Interview Date: **Starting Time:** **Ending Time:**

Goals for Interview:

Location of interview:

People present:

Description of environment (e.g. layout, any physical patterns, significant objects in the area, placement of people and furniture):

Non-verbal behaviour (e.g. tone of voice, posture, facial expressions, eye movements, forcefulness of speech, body movements, and hand gestures):

Content of interview (e.g. use key words, topics, focus, exact words, or phrases that stand out):

Researcher's impressions (e.g. participants responses to certain topics, to people, events, or objects):

Analysis (e.g. researcher's questions, tentative hunches, trends in data, and emerging patterns):

Situational problems (e.g. timing of meetings, people coming and going, interruptions, available material for decision making):

Adapted from Morse and Field (1995, p. 115).

APPENDIX F

Interview Following Participant Observation

Second Interview with Marilyn, 13 November, 1996.

ANTOINETTE: I've noticed as we move around that you do an awful lot of informal teaching and its almost as if you're teaching them to behave differently and you are teaching them to access different resources...its very quietly teaching....
MARILYN:
Nudging them..... yes....its like ... I know she's writing down what I'm saying because I saw her. And I know she's coordinating. And I also know that she waits each day when she's coordinating and she finds and seeks me. And she waits each day ... and she either sits where she's sitting or she stands at that desk and waits until I've finished. And I know that behaviour in her ... she is listening and asking those questions. And yes, we've referred that person. Very good. Now what about so and so? Oh, OK, that's a good idea. And you're reminding them of their processes really and because they respect that person's position - you know with the IV, who needs to be told? It needs to go on that channel so it doesn't happen again to the next patient. Not just ignore that it happened because it's not a very good thing to happen. And saying "Well, he's really unwell with bacteraemia" and she says "Right" and it will pop into their heads as to why that person is so sick "And don't take your eye off him!" "No! We're not!" Now they may have taken their eye off the patient but when you say that to them you know dam well they'll go back to the chart and have another look because [Marilyn] said don't take your eye off the patient. They'll go and find out why. I'm not going to tell them why. They will then ring me if they need to.... It's all in here (pointing to the head), it's all in here....

ANTOINETTE: So you're putting out the prompts and the cues that they need?
MARILYN:
Yes because I know that they know but they just got immersed in the day to day stuff. And I, fortunately, am not bogged in by that day to day stuff so I can see the whole picture. But that's why.

ANTOINETTE: You know with that teaching role - I'm calling that the informal teaching role - there is a lot written about organisations which would suggest that they are learning organisations and I really wonder if I am seeing it right? It seems to be teaching. Is it teaching or is it learning?
MARILYN:
I would see it as teaching. I wouldn't see it as learning. I see learning when I am standing, observing something - and I go and find out and wonder what happened to whatever and then I'm learning. No. I have a huge teaching role and I've always had it and I won't shake it off. It is important to me and its also my way of verbalising my concerns and [me saying] "I've told you and you've heard me!" If I'm really worried I'll write it down. But the next day when I go back I would expect to see or ask that question "Did you call

... about?" "Yes, we did?" and when I pass her in the corridor I will tell her about that patient too.
ANTOINETTE: With that teaching thing it seems to me that there are some people in this organisation who have expert knowledge - and I would see you as one of them - as a person who has expert knowledge based on enormous experience - and you are dealing a lot with people who are very new and learning (M: Mmm). And there isn't the time to be processing the learning as this is what you need to be doing. Have I got that?
MARILYN:
Absolutely. And you do the same with the housemen and one of the things I did in my other job and I do more now is that the houseman is exactly the same as the nurse on the floor. And they actually need more support than the nurse on the floor because they are alone. You know, [refers to a houseman]] - with those two patients coming up, he has to process them. Now, when I was talking to [the charge nurse] our registrar was talking to [the houseman]. So, you've told those people the story, the bits they want to know; [the houseman] wants to know about all the surgeries, he wants to know the medical stuff and [the charge nurse] wants to know all the nursing stuff.

ANTOINETTE: Yes [Richard] was teaching [the intern] last week, wasn't he. And the other thing I noticed on that round was that you said to [the charge nurse], "If you need any help when Mr Z arrives, give me a call" and you spoke about setting the ground rules and then [Richard] immediately came in and said "I'll come in and talk to him as well". (M: Yes). It was almost as if you were mustering yourselves as if you knew you were going to be needed (M: That's right) to get that patient settled into the ward.
MARILYN:
That's right because the ward don't want the patient back. He was extremely rude to the nurses, he had them in tears. They do not like the person. They won't refuse him of course. But what they need is back-up from us. [Richard will] lay down the rules for this patient "This is what you must do if you want to get well" and for me to do the bit about "Some of your behaviours were really not acceptable to the nursing staff here and they will not tolerate them this time". And I've told them, and I will tell him, if you've got a problem, you tell me. I'll come each day and you tell me what your problem is.

ANTOINETTE: And you will try and act as the mediator to sort it out?
MARILYN:
I do. Then the patient doesn't feel he's not being heard and the nurse doesn't start the, "He's going to pick on me!" stuff and they can just get on with their work. And another thing - I'll also ask the nursing staff to forget what happened before. We're moving to the next phase now - those of you who don't want to nurse him, don't go near him. Just regroup yourselves.

ANTOINETTE: But you'll offer the support systems to try and find different ways of doing things.
MARILYN:
Yes. Because otherwise if something happens to this patient then they'll miss it. And the bottom line is that I don't want this patient to be ignored because he's obnoxious - and they won't - *but you just make dam sure that they don't!*

Appendix G

Field Notes for Participant Observation Team A

23 October 1996
07 30 – 1100

Present:

- Case coordinator
- Registrar
- Clinical director joined round later on (*had been in theatre)*

Goals – emerging

Began the day by going to ED to look for admissions in the past 24 hours. Case coordinator begins the day for the Service by sifting through admissions looking for potential patients for the team. Talked about the hospital being a ***global village*** - every place is different. The official entrance to the service is through ED. The team finds other patients as they travel around the hospital.

Boundaries were talked about very early on in relation to geographical boundaries and returning patients to their catchment areas as soon as possible due to ***funding*** and ***political*** issues. Everybody is very conscious of the geographical boundaries as in the final analysis they will be critical when the [accountants] are squabbling over who will pay the bills. ("The bill will be sent but no-one will pay, no-one will ever pay - it's a paper exercise"). The hospital was full and had a backlog of patients in EW so there was nowhere for them to go until other patients were discharged. Boundaries seem to change according to need and many complex contextual issues. For example, the hospital has closed beds because of a funding deficit and a difference of opinion with the RHA. Consultation seems to be limited there. This seems to change the admitting procedures which become ***informal*** as medical staff find ways around the road-block. .... Said medical staff are blamed and are now fighting back as are the nurses. (RHA seen as the "old boys" and the "old girls" network). Nurses are concerned because closed beds means fewer jobs so the perspective are different. ***Entry*** across the official boundaries seems to be a problem. If patients who are to transfer to [another hospital] and it will not accept a patient then that patient will be discharged home and will be booked back to the [outpatient clinic] which is seen as the ***open door*** to the hospital. What this means is that some patients, who should have been admitted in the first place, go home and are eventually admitted one week later through the clinic. The route is a ***roundabout route*** of getting into hospital.

Boundaries are political though when the patient comes from various geographical locations. For example, Niue, Tokolau, and Cook Islands are non-NZ citizens but do not have to pay. Patients from Tonga pay. Interesting that with treatment an official will have to OK the payment but no money is ever likely to change hands at all - just paper and that seems to be enough. Check out.

The ***bottom line*** is that doctors and nurses end up with the struggle - they are at the front-line in the everyday world. They are coping with the day-to-day management of the patients and all the problems.

Marilyn seems to have broad ties with lots and lots of people from all disciplines. Well known, ***experienced, respected***, and appears to have strong ***collegial relationships*** with many other health professionals.

Time factors kept coming up in various guises. Time is critical in many instances. Some hospitals, health professionals, outside consultants resort to ***delaying tactics*** - OK to a point but in the end someone has to pick up the problems. It sounds to be the doctors and nurses who do that. For example the RHA has closed elective surgery beds and the first people to be hurt are the patients and then the junior medical staff. But this hospital is one that is known for ***making a stand.***

Marilyn ***sees the problem as being funding*** - have the manpower and the expertise but not enough funding for a hospital that is so specialist and deals mainly with acute cases - there is an incongruence here between the business culture and the nature of the service. The good thing with funding issues is that people have had to clarify their agenda. But NZers do not understand that you now have to pay for health care. That message has not got across. Patients, people in society do not understand that health care is no longer free.

Team interactions - everyone is looking for something different. They all have specialist knowledge and then pool information and share ideas so that the patient will be helped to recover in the best possible way. There seem to be some "sensitive" geographical areas eg. [a special unit] where the team is tolerated by invitation only in an advisory capacity. They have no control over the general management. Team members were highly conscious not to step over the boundaries there and would build stronger links with patients and families once the patient was transferred to the wards. In the ward settings, nurses pass on a lot of informal information to the case coordinator. There are ***messengers***. A great deal of ***talking, talking, talking*** goes on because case notes are so far away and not easily accessible. Talking with many members of different teams was important to ***check perceptions***. Lots of ***sharing of information, teaching role, linking education to practice, mentoring*** of colleagues. Everyone was teaching each other, checking things out, referring and facilitating others in to see the patient, drawing others in to try to move the recovery process forward. Teaching was ***quietly teaching*** and involved the passing on of specialist knowledge by the experts to those who were still learning.

The ***service is a catalyst*** for developing or extending practice. ....Marilyn saw her role as showing staff what they already knew but were unable to put into words. Staff get bogged down in the daily grind of work and because the service is on the periphery the team can often see more clearly what is going on..

Friendly competition between other specialist services - the size of the entourage on the ward round was significant here! (Rent-a-crowd tomorrow!). The different teams seemed respectful of each other - ? ***synergistic relationships*** here.

Appendix H

Excerpts from Theoretical Memo

Notes on Teaching and Learning

26/1/97

Learning

- The teams are so specialised that they may have limitations to their knowledge so they are often in a position of learning new things. They use each other as much as possible to teach each other and to share information so they can be better informed. They just want to understand better!
- They see learning as being continuous process that is ongoing, never-ending. "The more you know the less you know".
- **Louise** 10/2/97 - **Teaching/learning** - an interesting dimension here - she suggests that her learning happened through teaching others, not by having learning facilitated. That is significant and is very different to theories of teaching and learning.
- 12/2/97 - Is ***teaching coaching?*** That term has come up several times. The teams coach each other. They also coach families about what is happening using the family meeting as the venue. The coaching knowledge is knowledge that can be easily picked up but it usually has some specialist aspect attached to it and knowing how to do something or where to go (See Bob 16 – talks about ***exploring possibilities together***).
- If teaching is in fact coaching it might fit in well with "grappling with different mindsets" as people need help to change their ways of thinking. Have to be coached through the process – how does that happen?
- Teaching is informal.
- With teaching I think we are talking ***learning opportunities*** which are a part of reflective practice. A few people talk about thinking things through and thinking about things. They are deeply reflective. That might be why they are willing to talk with me. Lee says she had to think things through when she had to teach others so teaching others becomes the catalyst to another opportunity to practice rather than being the focus as such. That's what I have seen! Everywhere! Teaching is a catalyst to learning and trying to understand practice more clearly. It has to fit under professional responsibility then.
- Lee goes on to explain this when she says she is not coaching but had moved into rehab which is changing the person's attitudes and environment - she is working with learning opportunities or has created them and is building on that.
- 23/7/98 – ***discourse in action → dialogue***

Appendix I

Excerpts from Open Coding of Earlier Interviews

Substantive Coding (Open Coding)	Interview Statements
	First interview with Janeanne – interview two
• Role definition important • Recognising difference between roles • Explaining roles • Hard to understand other roles	Absolutely and the whole role definition thing for general managers is *really, really* important and that's where general managers are having so much trouble. If they don't know the difference between a therapeutic radiographer and a diagnostic radiographer them it's really very hard. I mean, I spent an hour trying to explain that to somebody and then at the end of it he said to me "Well, why then, are they both called radiographers?" and you go back to square one about the definition.
• Change agent must understand roles • Restructuring begins with understanding • People need some role clarification	Yes, yes and on both sides. If the change agent or the manager doesn't have a good concept of what role people should be doing you can't expect them to actually develop structures and the services that go with that to fit those groups. On the other side you can't expect individuals to do anything different to what they've always done if they don't know what it is they're supposed to be doing.
	First interview with Wayne – interview four
• Hospital a business • Many disciplines fix the patient • Teamwork essential to provide patient care	Well the model is predicated on the fact that this is a hospital business and the only outcome input and output is the patient. And a nurse doesn't fix a patient. Nor does a dietitian or a doctor. They all do it. The one patient, the same person, there's about 25 disciplines that create that satisfaction outcome or not. So if they don't work as a team on that patient with cancer it doesn't happen. If nursing is going this way and they're fighting and radiotherapy's not on time and the orderlies don't roll up to take him to theatre it just doesn't happen.

	Discussion with Wayne continues. We have been talking about commitment:
• Professional commitment a luxury • Hospitals patient-focused everything • Patient is central	Well, yeah! [Commitment] will never stop and that's a luxury we've got. And that's probably pivotal. We've moved from patient focused care to patient focused everything - management, support, structure, everything! To, the extent that that's the pivot of all this. The patient is the centre of all our attentions and the way we manage and the way we empower and the way we orchestrate ourselves, the number of staff we have, the type of machines and how the gardens look! If that's true, you'll have a great hospital!
• Money for health has dropped significantly • Expectations for change rapid • Need time for change • Indecent haste • Health services people oriented – not machines • People working faster • People better motivated	We started from here where there was lots of money for health and we want to get to here where there's no money for health. And unfortunately, the owners want to go from there to there - bang! There's somewhere that you've got to have breathing space, return to patient for the productivities, all those things that you do in that interim way, some way, in a reasonable percentage of way and get from A to B in a lot longer. There's this indecent haste. And where the base of getting from A to B requires those people in the middle to come with you - it's not like a factory I don't think, where you can just pull the plug faster. It's the people who are getting faster and better and motivated...

Appendix J

Excerpts from Selective Coding

Selective Coding	Interview Data
Team work ethic **Trustworthiness** • naïve trust • honesty • interactional style **Individual-collective agency** **Moulding with Individuals**	***First interview with Caroline – interview eighty-seven. I want to know more about the team work ethic:*** *Q.1: People seem to be talking about a team ethic. Now they seem to be talking about things you do and things you don't do in a team - the acceptable behaviors - I wondered whether it possibly fits here, under this 'team gel' – I think its very much a part of the collective responsibility, obligation and willingness. What does the idea of the team ethic mean to you? CAROLINE: I think that's actually quite a difficult one. I think my understanding of that has changed a lot over the time that I've worked in teams. I think I went through a very difficult patch where I didn't understand what a team ethic was. I was an individual in a group. I was outside of the team, so I didn't have any understanding. From there I went into an odd state where I though that being a team was having no conflict at all. And so I used to keep quiet all the time – which isn't part of being a team – but that was my understanding: being a team. Everything is happy and joyful, and you don't do anything to rock that. I can remember at the time feeling very dissatisfied with myself because I kept thinking this isn't me, I'm being really unclear myself here, and if I'm being like that, I don't know how I can be in a team. From there I think I've moved again to much more of an understanding that what teams are about is individuals together so you don't loose you individuality because you are part of a team. If you are committed to a team – actually really committed to the team, and not just paying it lip service – I think that the team achieves far more that ordinary individuals together. I guess that can be quite fragile. It's very dependent on having a whole group of people all of whom are truly committed to the team, and all who have haven't lost their individual sense of self as well. I've often wondered because of that if every time you loose a team member do you actually have to that team rebuilding? I'm almost at the point now where I think you do.

	First interview with Emily. This is interview ninety-six. I am looking for more data about reframing team responsibility:
Reframing team responsibility	ANTOINETTE: Yeah what does it mean to you when you have a person coming into your team - you have an expectation that they will take individual responsibility and they presumably bring in some skills - I've made the statement that I think they then have to re-frame. How do you see individual responsibilities working in the team? EMILY:
Moulding with individuals	I think people bring their usual way of doing things with them. And then I think how that re-frames can happen in two ways. I mean some times some people kind of suss out the team situation, adapt whether they are aware consciously or not they just sort of think oh so this is how it works. There's a bit of it they don't like it and actually I don't like that. It kind of happens easily. Some people automatically are good at that. And some people find it more difficult. I think too that probably these days there is far more in the way of overt [expectation] - with job descriptions and contract negotiations and performance appraisals. I think that is supposed to address that so that those things can be negotiated within teams. And if they are done how they are supposed to be, you know how the booklet says you are supposed to do them, then, that is a very good process. But it does depend on the abilities of all the individuals concerned. ***And*** *Checking out the meaning of individual-collective agency:*
Moulding with individuals	ANTOINETTE: In the management literature there's a lot of work around at the moment about the individual and their core competencies. Everything begins with the individual and it doesn't matter what you do that it is what each person contributes. Then they work as the team. In the health service we have some people who are highly committed to the collective. And yet there are others that say but we can't have the team unless we are standing as individuals. So it is the and-both. What are your thoughts there about the collective operating as a collective and

	perhaps some of that individuality being subsumed within the collective? EMILY: I think you need both. I think that you can't have a team if people don't .... it's like you can't have a relationship if you are not prepared to concede something. With any kind of working together or partnership, by definition people have to modify a bit of what they do. And I think that for the individuals within a team to do the team work they have to mesh with each other to a certain extent. And I think each person has to do that; for a team to work well they have to decide is this teams approach and this teams business something that I can endorse and go along with? Now if they don't, then they've got a choice of trying to change it and that may change. That may be a really productive thing. If it doesn't change and they are still unhappy then they either leave or they can stay there and end up with split teams and quite destructive processes. And I think that impacts really badly on good patient care. So I think it's always a bit of an uneasy balancing between individual integrity and that sort of lateral thinking. You say this is important. And how much people mesh together.

Appendix K

Excerpt from Category Memo

Personality Differences

Indicators

- flexibility
- sensitivity

1. Where there are personalities in teams that are difficult, one way that team members respond is to negotiate around that person. This is avoidance behaviour - they recognise that the problems the person has are so deep that they cannot be changed so the people use other approaches to make a point and try to find other team members who are trusted to have influence on that person.
2. The team is generally very tolerant of those who cause friction in a team. For example a person may be someone who is always very stressed person or have an abrasive personality or be a poor communicator or a poor manager of time. Some people are all of those things. Lilly talked about using the "watchdog strategy" to monitor those people and get them to perform at the expectations of the team. Another person who understands the work to be done will be put in to oversee a team member who is not performing to the team's expectations.
3. It is difficult to always communicate openly in a team if the leader has a personality that does not encourage that. With the personality who is awkward there seems to be a lack of collegial respect and valuing of individual team contributions. These people seem to be very choosy about who they listen to and where and when and it is not consistent. In fact they wield the power of their position.
4. The team seems to be more tolerant of the personality who is good at their job. Competence is crucial. While this may be so an awful lot of energy goes into working around these very difficult people who become powerful in a negative sense. The trouble with working around these people is that it takes time and energy that would be more profitably put into the team purpose and service provision.
5. The difficult personalities usually have poor interpersonal skills. Poor communicators. Do not listen to others. That means other team members have to make up for what that person is lacking there to be able to deliver the service in the best possible way. So other team members take on the roles those people do not do well and cover other HPs. However, they will only cover if the HP is competent and they are generally respected in their work. If they are not good at their job, others will not make up for the deficits.
6. Some team members have life circumstances, which are challenging, insolvable, and ongoing. This effects how that person behaves and interacts in the team. The team learns to accept different human experiences and are tolerant of situations that cannot be changed. While the team acknowledge the situation and are tolerant of difference they also need to support each other in order to be able to interact with a colleague who is not always easy to work with and who is unlikely to change his or her behaviour. This seems to be a tolerance of human frailty. Often judgment calls about personalities are intuitive decisions. The human element of people cannot

always be reduced to technical rationality. It is important that teams have compatible personality working together if they can because the working environment is very hard and people need to be able to relax with each other.

7. The individualistic personality does not fit in the team. They are too isolated and forget to take note of what others want to do and are not really interested either. An individualist wants to be in control and does not want to be helper to others. They may not be fitting in with that context they are in. They may not be suited to it. Being an individual is a powerful position. There is an underlying selfishness here. A person who is not fitting into the team may be quite competent but be individualistic afraid of being put in a position of not knowing. These people are usually brilliant but afraid they are not good enough so they isolate themselves. Likely to be perfectionists. They do not share anything with others, supposedly because they do not trust others, have a fear of failure. That fear can be turned into power but in the end fear is of loosing power.

8.People who present as "personalty problems" to the team have often had a lot of personal problems over the years. These people tend to be somewhat inflexible in their personalities and they cannot see why things are being done in different ways. There seems to be a tendency to dwell on the fact that things have always been done like this and they want to maintain the status quo - probably to feel some sort of control. Do they have problems with divergent thinking as well? Are they concrete thinkers? Dysfunction is a part of life. Lack self-awareness. May not feel valued and might respond positively to responsibility and recognition of their roles. The unfortunate thing about the personalities is that they have a reputation for causing trouble with many different people and working for a series of different managers.

9. It is fascinating they can make life miserable for colleagues. Because self-awareness is poor, they do not know the havoc they cause. When bad behaviour is accepted, it is being condoned. They are not being challenged for their utter rudeness and the way they treat others. And there is no form of professional supervision to cope with this.

10. It seems some people who enter a team are bent on being disruptive, refusing to recreate their place in the group. May have been rotated into the service that is not one of their choice. They seem to be absolutely insensitive to the effects they have on the team as a whole and are totally selfish in their individual attitude. This disruption is usually deliberate but there are others who are more willing to compromise, to discuss new ideas, offer different approaches. What the HP gets out of the experience seems to be over to their individual motivation to recreate collectivity responsibility.

11. With personality people can be trained to behave differently as long as they know what they are doing that is not working within the team. That cannot always happen though if a person is closed in their outlook. Then others cannot be bothered to put the effort into trying to help a colleague develop. So the person has to show some willingness to work with others and change and that may also mean the team members changing as well. The changes might happen simply by role modelling and example of what is acceptable behaviour and what is not. In that case it would take a certain degree of awareness on the part of the person with the "problem" to recognise how they might behave differently. That change within the group is suggested by Ian Marshall, in Quantum Society:

> When there is tension in the group because of the behaviour of one or more members, there is a temptation for others to focus on that

> behaviour and to demand that it change. But when a disturbed person is focused upon, he or she becomes fixed in that behaviour pattern, becomes locked into a role, and remains alienated from the group. Things usually work out better if the group can learn to communicate indirectly, can learn just to be together, without focusing on any one member. Then a sense of their group cohesion usually re-emerges (p.116).

12. It seems that some tensions are ignored in the interests of the overall goal and ultimate output. Sometimes a team will decide to ignore processing issues in the interests of pursing tasks and completing the work to be done. That is not always fait on other team members who then are likely to be undermined, destroyed, manipulated by the "difficult" personality. The team needs to be mindful of the particular messages they are giving when they are seen to support dysfunctional behaviour. In fact they are indicating collectively that behaviour is acceptable in that group. With personality it needs to be taken away from the self if the person is thinking in a professional sense. Problems should be reconsidered in the professional light. The team will help each other with personality differences to bring the person back into line with team thinking.

Appendix L

Memo on Category of Cooperation

CHECKED 6 CS 18/5/97 – 12/2/98 – needs more work

DEFINITION - COOPERATION IS THE WAY THE TEAM SHARES PROFESSIONAL RESPONSIBLITY AND SUPPORT EACH OTHER AS THEY WORK TOGETHER.

COOPERATION IS A CONSEQUENCE OF GRAPPLING WITH DIFFERENT MINDSETS

THESAURUS - COLLABORATE, ASSIST, CONTRIBUTE, COORDINATE, HELP, PULL TOGETHER, POOL RESOURCES, WORK TOGETHER.

CHAMBERS - WORK TOGETHER, WILLINGNESS TO HELP, COLLECTIVE OWNERSHIP OF CONTROL

INDICATORS
- WILLINGNESS
- NEGOTIATION

CAUSE - (Reasons, explanations) Cooperation is teamwork. It is the way the team identifies its strengths, accepts its shared professional responsibilities, reviewing how it will work together as a team unit rather than as individuals. This is consistent with the symbolic interactionist thing of understanding the role of another. For a team to be able to cooperate they need to be clear about their roles and what others do and they need to have sorted out their goals and perspectives.

So far, the team has checked each other out to see if they think they can work as an interdisciplinary group. They have examined their philosophical basis of practice, looked at beliefs and values, knowledge, competence and expertise. Once these facts have been accepted team members welcome colleagues who are trusted and respected for their specialised contribution to the team as a whole. Everyone in the team contributes to fix the patient; everyone has a part to play. The team person is someone who is not an individualist. They can be very good at their job, in fact excellent, but that is not enough if they cannot, will not get on with others. It begins with cooperating around the things you feel comfortable with (Alec, 372:475). That is an interesting comment as it is to do with getting to know other HPs at a different level of interdisciplinary practice. The team draws on an individual's specialist knowledge to provide an effective client service. Cooperation is to do with doing the best for service delivery.

Sarah (1a, 13-13) suggests every person is absolutely vital to the life of the team. And that was built on the acceptance that each person had equal status (or more like contribution) in that team. Because team members appreciate they cannot make their patients better by them selves they respect the contribution of all other team members. That view is different to medical dominance because in the past, and still today, many doctors

believe they are the only ones who can make the patient better. Too many medical staff still do not recognise overtly they need paramedics and therapists to help them get the patients better. And that attitude does not foster the team spirit or cooperation. One of the reasons behind this may be gender related in that medicine has been, until recently a male bastion. That is no longer so and today many health professionals are women and are more used to working together and sharing ideas, working as a group. Women are better group players as they are used to relying on each other. Men have been more trained to rely on themselves.

CONDITIONS - In teamwork you cannot pull back into one particular discipline because the team just will not work. It is very easy to focus on your discipline whereas in fact, in the interdisciplinary team, some health professionals must be able to stand back and look at the whole picture to identify and clarify priorities. It is very, very hard to take an overview perspective when actively involved in a situation. But in an ID team no one person fixes the patient. There are many disciplines needed to contribute to create a satisfactory outcome for the patient. The team is an entity in itself. It is not the conglomeration of a series of individuals. People bring different ideas to the job in terms of what they want to get out of the work and what should be improved on next and those ideas vary according to each person's background, specialist knowledge and particular interests. But the team knows what it wants to achieve and sets about doing that together.

Another dimension of cooperation is willingness. Because team practice is not always clear it requires a flexible approach. Team people need to be adaptable in order to be able to respond in ways, which not have been specified. They need to be able to respond to other team members, the patient, and the service environment. In the teams people have to cover each other in a general sense. They cannot cover fully as everyone is so specialised but, because they are so experienced and understand the wider picture they are able to pick up transferable roles which normally come under the auspices of others.

CONTEXT - It is much easier for health professionals to focus on a bit of the patient and to forget to think of the bigger picture. And part of that is self-protection for the medical and nursing people - it is safer to remain with what we know than to have to work with what we do not know. It takes confidence to admit to not knowing and to be prepared to ask colleagues for advice. Another aspect is self-preservation - a person can only cope with so much at one time. And the other aspect is going against tradition where it has been normal to ask other specialists in to consult about a patient and particular parts. That is the normal way of doing things in medicine and is accepted easily. See Richard (p.179). Few health professionals have been trained in teamwork. Even if they have it may be socialised out of them when they are exposed to the role models in practice and experience the apprenticeship system and the pressures of work.

CONSEQUENCES - Richard gives an excellent description of the stages of development of the team. The FIRST STAGE is easing in gently where the team is establishing their roles and working quietly in the background. (Similar here to being and settling in of Masters thesis) Juggling and balancing roles here and means the practitioner may not function fully the way they might want to. This may place the team in difficult situations, as

the specialist clinicians will not want to support ineffective practice. Feeling the way. They have a low profile here and are working
on the informal communication and networking with colleagues. In the SECOND STAGE of development they can become more overt as they are openly recognised for their roles and the work they do. During stage most people know who they are and what they do. The team is visible now. Any contacts with others outside the team are carefully monitored so the "new" team on the block is not seen to be criticising others.
Non-judgemental. Are very careful not to upset other colleagues. New ideas need to be woven in gradually. There is still reluctance on the part of some health professionals and that means some teams do not pass on the referrals. Some of that reluctance may be due to the fact that many consultants work part-time in the hospital so do not know what is going on. They are not there. The team has to be seen all the time. That may be related to Finding a niche.

In the THIRD STAGE there is free and open recognition where teams approach directly and consult about patient management. Have a high profile now but there is vulnerability there in maintaining that. That vulnerability may be because they are known as the "best" team and an element of competitiveness may surface. Important for colleagues to realise these teams are not competitive in a disciplinary sense but have cooperative approach to their work and are more interested in working alongside others. Thus the service is eventually accepted as long as it is built up by people who are credible amongst colleagues.

12/2/98 - these stages do not fit here! Will have to be moved. That data is so good it has to have a place somewhere! Could they be stages of development of individual-collective agency? Am concerned that I have too many categories today but possibly if the stages fitted together, that might move me onwards. Back to the data - again!

Alec talks about the energy innate within teams. When a team synergises together it isn't because of the connection with the patient. It is to do with the energy between the people working in a difficult situation - sharing the collective responsibility and supporting each other as they provide a service for others. That synergy is likely to be related to confidence in roles. So those situations where there is energy innate means strangers can and do gel together as a team as they have the competence and ability and are clear about their roles and are able to respond. Team members have brought their competence, expertise and technical skill to the team as individuals and are now using it as a group. Even though everyone brings specialist skills to the team, the collective responsibility is more likely to be realised when there is someone to manage the process. For the best results the team needs to be managed. Otherwise all sorts of stupid things happen (GEORGE 339).

Another consequence is the emergence of the united front as the team gets to know each other well. The united front is supporting each other in the job. And it means the team is saying the same thing, which is important for the client. And the team still discusses problems and sorts out what is the best plan of action for client management. Another part of cooperation is that it is important that things run smoothly, problems are picked up and

sorted out. People have to accept each other and it is easier for the team as a whole if they are happy in what they are doing.

Another consequence of cooperation is the emergence of personal and professional self-confidence. Wonderful quote from Sarah (1B 358-375):

> We weren't the best when we came to the team. I wasn't the best when I came to the team. But because of the team I am the best now. I have become my knowledge base and because of the facilities I have been given and the people I work with my knowledge base is so great I now consider myself to be one of the best practitioners in the country. Not the best as in the most brilliant but with the broadest knowledge base because I've had access to learning.

This situation has the potential to be empowering for the team member. Sarah goes on to say:

> The power I've been given is the power of knowledge and I've been given that by the five other team members. I've had the opportunity to go overseas and learn. It's not that I have miraculously changed into a new person overnight. I am the same Jo Bloggs average but I've had much more access to people who are prepared to teach.

12/2/98 – that looks like individual-collective agency to me. Not in the right place – move it.

Another consequence of the team working together is the team is much better at understanding what everyone does and there is a dynamic where people understand better the pressures on them as a team as a whole rather than thinking organisational change is being directed at one discipline in particular. In this sense the team becomes a means of teaching each other how to cope with change and look at the whole.

STRATEGY - One of the keys to cooperation is open communication in the team. ***So why isn't talking an indicator. It sounds as if it should be.*** Team members need a place where they can express freely, be open and honest and don't have to worry about being politically correct, saying the right thing all the time. The most effective team members are those who will communicate with others and those who are genuinely interested in supporting others.

Agency – wrong place – move – 12/2/98
George3 16-26 puts this well. He says the team has a joint responsibility for what is happening and while they are dependent on each other they also have a sense of interdependence. It is all to do with the fact that they are cooperating to do the same job but at the same time everyone is doing a different, quite unique job.

Appendix M

The Theory of Pluralistic Dialogue – *An earlier working model*

- **Rethinking Professional Responsibility**

Breaking Stereotypical Images – *Apolitical-Political Approach*

Coding Family	Properties of Category	Indicators
Causes	Specialist-Generalist Practice	Complementary skills, expertise, knowledge
Conditions	Pioneering Roles	Role understanding, role identity
Context	Blurred Boundaries	Certain-Uncertain Expectations
Strategy	Confirming Competency	Performance, reliability, confidence
Consequences	Colleagueship	Equal worth, respect
Covariance	Traditional Approaches	Disciplinary knowledge, professional tensions

Grappling With Different Mind-Sets – *Cooperative-Competitive Spirit*

Coding Family	Properties of Category	Indicators
Causes	Collective Practice	Interdependence, change
Conditions	Alternative Worldviews	Individual beliefs and values
Context	Differentiated Commitment	Dedication, vocation, integrity
Strategy	Practising Team Philosophy	Common purpose/goal, shared vision/direction
Consequences	Team Learning	Learning opportunities, trial and error learning
Covariance	Team Management	Leadership, motivation

- **Reframing Team Responsibility**

Negotiating Service Provision – *Formal-Informal Connections*

Coding Family	Properties of Category	Indicators
Causes	Service Coordination	Liasing, client continuity, clinical input
Conditions	Information Exchange	Sharing, withholding, networking
Context	Business-Humanitarian Clashes	Economic scarcity, bureaucratic constraints
Strategy	Deciding Together	Consulting, challenging, reassuring
Consequences	Collective Accountability	Reviewing, abdication
Covariance	Optimisation of Client Care	Resource management, quality care

Engaging in the Dialogic Culture – *Both-And Thinking*

Coding Family	Properties of Category	Indicators
Causes	Trusting Interactions	Honesty, sharing
Conditions	Interprofessional Safety	Openness, confidentiality, subversion
Context	Values-based Leadership	Facilitation, partnerships, encouraging
Strategy	Actively Listening	Valuing contributions, acknowledging
Consequences	Sense of Community	Willingness, team person
Covariance	Personality Differences	Self-awareness, sensitivity-insensitivity