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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.

Contents

Acknowledgments / ii

Abstract / v

Table of Contents / vii

List of Tables / xii

CHAPTER ONE: Introduction / 1

Refining the Research Topic / 2

Aim of the Research / 5

Purpose of the Research / 6

Significance of the Study / 6

The Key Argument of the Thesis / 7

Structure of the Thesis / 9

CHAPTER TWO: Meaning and Method / 12

Introduction / 12

Modern Ways of Thinking / 12

 The Rise of Pragmatism / 15

 Symbolic Interactionism / 18

General Ideas of Blumerian Symbolic Interactionism / 21

 The Self / 23

 The Act / 24

 Social Interaction / 24

 Objects / 26

 Joint Action / 26

 Society / 27

The Methodological and Philosophical Position of this Project / 28

 Grounded Theory as a Research Method / 28

 The Credibility of Grounded Theory / 31

The Grounded Theory Style Used in this Study /	32
Conclusion /	34

CHAPTER THREE: The Historical Backdrop of Teamwork / 35

Introduction /	35
The Rise of Professionalism /	35
The Concept of Profession /	39
The Discourse of Professionalism /	40
The Professions – Power and Social Control /	45
Conclusion /	51

CHAPTER FOUR: The Political Context of Health Reform / 52

Introduction /	52
Changing Social Demands in Health Care /	52
The Political Impact of the Health Reforms /	55
The Management Challenge to Health Care in the Post-Industrial Society /	62
Conclusion /	65

CHAPTER FIVE: Teams and Teamwork in Restructuring Health Care Organisations / 66

Introduction /	66
Some Basic Terminology /	66
Developments in Work Redesign /	67
Patient Focused Care /	69
Case Management /	73
Total Quality Management /	75
Teams and Teamwork - What is the Difference? /	77
Conclusion /	87

CHAPTER SIX: The Research Process / 89

Introduction /	89
Aim of the Research /	89
Purpose of the Research /	89

The Participants / 90
Location of the Research / 90
Sources of Data / 90
Recruiting Participants / 90
Access to the Teams / 91
Making Connections / 92
Characteristics of the Participants / 94
The Teams / 95
Ethical Concerns / 97
Informed Consent / 97
Anonymity and Confidentiality / 98
Researcher Involvement / 98
Data Collection and Analysis / 101
Concurrent Collection and Analysis / 101
The Interviews / 103
Participant Observation / 103
NUDIST – A Computer Tool for Analysis / 106
Generating the Grounded Theory / 108
Substantive and Selective Coding / 108
Memo Writing / 111
Finding the Basic Core Category / 113
Generating the Theoretical Framework / 115
Overview of the Grounded Theory / 116
Theoretical Frustrations / 120
Conclusion / 121

CHAPTER SEVEN: Pluralistic Dialogue / 122

Introduction / 122
Pluralistic Dialogue / 124
Breaking Stereotypical Images / 129
Grappling with Different Mind-Sets / 132
Negotiating Service Provision / 135
Engaging in the Dialogic Culture / 137

Implications of Pluralistic Dialogue / 141

Conclusion / 143

CHAPTER EIGHT: The Meaning of Rethinking and Reframing / 144

Introduction / 144

Rethinking Professional Responsibility / 144

Reframing Team Responsibility / 153

Conclusion / 164

CHAPTER NINE: Breaking Stereotypical Images / 165

Introduction / 165

Blurred Boundaries / 167

Pioneering New Structures / 173

Confirming Competence / 178

The Collegial Attitude / 184

Conclusion / 190

CHAPTER TEN: Grappling with Different Mind-Sets / 191

Introduction / 191

Pluralistic World Views / 192

Differentiated Commitment / 198

Practising a Team Philosophy / 203

Collective Practice / 208

Conclusion / 213

CHAPTER ELEVEN: Negotiating Service Provision / 214

Introduction / 214

Continuous Information Coordination / 215

Business-Humanitarian Clashes / 222

Deciding Together / 228

Collective Accountability / 232

Conclusion / 238

CHAPTER TWELVE: Engaging in the Dialogic Culture / 239

- Introduction / 239
- Interprofessional Safety / 241
- Pluralistic Leadership / 248
- Tolerating Personality Differences / 253
- Sense of Community / 257
- Conclusion / 262

CHAPTER THIRTEEN: Overview of the Research Findings / 263

- Introduction / 263
- Pluralistic Dialogue: A Summary of the Grounded Theory / 264
- Pluralistic Dialogue: A Discussion / 266
 - Implications of the Research for Practice / 274
 - Implications of the Research for Education / 277
 - Implications for Further Research / 279
 - Limitations of the Research / 280
 - Personal Reflections on the Research / 280
- Conclusion / 281

CHAPTER FOURTEEN: Discussion / 283

- Introduction / 283
- Leadership in the Pluralistic Era / 283
- Team Agency / 289
- The Responsibility-Based Organisation / 294
- Concluding Statement / 301

REFERENCES / 302**APPENDICES / 329**

- Appendix A - Information Sheet / 329
- Appendix B - Consent Form / 332
- Appendix C - Participant Observation Information Sheet / 333
- Appendix D - Team Consent / 334
- Appendix E - Field Notes for Team Observation / 335

Appendix F - Interview Following Participant Observation /	336
Appendix G - Field Notes for Participant Observation Team A /	338
Appendix H - Excerpts from a Theoretical Memo /	340
Appendix I - Excerpts from Open Coding of Earlier Interviews /	341
Appendix J - Excerpts from Selective Coding /	343
Appendix K - Excerpt from Category Memo /	346
Appendix L - Memo on Category of Cooperation /	349
Appendix M - The Theory of Pluralistic Dialogue /	353

TABLES

1. The grounded theory of pluralistic dialogue / 118
2. The basic social structural process of pluralistic dialogue / 123
3. Deconstruction and resynthesis in pluralistic dialogue - 129
4. The location of breaking stereotypical images within the theory of pluralistic dialogue / 165
5. The properties of breaking stereotypical images / 166
6. The location of grappling with different mind-sets within the theory of pluralistic dialogue / 191
7. The properties of grappling with different mind-sets / 192
8. The location of negotiating service provision within the theory of pluralistic dialogue / 214
9. The properties of negotiating service provision / 215
10. The location of engaging in the dialogic culture within the theory of pluralistic dialogue / 239
11. The properties of engaging in the dialogic culture / 240

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: