GROUNDED THEORY REVIEW
An international journal

Pluralistic Dialoguing:
A theory of interdisciplinary teamworking

Antoinette M. McCallin, Ph.D., RN

November 2004

Grounded Theory Review, Vol 4 (Issue #1), 25-42

The online version of this article can be found at:

https://groundedtheoryreview.org

Originally published by Sociology Press

https://sociologypress.com/

Archived by the Institute for Research and Theory Methodologies

https://www.mentoringresearchers.org/

The Grounded Theory Review (2004) vol. 4, no. 1

Pluralistic dialoguing: A theory of interdisciplinary teamworking

By Antoinette McCallin, Ph.D., M.A. (hons), B.A., RGON

Abstract

The aim of this emerging grounded theory study was to discover the main concerns of health professionals working in interdisciplinary teams, and to explain the processes team members used to continually resolve practice problems. Data collected from forty-four participants from seven disciplines in two teaching hospitals in New Zealand, included eighty hours each of interviewing and participant observation. In this paper the theory of pluralistic dialoguing is presented. It is argued that interdisciplinary work is possible when the team replaces the discipline focus with a client-focused care and thinks differently about service delivery. Thinking cooperatively requires individual team members to dialogue with colleagues, thereby deconstructing traditional ways of thinking and reconstructing new approaches to interdisciplinary practice. Although dialoguing was an informal process occurring within clinical spaces, as the effects of health reform and restructuring intensify teams also need to establish formal dialogue groups to facilitate team practice development and support team learning in the continually changing fast-paced practice context.

Introduction

Over the past decade the interdisciplinary team has received mixed reviews. While the interdisciplinary team is generally seen as a means to change professional practice and foster interprofessional collaboration (Leathard, 2003; Sullivan, 1998) it is also viewed as a means to promote clinical improvement in care and the outcomes of care, thereby improving public health and quality service provision (Lax & Galvin, 2002; Manion, Lorimer & Leander, 1996). As the care needs of clients have changed health care organisations have challenged traditional models of service delivery and endorsed the interdisciplinary team as a new model of practice that will supposedly reduce costs and improve the quality of care (Dodge, 2003). Interdisciplinary teams are usually expected to provide efficient, effective integrated care in restructuring health organisations (De Back, 1999). While team effectiveness is important (Millward & Jeffries, 2001; Schofield & Amodeo, 1999) integrating the disciplines in practice is much more challenging. This suggests that the process of teamworking has received less attention despite the fact that no one discipline

can provide integrated care for clients with multiple needs, which often crosses many disciplinary boundaries (Gillam & Irvine, 2000).

The interdisciplinary team is defined as one in which clinicians from various disciplines such as medicine, nursing, occupational therapy, physiotherapy, and social work cooperate with each other, sharing leadership, assessment, goal setting, problem-solving and decision making so that care is coordinated and client outcomes optimised. While the assumption that clinicians from different disciplines will automatically integrate care effectively is a worthy goal the reality may be somewhat different (Long, 2001; Masterton, 2002) suggesting that interdisciplinary team members may lack understanding of what is involved (O'Connell, 2001). Too often interdisciplinary teamwork seemingly evolves from trial and error learning. Indeed, Long (2001) observes that while there is longstanding general support for interdisciplinary work many variables limit implementation in less-than-ideal environments. Long though urges colleagues to concentrate on the successes.

In this paper one of the successes, some of the findings from an investigation into interdisciplinary teamwork in the acute care hospital are presented (McCallin 1999a, McCallin 1999b). The theory of pluralistic dialoguing is introduced and hopefully offers insights into interdisciplinary teamworking explaining how health professionals from different disciplines support colleagues as they put aside disciplinary differences, thinking through and learning new ways of working cooperatively for the common good of the client. Discussion begins with a brief outline of the research topic, the approach and the findings of the research. Next, the meaning of pluralistic dialoguing is presented and explored as thinking processes involving breaking stereotypical images, grappling with different mind-sets, negotiating service provision and engaging in a dialogical culture. Implications for practice are considered in the discussion and the limitations of the study are evaluated.

Refining the Research Topic

Research began with a general interest in examining nursing practice in the health reform context. Nursing practice was challenged by organisational change and wider social reform on a scale that was unprecedented in the history of health service delivery in New Zealand. However, perusal of the literature suggested that the magnitude of changes was such that reform could not help but affect all health professionals (McCallin, 2001, 2003). Scrutinising one professional group in isolation from others raised questions. 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 for all health professionals. But, what exactly was the research problem?

The topic was eventually refined becoming interprofessional practice. An initial literature review suggested that while there were anecdotal accounts of interprofessional work there was little published research in the area (Bishop & Scudder, 1985; Casto & Julia, 1994; Gabe et al. 1994; Leathard, 1994; Ovretveit, 1993; Petersen, 1994; Soothill et al. 1995). Existing literature emphasised power issues and problematic professional relationships (Ashley, 1976; Daniel, 1990; Davies, 1995; Hugman, 1991; Willis, 1989; Witz, 1992). Although literature heightened sensitivity to interprofessional tensions questions were raised about predetermining problems that possibly supported unsubstantiated myths and assumptions as well.

The Research Approach

Glaser's (1978, 1992, 1996) style of grounded theory was selected for the project because it supported the emergence of problems as identified by the participant group. Grounded theory is based on the belief that, as individuals within groups comprehend events personally, common patterns of behaviour are revealed (Glaser, 1998). As a group interacts together people do in fact make sense of their environment despite apparent chaos (Hutchinson, 1993). While there was a new emphasis on the development of interdisciplinary teamwork there was no research-based knowledge documenting how health professionals worked together in an increasingly complex, changing context. The method was well suited to understanding the social processes inherent in interdisciplinary teamwork in a seemingly chaotic environment.

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 as issues were varied making it difficult to identify a particular problem. The method created a scientifically legitimate space whereby participants could explain their main concern and how they continually resolved that. Concepts did not have to be identified as predetermined variables, but would emerge from participant observation and interview. The goal was to present an "integrated set of hypotheses [that accounted] for much of the behaviour seen in a substantive area" (Glaser, 1998, p. 3).

Therefore, the aim of this research was to discover the main concerns of health professionals working in interdisciplinary teams, and to explain the processes team members used to continually resolve practice problems in a restructuring workplace in New Zealand. In the study the term interdisciplinary referred to people with different training and preparation (e.g. management, medicine, nursing, occupational therapy, physiotherapy, dietetics, and social work) who shared common objectives but made differing, complementary contributions to patient care (Leathard, 1994). Forty-four participants from three teams in two major acute-care teaching hospitals joined the study. In total there were eighty hours of interviewing and eighty hours of participant observation.

The Research Findings

In this research it was clear that health professionals working in interdisciplinary teams were concerned about the client service and meeting service needs. Concerns were resolved using the process of pluralistic dialoguing. This was a means for discussing differences that supported team members who were thinking through and constructing new ways of working together. It emerged as clinicians integrated multiple perspectives, which contributed to the clinical and organisational management of the client service. Pluralistic dialoguing had two complementary phases. These were rethinking professional responsibilities and reframing team responsibilities that reshaped thinking and team learning. Thus health professionals learned to think differently about meeting service needs as they broke stereotypical images and grappled with different mind-sets. Thinking continued to change as team members negotiated service provision and learned how to engage in the dialogic culture (McCallin, 1999a; McCallin 1999b).

The Meaning of Pluralistic Dialoguing

The one variable that recurred constantly in this research was communication. Participants were always talking, talking, talking. Talking is so commonplace that we tend to regard it as a ubiquitous process although it is the means by which people confirm what is happening and why (Hewitt, 1997). In this study, most team members had specialist knowledge, but in order to function cooperatively, they had to pool information, share ideas, consult and network so they could manage service needs. Clinicians talked formally and informally, collectively and casually as they moved around the clinical spaces. Clinicians agreed, disagreed, discussed, debated, explored, explained, liaised, listened, networked, negotiated, questioned, challenged, connected, and communicated. Over and over again team members were observed conversing together, propping up walls, liaising in lifts, chatting in corridors, musing at meal breaks, and discussing disciplinary differences at team meetings or in spontaneous conversations taking place as they worked together. Dialoguing, the basic social process, pervaded practice and was confirmed as the essence of successful interdisciplinary teamworking.

Pluralistic dialoguing was the means for drawing together diversity and difference as professionals from various disciplines learned how to work cooperatively with complex patients in a context where change and complexity prevailed. Discussions supported clinicians coordinating individual actions and interactions so that teamworking was possible. Clearly, pluralistic dialoguing helped clinicians redefine situations as they focused on the client and searched for shared meaning in practice. Dialoguing eased cooperation between disciplinary groups, and was the medium for channelling differences into a new form of interdisciplinary practice.

Dialoguing was possible because many participants in this study were willing to think differently about their professional work as they deconstructed traditional thinking in order to provide client-focused care. Clinicians changed thinking by breaking stereotypical images and grappling with different mind-sets. Thinking differently helped experienced practitioners to respond to restructuring, as they sought new ways of fulfilling functional responsibilities for the organisation. They also made sense of their world by reframing team responsibilities, discussing new approaches and resynthesising thinking while negotiating service provision and engaging in the dialogic culture. In this study, the client was the catalyst for cooperative work that facilitated political and cultural change in increasingly pluralistic organisations.

As health services are modernised hospitals have become pluralistic as widespread interests, conflict, and power influence the organisation (Morgan, 1997). Pluralism is a political concept, which challenges authoritarian control as it emphasises integration across diverse, powerful interest groups. Pluralism is not new in society (Drucker, 1989) yet its introduction into health service management has challenged the historical disciplinary power bases found in hierarchical hospital bureaucracies. Pluralism emphasises function and performance impacting on professional practice in the knowledge based pluralistic organisation (Drucker, 1989). While professional practitioners respect specialised knowledge, skill and expertise, today knowledge must support organisational task and function (Drucker, 1995). Effective function in the team-based organisation is promoted if people work together in small teams, which share a vision, goals, and a meaningful purpose (Zohar, 1997). Yet, this approach requires a radical new way of thinking to understand a world where meaning is paradoxical, uncertain, and complex.

Changing Thinking

The process of pluralistic dialoguing is about changing thinking. Interestingly, the thinking processes revealed in this study, rethinking professional responsibility and reframing team responsibility, mirror the dialogue process described by David Bohm (Bohm & Peat, 1987). Bohm described a dialogue process that encompasses deconstruction and resynthesis. During the deconstructive stage people let go of personal viewpoints that are compared and considered in dialogical conversations (Zohar & Marshall, 1994). All points of view are analysed for meaning and underlying assumptions so that deep understandings surface as insights are revealed (Bohm, 1994). As self-understanding, prejudice, and emotions are uncovered the flow of meaning between people begins.

Dialogue has the potential to affect collective thinking (Nichol, 1994, p. xv). As individuals redefine thoughts in conversation with others, possibilities are explored and interpretation and understanding of the whole changes (Bohm,

1994). In order to dialogue meaningfully with others clinicians had to let the usual ways of thinking go by breaking stereotypical images. Comparisons and analysis proceeded as team members grappled with different mind-sets when they examined alternative worldviews in team learning situations. Frustration lessened once clinicians realised that professional responsibilities could be realised differently if thinking changed. In this sense rethinking was an unlocking process. Clinicians had to identify the routine images first in order to find out exactly what shaped existing agreements before they were free to explore conventional thinking, and consider changing interactions and behaviour. Rethinking did not happen as a neat and tidy process but took place as clinicians discussed options for client-focused care in the changing context.

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 dialogue 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 blended into shared understandings. In this study, differences were diffused when clinicians centred on client-focused care. It was easier to let go of the traditional disciplinary thinking if the patient was the centre of attention when the team negotiated service provision. Likewise, after clinicians accepted that the many different approaches to client-focused care supported improved service delivery, the team was ready to engage in the dialogic culture. Thinking differently was relatively straightforward once clinicians realised that thinking outside of the square was acceptable. The stages of thinking are summarised:

Pluralistic Dialogue – Changing Thinking	
Deconstructing Thinking	**Resynthesising Thinking**
Rethinking Professional Responsibility	**Reframing Team Responsibility**
Breaking Stereotypical Images	*Negotiating Service Provision*
Grappling with Different Mind-Sets	*Engaging in the Dialogic Culture*

Breaking Stereotypical Images

Clinicians broke stereotypical images as clinicians integrated individual responsibilities for meeting service needs with the other disciplines. Thinking differently was challenging. Cultural stereotypes pervade interprofessional interactions in the health professions, and traditionally, these have blocked exploration of disciplinary differences between colleagues. Before thinking could change disciplinary contradictions and tensions had to be exposed.

That word equality is an awkward word really because it brings in all sorts of connotations about the hierarchy of systems and 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.

Part of the deconstruction process was undoing existing images of the world so that the team could think about the client and focus on working together.

> *So much is about chaos. I might have a rule now but suddenly something else has come along and …… we've changed our minds! [Some people] are pedantic black and white thinkers - there is no gray in their 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, staff have taken annual leave and she's sticking to her guns! … 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. Those people are patient focused enough to understand that it is a bit gray 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 a little group has collaborated here ...*

Conversations were critical in pluralistic dialoguing and a means to break down the stereotypical images of reality so teamworking could proceed. Sometimes a team retreated into familiar disciplinary territory.

> *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.*

The impulse to resort to disciplinary defensiveness (Senge, 1990) that undermines cooperative action protects unconscious assumptions and emotions

thereby blocking thinking. Then, the interdisciplinary team struggled to cooperate, as individuals had to change their thinking first if the team was to change.

> *It's about people and how they manage change … they have been exposed to so much change … and it's the face-to-face communication and talking through the issues that is important. If people are threatened they go into siege mentality without really thinking through that there may be a better way to do things.... 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.*

This deconstructive stage of pluralistic dialoguing was an active learning process whereby individuals challenged familiar ways of looking at the world. Freire and Shor (1987) suggest "dialogue seals the act of knowing, which is never individual, even though it has an individual dimension" (p. 4). Pluralistic dialoguing helped team members to suspend differences until they were ready to examine situations openly, honestly and talk with colleagues.

Grappling with Different Mind-Sets

In this study grappling with different mind-sets referred to the way an individual questioned familiar patterns of thinking that were out-of-step with either colleagues of the changing organisation. It was founded on a commitment to understand. Conversations were a means not only to learn, but to discuss problems and ideas.

> *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.*

Conversation was critical to understand the whole as too often fragmented thinking has unexpected consequences if individuals think and act individually (Bohm, 1994). Some participants spoke of the disciplinary socialisation that tended to emphasise disciplinary differences. Once this was put aside, dialogue followed.

> *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.*

The struggle to explore conflicting views was seemingly impossible for some though. Bohm (1994) observes that when automatic thinking is well entrenched, thought is fixed, static, rooted in the past. Sometimes an individual had such different values and beliefs that any sort of teamworking was simply impossible.

> *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 ... 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.*

Compromise was fraught with tension if a collective purpose was lacking. Those who struggled to think differently insisted on defending their thoroughly entrenched thought processes despite the changing context.

> *There are always some that won't see themselves as changing, or growing.... 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.*

While experienced clinicians were used to working through differences to improve client care there were others who had strong disciplinary allegiances, who did not appreciate that traditional adversarial interactions threatened interdisciplinary teamworking. Changing thinking was easier when the team had a common goal.

> *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.*

Compromise though was not necessarily healthy as it implied powerful interactions clarifying winners and losers that thwarted the cooperative spirit (Zohar, 1997).

Negotiating Service Provision

Nonetheless, new understandings and meanings emerged as clinicians negotiated service provision, integrating individual contributions with the common purpose and the activities of the wider organisation. Negotiation of interests was consistent with Bohm's (1996) idea that resynthesis as a continual movement, backwards and forwards between people, that draws out shared ideas. 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, i.e., creating something new together" (p. 2). When every discipline focused on the client pluralistic dialoguing was dynamic.

> *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.*

Much of the negotiation in pluralistic dialoguing centred on problem solving for clients. Although Bohm (1996) questions whether dialogue is possible in bureaucratic organisations where superior-subordinate relationships prevail, clinicians questioned contradictions and confusions, seeking what Bohm (1994)

calls some coherence in an incoherent whole. In this sense negotiation was 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.*

Talking through patient-focused care was more than persuading others to change thinking. Dialogue was important to support collective thinking. As clinicians understood each other better, collective thought became more coherent. Bohm (1996) argues that when the thinking process is shared, communication becomes explicit, as "we have to share our consciousness and to be able to think together, in order to do intelligently whatever is necessary" (p. 15). Free, open discussion involving everyone was important to work through different points of view and find a place for team agreement.

> *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.*

Engaging in the Dialogic Culture

In this study clinicians engaged in the dialogic culture when they shared ideas freely and frankly, while they consulted over the most effective means of fulfilling functional responsibility for meeting client needs. Both-and thinking underpinned dialogue and reflected the clinician's ability to think simultaneously in parts and re-look at the whole, that was always much greater than the sum of the parts. 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 emerged, anything was 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.*

The team culture changed gradually as clinical experts looked beyond the familiar disciplinary boundaries to engage in a new approach to interdisciplinary practice. It was easier to change thinking when team members listened carefully to colleagues.

> *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 not going to fall apart if someone says something out of place.*

Acceptance of diversity created a climate whereby team members talked together as they sought a common understanding that was client focused. Dialogue certainly challenged traditional cultural patterns of domination (Freire & Shor, 1987). If thinking was to change openness and honesty were essential.

> *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 lacks honesty.... If we were being facilitative we could be open and talk honestly ... it's all about developing a culture. When new people come in, can they actually fit in with what's there?*

Sharing ideas, opinions, and thoughts frankly was very much a part of everyday teamworking. Building a team and engaging in the dialogic culture was an ongoing, dynamic activity.

> *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.*

Engaging in interdisciplinary teamworking also involved a genuine desire to understand and work cooperatively with colleagues. In this study, the team person who accepted individual responsibility for the collective team outcome was highly valued.

> *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.*

Thus pluralistic dialoguing was fundamental to the culture of care that is based on shared meanings. It supported 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 were the essence of pluralistic dialoguing.

Discussion

Pluralistic dialoguing did not evolve in a purist, theoretical sense. Dialogue was self-activated by highly motivated practitioners who were committed learners. The dialogue process was self-generated because individuals invested in the team and accepted an individual-collective responsibility for cooperative practice. While pluralistic dialoguing was well developed in the smaller teams studied 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 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. Although Bohm (1994) believes that dialogue works best in a dialogic seminar of thirty to forty people representing a microcosm of society, in this study the dialogical groups were teams working in a changing context. The dialogical culture was the everyday reality; it was a constantly moving construction that was not fixed in time and space.

The basic social process of pluralistic dialoguing is possibly tenuous and dependent on particular personalities in a certain context, because it emerged in practice and not from a forum separate from the usual activities of practical life. Clinicians had to dialogue in action because it was well nigh impossible to release complete teams from specialist acute-care areas for weekends of dialogical seminars. However, clinicians learned quickly how to share meaning as they worked closely together discovering common problems, which had no easy answers. Close connections in adversity foster fellowship and cooperation (Bohm, 1994). Professional and team responsibilities were explored in action. There was no other way in the acute care environment.

The focus on dialogue in action suggests that conversations may have concentrated on tasks at the expense of process-based teamworking issues, which are just as important. While organisations value efficiency and effectiveness if more than lip service is to be paid to the interdisciplinary team as a means to improve quality service provision, the organisation must also recognise that interdisciplinary teams may be changing professional culture and require learning support if team practice development is to progress. Health reform encompasses cultural change so health professionals need time, coaching and mentoring, to work through changing values, beliefs, and attitudes, as they assimilate new ways of thinking into new approaches to practice.

Limitations

While it is recognised that theoretical coding needs strengthening the main limitation of this research concerns theoretical sampling. Data was gathered from hospital teams and although the original research design included study of community teams, as well as clients and families who were the recipients of

care, the latter two groups were not interviewed or observed due to time constraints associated with doctoral research. Further research to evaluate differences, if any, working in teams in the hospital or community and more importantly, to talk to the often unrecognised team members, the lay members (clients and their caregivers) who also shape interdisciplinary teamworking is necessary.

Conclusion

In this paper it has been argued that, pluralistic dialoguing is unique in that it is a form of dialogue in action, which is created by clinicians challenged with health restructuring in acute care hospitals. Dialogue is a fluid, evolutionary process that is time-dependent and affected by constant change. Involvement in pluralistic dialoguing 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 integrated it into a cooperative practice that benefited clients, colleagues, and the organisation. Pluralistic dialoguing facilitated interdisciplinary teamworking.

Author
Antoinette McCallin PhD, MA (Hons), BA, RGON
Senior Lecturer
Division of Health Care Practice
Faculty of Health
Auckland University of Technology
Private Bag 92006
Auckland, NEW ZEALAND

Correspondence
Phone: 64 09 480 7667
E-mail: mccallin@ihug.co.nz (Home)
amccalli@aut.ac.nz (Work)

References

Ashley, J. A. (1976). *Hospitals, paternalism, and the role of the nurse*. New York: Teachers College Press.

Bishop, A. H., & Scudder, J. R. (Eds.). (1985). *Caring, curing, coping: Nurse, physician, patient relationships.* Alabama, AL: University of Alabama Press.

Bohm, D. (1994). *Thought as a system*. London: Routledge.

Bohm, D. (1996). *On dialogue*. London: Routledge.

Bohm, D., & Peat, F. D. (1987). *Science, order and creativity*. New York: Bantam.

Casto, R. M., & Julia, M. C. (1994). *Interprofessional care and collaborative practice: Commission on interprofessional education and practice*. Pacific Grove, CA: Brooks/Cole.

Daniel, A. (1990). Medicine and the state: Professional autonomy and public accountability. Sydney, Australia: Allen & Unwin.

Davies, C. (1995). *Gender and the professional predicament in nursing*. Buckingham, UK: Open University Press.

De Back, V. (1999). Interdisciplinary, collaborative team practice in managed care: The provider perspective. In E. L. Cohen & V. De Back (Eds.), *The outcomes mandate: Case management in health care today* (pp. 207-214). St Louis, MO: Mosby.

Dodge, C. (2000). Health care without borders: The interdisciplinary approach. *Geriatric Times*, 1(1). Retrieved 20/04/03 http://www.geriatrictimes.com/g000604html.

Drucker, P. F. (1989). *The new realities*. New York: Harper-Collins.

Drucker, P. F. (1995). *Managing in a time of great change*. New York: Truman Talley Books/Dutton.

Freire, P., & Shor, I. (1987). *A pedagogy for liberation: Dialogues on transforming education.* London: Macmillan.

Gabe, J., Kelleher, D., & Williams, G. (Eds.). (1994). *Challenging medicine*. London: Routledge.

Gillam, S. & Irvine, S. (2000). Collaboration: in the NHS. *Journal of Interprofessional Care*, 46(1), 5-7.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* Mill Valley, CA: Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis: Emergence versus forcing.* Mill Valley, CA: Sociology Press.

Glaser, B. G. (1996). *Origins of grounded theory*. Edited transcript of proceedings of a grounded theory workshop conducted by Dr Barney Glaser in Christchurch, New Zealand.

Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.

Hewitt, J. P. (1997). *Self and society: A symbolic interactionist social psychology* (7th ed.). Toronto, Canada: Allyn & Bacon.

Hugman, R. (1991). *Power in caring professions*. London: Macmillan.

Hutchinson, S. A. (1993). Grounded theory: The method. In P. L. Munhall & C. O. Boyd (Eds.), *Nursing research: A qualitative perspective* (2nd. ed., pp. 180-212). New York: National League for Nursing Press.

Lax W. & Galvin K. (2002). Reflections on a community action research project: Interprofessional issues and methodological problems. *Journal of Clinical Nursing* 11(3), 376-386.

Leathard, A. (Ed.). (1994). Going interprofessional: *Working together for health and welfare.* London: Routledge.

Leathard, A. (Ed.). (2003). *Interprofessional collaboration: From policy to practice in health and social care*. Hove, UK: Brunner-Routledge.

Long, K. A. (2001). A reality-oriented approach to interdisciplinary work. *Journal of Professional Nursing*, 17(6), 278-82.

Manion, J, Lorimer, W., & Leander W. J. (1996). *Team-based health care organisations: Blueprint for success.* Aspen, Gaithersburg, MA.

Masterton, A. (2002). Cross-boundary working: a macro-political analysis of the impact on professional roles. *Journal of Clinical Nursing*, 11, 331-339.

McCallin AM (1999a). *Pluralistic dialogue: A grounded theory of interdisciplinary practice*. Unpublished doctoral dissertation, Massey University, Palmerston North, New Zealand.

McCallin AM (1999b). Pluralistic dialogue: A grounded theory of interdisciplinary practice. *The Australian Journal of Rehabilitation Counselling*, 5(2), 78-85.

McCallin AM (2001). Interdisciplinary practice—a matter of teamwork: An integrated literature review. *Journal of Clinical Nursing*, 10(4), 419-428.

McCallin, A. M. (2003). Grappling with the literature in a grounded theory study. *Contemporary Nurse*, 15(1-2), 61-69.

Millward, L. J. & Jeffries, N. (2001). The team survey: A tool for health care team development. *Journal of Advanced Nursing*, 35(2), 276-287.

Morgan, G. (1997). *Images of organisation* (2nd ed.). Thousand Oaks, CA: Sage.

Nichol, L. (1994). Forward. In D. Bohm, *Thought as a system* (pp. ix-xv). London: Routledge.

O'Connell K.A. (2001). Research: Barriers to interdisciplinary research. *Journal of Professional Nursing,* 17(4), 153-154.

Ovretveit, J. (1993). *Coordinating community care: Multidisciplinary teams and care management*. Buckingham, UK: Open University Press.

Petersen, A. R. (1994). *In a critical condition: Health and power relations in Australia*. Sydney, Australia: Allen & Unwin.

Schofield, R. F. & Amodeo, M. (1999). Interdisciplinary teams in health care and human services settings: Are they effective? *Health and Social Work*, 24(3), 210-219.

Senge, P. M. (1990). *The fifth discipline: The art and practice of the learning organisation*. Sydney, Australia: Random House.

Soothill, K., Mackay, L., & Webb, C. (Eds.). (1995). *Interprofessional relations in health care*. London: Edward Arnold.

Sullivan, T. J. (1998). *Collaboration: A health care imperative*. New York: McGraw-Hill.

Willis, E. (1989). *Medical dominance: The division of labour in Australian health care*. (Rev. ed.). Sydney, Australia: Allen & Unwin.

Witz, A. (1992). *Professions and patriarchy*. London: Routledge.

Zohar, D. (1997). *Rewiring the corporate brain: Using new science to rethink how we structure and lead organisations*. San Francisco: Berret-Koehler.

Zohar, D., & Marshall, I. (1994). *The quantum society: Mind, physics, and a new social vision*. New York: William Morrow.