Complexity and the Practices of Communities in Healthcare: Implications for an Internal Practice Consultant

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ABSTRACT

Current literature regarding quality health services frequently identifies interprofessional collaboration (IPC) as essential to patient-centred care, sustainable health systems, and a productive workforce. The IPC literature tends to focus on interprofessionalism and collaboration and pays little attention to the concept of practice, which is thought to be a represented world of objects and processes that have pre-given characteristics practitioners can know cognitively and apply or manage correctly. Many strategies intended to support IPC simplify and codify the complex, contested, and unpredictable day-to-day interactions among interdependent agents that I argue constitute the practices of a community. These strategies are based in systems thinking, which understand the system as distinct from experience and subject to rational, linear logic. In this thinking, a leader can step outside of the system to develop an ideal plan, which is then implemented to unfold the predetermined ideal future. However, changes in health services and healthcare practices are often difficult to enact and sustain.

This thesis problematises the concept of 'practice', and claims practices as thoroughly social and emergent phenomenon constituted by interdependent and iterative processes of representation (policies and practice guidelines), signification (sense making through negotiation and reflective and reflexive practices), and improvisation (acting into the circumstances that present at the point and in the moments of care). I argue that local and population-wide patterns are negotiated and iteratively co-expressed through relations of power, values, and identity. Moreover, practice (including the practice of leadership or consulting) is inherently concerned with ethics, which I also formulate as both normative and social/relational in nature. I argue that theory and practice are not separate but paradoxical phenomena that remain in generative tension, which in healthcare is often felt as tension between what we should do (best practice) and what we actually do (best possible practice in the contingent circumstances we find ourselves in). I articulate the implications this has for how knowledge and knowing are understood, how organisations change, and how the role of an internal practice consultant is understood. An important implication is that practice-based evidence and evidence-based practice are iterative and co-expressed (not sequential), and while practice is primordial, it is not privileged over theory. I propose that a practice consultant could usefully become a temporary

participant in the practices of a particular community. Through a position of ‘involved detachment’, a consultant can more easily notice and articulate the practices of a community that for participants are most often implicit and taken for granted. Reflective and reflexive consideration of what is taken for granted may change conversations and thus be transformative.

Keywords: Practice, Complexity, Theory/Practice, Interprofessional Collaboration, Practice Consultant, Healthcare.

DEDICATION

I dedicate this thesis to the memory of my parents, to whom I owe so much:
James Walter Briggs (1916 – 1998) and Agnes Christine Briggs (1915 – 2005).

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INTRODUCTION

Over more than 40 years as a clinician, administrator, researcher, and consultant in healthcare, I have advocated for collaboration between members of the health disciplines. Over the last 20 years, the health policy, human resource, and patient safety literature has pointed more intensely to the need for interprofessional collaborative practice (IPC). Despite this widespread interest in and commitment to the principles and practices espoused in the IPC literature, its enactment in practice settings has been slow to emerge. This has given rise to efforts to promote interprofessional education and collaborative practice through defining what is meant by 'interprofessional' and 'collaboration', articulating the competencies required for interprofessionalism and collaboration, and by identifying processes through which teams can: develop shared goals and values and enhance skills in interprofessional communication and conflict resolution, commit to shared leadership, and work together in ways that support learning about and appreciating one another's roles (Canadian Interprofessional Health Collaborative, 2010).

Thinking about organisation and change in the dominant discourse is grounded in systems thinking (Senge, 1990/2006), which assumes a system exists apart from ordinary interactions between people as they work together. It is thought that a leader/consultant can stand outside the system to observe and analyse it, determine 'best practice', and develop a plan that can be rolled out to increase the correspondence between the predetermined ideal and what is actually happening in practice. For some time, I accepted this view unreflexively. However, I grew increasingly sceptical that this was a useful way of thinking about organisation or change. If, as systems thinking claims, leaders can isolate, disarticulate, improve, then rearticulate and unproblematically 'roll out' an improved system that will achieve the desired state, how is it that these well-designed systems remain imperfect when they are implemented?

Through a chance encounter with the work of the Complexity Research Group (CRG) at the University of Hertfordshire (Griffin, 2002; Shaw, 2002; Stacey, Griffin, and Shaw, 2000; Stacey, 2005; 2007; Stacey and Griffin, 2005), I encountered another view—something quite different. These scholars claimed that organisations are not systems, but "*on-going iterative processes of cooperative and competitive relating between people* [and that these] *... patterns of human interaction simply*

*produce further interactions not some **thing** outside of the interaction"* (Stacey, 2005: 1, original emphasis). They argue there is no detached way of understanding, engaging with, or changing organisations, and no single right way of working together that can be predetermined and rolled out organisation wide and achieve the predicted benefit. The emphasis in the body of work they call complex responsive processes of relating is on understanding the social processes of how people work together and how change emerges in both predictable and unpredictable ways, whether or not there is a blueprint to guide action (Stacey, 2007).

My initial research question was, "How can I, as an internal practice consultant, support the emergence of IPC?" The question held assumptions that some practices are not interprofessional and collaborative and that, as a style of practice, IPC can be objectively represented and 'rolled out'. That implied rational or linear if/then causality, in which an expert/consultant, who is distant from the sites of practices, plans means and ends in advance. Also implied was a particular view of knowledge as a possession acquired and stored in the head of an expert who transfers it to others, who then apply it in another context. Finally, the question continued to hold theory and practice as distinct and separate, and privileged theory. Through this work, all of these assumptions became problematic for me.

This thesis is an account of the research process I engaged in for the University of Hertfordshire's Doctor of Management research program, through which I sought to make sense of and explain my own practice-based experience, not to discover ultimate truths or universal law. The animating questions for this work shifted from promoting *a* style of practice (i.e., IPC) to understanding practice from my own experience as an internal practice consultant, and from how a consultant could support the emergence of IPC to understanding how I engaged with others as I worked.

The research method is qualitative and takes an interpretivist stance grounded in pragmatist philosophy, which Weiss described as *"a method, not a creed; an attitude, not a conclusion"* (1942: 185), and the specific discourse of complex responsive processes of relating. The research is presented in four Projects and a Synopsis in which I present and reflexively consider my own practice-based experience. In Project 1 I reflect on my own development as a leader and consultant and explore how my thinking changed over more than 40 years in practice. In that project, I present experiences in which I had encountered conflict. Two related

questions began to form for me. First, my actions in the face of conflict revealed a particular way of thinking about leadership, notably that the leader/consultant is an expert—a wise and charismatic hero. This stance felt incongruous with my emerging doubt about systems thinking and the ability of anyone to predetermine how people and organisations change, but if a leader/consultant is not an expert, then what are the practices of a consultant? Second, I saw that how I had been thinking about IPC was also based in systems logic—IPC was a "thing" outside the day-to-day interactions among interdependent people that could be described and implemented. That way of thinking failed to account for the temporal, embodied experiences of everyday practices. Practice seemed conceptually taken for granted, and understanding practices became the related animating question of this work. In Projects 2 through 4, I explore these questions reflexively through narratives of my current work experience as a Practice Consultant for Interprofessional Practice, Education in a large Canadian health service organisation.

Three broad themes that emerged from the work are articulated in the Synopsis, which takes a final reflexive turn through all four Projects. In Theme 1 I explore a movement of my thought from IPC as one style of practice, to practice as a social phenomenon that is inevitably interprofessional and collaborative. Theme 1 also develops a plural articulation of *practices* to acknowledge the inherent complexity of this social phenomenon. Mainstream literature often attempts to find or define practices in homogeneous forms represented, for example, as policy or evidence-based practice statements. This acknowledges similarities but covers over differences in the practices of multiple particular communities, even if they are engaged in caring for similar patient groups. Thus, Theme 2 articulates the movement of my thought from practices as generalisable in any setting to practices as discursive interactions unique to particular communities. Theme 3 articulates the movement of my thinking about the role of a practice consultant. Moving from the view of a consultant as an expert who defines what the practices of a particular community 'should' be, I suggest that the role of a practice consultant includes becoming a temporary member of a particular practice community and (following Elias, 1987) taking a stance of involved detachment so that the practices of a community can be articulated, and in the process, potentially transformed.

Throughout all three Themes, I place key emphasis on theory and practice as iteratively co-pressed aspects of a single phenomenon. I further argue that practices

involve generative tension between processes of representation (guidelines, policies, and epistemic evidence), sense making (reflective and reflexive practices), and improvisation (as complex responsive processes of relating). I have not abandoned IPC in the process of completing this research program, but find it conceptually limited in understanding the practices of particular communities that constitute the conditions of intelligibility for people as they work together. Nor is IPC conceptually helpful to the complex and on-going processes of sense making and improvisation through which organisation and change occur. Traditional descriptions and representations are insufficient alone to explore or explain the richly nuanced social phenomena that constitute the continuously iterated, embodied, and temporal practices of a particular community.

The reader will see these shifts in my thinking in the pages to follow and may experience in the writing my own resistance to being changed by this process of research. The journey from leader/consultant as an expert and charismatic hero to engaged participant in processes of sense making and from change as a planned event to change as a predictably unpredictable emergent phenomenon has been exhilarating, shaming, exciting, and daunting—all of which is evident in the Projects and Synopsis. I have been most influenced by having taken practice very seriously and understanding it as a highly complex sociomaterial phenomenon enacted through complex responsive processes of relating. This has opened new ways of thinking about and working within the practices of particular communities as an internal practice consultant.

PROJECT 1: TOWARD THE UNKNOWN

Introduction

I will soon be engaged as an internal consultant for interprofessional practice, education, and research. As I move into that role, I want to make sense through the Doctor of Management program of how members of the teams I will work with and I understand what we are doing together and what is transpiring as we work. The role of internal practice consultant (PC) will be new to me and also to the organisation. There is bound to be uncertainty about what this consultancy will look like, what I will actually do, and what it means to engage and negotiate with new or existing teams. I anticipate that I, as well as others including the Vice-President who established this position, will want to resolve this uncertainty. My own and others' expectations will likely be articulated in terms of the dominant discourse in hospital management, such as gaining improvement in quality of staff work life, clinical outcomes, and financial performance. In addition, there will be expectations—some explicit, some tacit—about the competencies an internal PC will bring to the teams I will work with and about what we do to ensure new (better) patterns of practice emerge. On the other hand, I have a sense that to work with, rather than resolve uncertainty offers an opportunity to explore a new way of thinking and working together. A significant part of our shared journey will include consideration of how collaborative team practice can be understood and negotiated in the context of the emerging power relations and inevitable conflict that we will all find ourselves in and that has been underrepresented in the literature about team-based practice. In this project, I will examine aspects of my own experience, past and current, to articulate how my thinking has evolved to date. This is the first of four projects in which I will explore how people working in teams negotiate their daily work together and how an internal consultant can be a partner in the emergence of novel team practice models in healthcare.

In various circumstances of my work and personal life, I have experienced interactions with others in which an unexpected intensity in my actions or reactions surprised me as well as others. In this project I will examine experiences in which I have been surprised by the intensity or character of my responses and try to make sense of these unexpected reactions. My choice to reflect on situations that have been surprising arises from my sense that it is in the unexpected that I am most likely to

recognise how taken-for-granted assumptions influence what I include and what I exclude from my thoughts, words, and actions (Townley, 1994: 2) and thereby increase the possibility for new insights to emerge. I have observed similarly intense and unexpected reactions among other healthcare team members as they negotiate their day-to-day interactions together. In this project I will make sense of my own experience and consider how this might be helpful to understanding similar responses in healthcare personnel who sometimes find it challenging to work collaboratively or become impatient when hoped-for change does not happen.

The narrative that follows briefly describes a situation in which staff members expressed concerns about their ability to be taken seriously and to influence their work. I will start the interpretation of what may be happening in this narrative by considering similar experiences in my own life that helped to form my own sense of the world and my place in it, and link my experience with literature that was informing my reactions at the time. I will then return to the narrative to understand more about what may be underlying the dynamics these staff members described. Finally, complex responsive process theory will be introduced. To date, this theory has not received wide attention in the mainstream literature related to healthcare teams or healthcare leadership. Complex responsive process theory offers radically new ways of thinking about the process of organisational development, including the development of team-based practices and may add significantly to understanding how relationships in healthcare team practice and consultancy can be considered.

Narrative

At the time of this writing, I am the Site and Operations Leader in two facilities. One is a 150-bed complex care facility that provides residential care for older adults no longer able to care for themselves independently and is the location in which the narrative occurs. Most of the personal care for residents in both facilities is provided by residential care aides (RCAs), many of whom are immigrant workers from the Philippines or India. These workers have a seven-month training program and work under the direction of a small number of registered nurses, most of whom are Filipina.

Recently, a contingent of RCAs came to my office. They expressed quite passionately a concern that decisions (for example, assignment of overtime shifts) and

behaviours (for example being ‘singled out’ and ‘picked on’ if mistakes were made) often felt unfair to them and they attributed this, at least in part, to racial discrimination. They also felt that as an occupational group (i.e., as RCAs) their concerns and suggestions about the condition or care of our residents were not always listened to or taken seriously by the nursing staff, despite the fact that they provide the bulk of the personal care. It was even more difficult to have their opinions taken seriously if they were casual rather than ‘regular’ staff, whether they were trying to get the attention of nurses or even other RCAs. Referring to the term ‘regular’ staff, one person (who was part of the casual staff pool) said, “I hate that word—it makes me feel unimportant—like I don’t have a right to an opinion. Sometimes I see things that ‘regular’ staff don’t because they are there all the time”. Several weeks after this meeting, an incident occurred in which a nurse provided instruction to an RCA that she felt were appropriate and respectfully delivered, but which the RCA took exceptional offense to since he perceived they were unnecessary and demeaning. He reacted with a surprising level of anger and was physically aggressive, cornering the nurse in the break room and shouting while pounding his fist on the table.

The latter incident was addressed immediately, but in thinking about how to respond to the more general call for action contained in all the reported incidents, I felt an authoritarian approach was not appropriate. It seemed the issues were more complicated than simply being discriminatory, but even if discrimination did factor into some decisions and behaviours, I felt I could not simply say that discrimination was not allowed or that it was incongruent with the organisation’s mission or values (although that was true). I could not simply insist that everyone listen to and respect one another and always make fair decisions. Staff who had raised these concerns seemed to think I should and could ‘do something’ and that somehow I should make people act differently.

To start somewhere (to do something), I initiated the “Lift EVERY Voice” campaign, the intent of which was to help staff to understand different patterns of communication (assertive, aggressive, and passive, for example) and increase the confidence with which individuals could select strategies to address concerns directly. My goal was to support conversation and build the capacity and willingness of individuals to negotiate solutions to interpersonal conflict directly with each other. This approach was grounded in a belief that is common in the dominant conflict resolution discourse (see, for example, Doherty and Guyler, 2008), and while conflict

may be ‘normal’, it can still be addressed, if not resolved, through effective communication. Nevertheless, I also understood that there were complex issues well beyond communication that weave through what we were struggling with. Communication seemed like a starting point that people would hopefully feel was at least building their understanding of and skill in negotiating their daily work, and it was a comfortable starting point for me. It was not clear to me how to identify and take into account the more complex themes that contributed to the issues staff had raised. The tangled threads of this situation seemed to include issues related to values, ethics and ethical action, and identity, and to a sense that some people were included and others excluded based on ethnicity or position. To begin to untangle those threads, I will first explore the development of my own sense of values and ethics and explore the idea of inclusion and exclusion. How power is understood and experienced is an important part of this situation and will be explored throughout rather than as a separate topic.

Thinking about Action: Values and Ethical Action

“Drawing Myself Up”

One of my earliest memories of consciously associating values with evoked ethical behaviour was when I was in the third grade and came to the defence of a girl at school. Dianna was shy and difficult to befriend, and she was often taunted by the school bullies who, among other things, declared that she had fleas. She kept to herself by choice and also because the bullies isolated her. Most days she could be found before school or at recess sitting alone in a far corner of the school yard. I felt badly for her and wanted to find ways to include her, but I was also afraid that if I did I might become the next target of the bully’s taunts. I was overweight, and my hair and skin tone were darker than many of my young schoolmates. There had already been murmured insults about both, and I was aware that if I befriended Dianna I risked being ridiculed in full voice. My ‘action’ was initially internal—I thought about and felt troubled by the injustice of what was happening to Dianna, but did nothing. Then one day, I heard them taunting Dianna again, but this time, someone actually threw something at her. My ambivalence vanished and I became instantly—and very righteously—angry. The possible threats to me no longer blocked overt action. I marched firmly toward Dianna calling back to anyone who would listen

something like, “She doesn’t have fleas. Don’t be so mean. Go away!” Dianna was frightened by my approach and scowled furiously, waving me away, *but I could not be turned back.*

There have been other circumstances in my life in which similar patterns of linking values and ethics to action occurred. The pattern seems to be one in which there is initially a weak link between strongly held values and the ethical action that holding such values would tend to call forth. Then something else happens—big or small—that takes me by surprise and unexpectedly creates a strong link between values and action, and action (or perhaps reaction), rather than thought, becomes the predominating response. I want to briefly recount one further example early in my career before making sense of how values and ethical action can inform each other.

> I selected a specialty in my clinical career (Cardiopulmonary) as a physical therapist (PT) that was not popular among PTs—many would have been just as happy to relinquish the PT role in managing cardiopulmonary disorders to any other discipline. This troubled me, as I felt it denigrated an important professional role and indicated a clear misunderstanding by most PTs about the value of the role of this specialty on its own and in all domains of PT practice. I probably also felt that, in some way, this dismissive and almost hostile attitude toward the specialty that I had chosen implied a similar attitude toward me; I do not recall being conscious of this possibility, so at the time I failed to see how what was ‘public’ and political was also at the same time, very personal. Through the unfortunate circumstances of a very ill young woman, an opportunity arose that I perceived could be pivotal in demonstrating the value of this practice. When the PTs did not step eagerly toward this opportunity, and in fact actively resisted getting involved, I was surprised and felt dismissed. I reacted with sudden and strong feelings of shame and anger towards my colleagues, who I perceived were acting with little or no integrity their profession or compassion for this patient, their profession, or their colleagues. Confronted with this unexpected violation of values that were important to me (integrity, compassion) and I assumed would also be important to others, I “marched resolutely toward the corner of the schoolyard” to come to the defence of this metaphorical Dianna sitting by herself accused of having fleas. My own behaviour (raising my voice, using highly accusatory language, slamming books and papers on the table, storming

in and out of meetings, and hitting a wall with my fist hard enough to damage both) was also shameful because it was violent, unfairly denigrated others, and could only move us further away from, not closer to understanding. When I was not held accountable for this behaviour, I felt even more dismissed.

Understanding Patterns of Ethical Action

In making sense of this pattern of acting, I see that the pattern includes holding strong values that lead to overt ethical action if the challenge to these values is great enough. I also see that while I identify some elements of the involvement of other people and the inherently conflictual nature of what was happening, I also present a lone heroine who attempts in the first instance to rescue a young girl and in the second a profession. I react in these stories to, not necessarily with, others. In the first case I resolutely ignore Dianna's discomfort of my heroic action (*"... I could not be turned back"*), and in the second, I felt no compassion for my colleagues, who also experienced their own discomfort in the situation. Other players in these stories are necessary for the drama to evolve, but in each I am ultimately convinced that I can 'draw myself up' and become a powerful being, who through compelling words and/or action can change the world to reflect my own ideal, which I fully take to be the right and rational choice. There is no recognition of how I co-created either of these situations, only that I alone could change them. In moving suddenly from private thought to very public and highly political action, I clearly believed that if I acted decisively and with great authority, things would change, and while indeed they might, it would likely not be because people had changed, but because the might of my anger and self-righteousness won the action. Staff members who presented me with opportunities for decisive action in the narrative also seem to believe, or at least want to believe, that I can and should come to their rescue. This illustrates how the various actors collude in the fantasy of the heroic rescue.[1]

[1] Several authors discuss collusion as a significant power dynamic. See for example Block (1993: 38-40); Pierce et al. (1995: 54-58); Gramsci (1971: 12-13). Gramsci specifically distinguishes between social hegemony, closer to collusive control, and domination, rather than command exercised unilaterally by the state or judiciary. (The point is that healthcare is particularly subject to the hegemony of medical and administrative hierarchy—that is, a power that tends to be taken-for-granted by all, rather than unilateral domination imposed on aware and unwilling 'subjects'.)

The Magico-Mythical Hero

These stories reflect a magico-mythical way of thinking that situates power in a role (hero or leader) or in a person (me). The relational contexts of the situations escaped serious notice. By this, I mean to draw attention to two things. First, such thinking necessarily understands individuals as discreet, autonomous entities who can unilaterally cause other discreet individuals to act, and even to believe, differently. Gergen referred to these separate and distinct wholes as *"bounded beings"* (2009b: xiv) and suggested that when we see ourselves first as individuals (as if a primary and natural state) and only then in relationship (as if a secondary and artificial state), we necessarily see relationship as instrumental—that is, as a means to another (personal) end. We assume then that others will interact with similar self-interest and we become suspicious of others' motive and intent (Gergen, 2009b: 51). I saw the self-interest of others (the bullies to gain power through fear; the PTs to not work extended hours or sacrifice their own less worthy interests to my more noble ones) as a direct threat to what I believed was right and just. I was the mythic hero poised to 'pull myself up' to the right size to save Dianna and a professional specialty from certain destruction. Second, by identifying those bounded beings as either antagonists or protagonists, I created the condition for combative discord and missed the possibility that protagonist and antagonist qualities co-occur in and between all. I also missed the possibility for collaborating with others to find solution together that none of us could find alone—or indeed to not find a solution at all—and instead continued to negotiate within the conflict. The hero must be right and only needs power to enforce her solution.

Interpreting the work of sociologist Elias, Mennell (1989/1992: 162) pointed out that the line between fantasy and reality is often quite thin for children and they may not realise that what can happen in, for example, dreams or on a television cartoon, may not be able to happen in reality. Until a child can make stronger distinctions between fantasy and reality, it is very easy to believe not only in the possibility of superheroes, but to also believe that s/he could actually be a superhero. Vestiges of this childhood confusion appear to remain into our adult years. It might not have been their expectation, but I felt that staff in the nursing home wanted me to 'fix' the situation they found themselves in and create a happily-ever-after ending. While it is seductive to believe I have extraordinary powers over others' actions and beliefs, such is not case.

In the situations I have described, I held idealised and uncompromising values that involved expectations of the behaviour of others and ideas about what is good and bad (e.g., no one should be bullied and all PTs should respect and embrace cardiopulmonary practice). Luhmann (1995) is an emeritus professor of Sociology at the University of Bielefeld whose work has focused on society as a self-producing system of communication. He pointed out that having expectations such as those I describe made me highly susceptible to disappointment. Luhmann suggested that when we face the disappointment, our sense of security and stability is challenged (1995: 332) and that we need, and therefore develop, a cognitive framework to explain the disappointment and re-establish the security of our expectations. One strategy is to decide that even though the change we desire is important, there is not yet *"sufficient occasion for it"* (1995: 333). My failure to convince others of my ideal would thus be explained not because the ideal was faulty, but because the occasion was not yet right. This contributed to a continued search for more convincing ways to present my idealisations, while waiting for the 'right time'.

More recently, I was challenged by a staff member involved in the narrative who felt that not enough was being done to resolve the issues that the RCAs had raised to my attention. My response was overtly sympathetic but covertly defensive. I pointed to the "Lift EVERY Voice" campaign as proof of action and indicated that this preliminary work in building everyone's ability to communicate effectively—especially around such difficult issues—was important. I implied that more direct action could only be considered once this was in place. Furthermore, I implied that if this staff member attended the sessions and put these new skills into action, he could be a vital part of the solution he was seeking. I reassured the staff member that I understood the problem and how urgent it felt, and that I took it very seriously. In truth, I remained unclear about how to approach the situation.

Drawing on Elias, Stacey suggested that mainstream organisational and management literature promotes this type of magico-mythical thinking and says,

> *I have come to the view that most of the explanations of, and prescriptions for, acting in organizations amount to a massive construction of a fantasy world so that we can preserve the illusion that someone is in control.* (2005: 5)

In 'drawing myself up' to become powerful, I clearly had a sense of power in space—that is an object being contained in or held by people who were 'up there'—taller,

older, in powerful roles such as parent, teacher, or leader. In this sense I saw power as something that can be held or possessed by an individual and used to enable or constrain others in what Townley (1994: 7) referred to as a zero-sum or negative struggle. Magico-mythical thinking also suggests a central organising force (power over) that can be held by an individual (e.g., a leader) or in a class of individuals (e.g., senior administration) and used primarily to constrain those who lack power. By contrast, drawing on Foucault, Townley saw power as a relation, not a possession—something that is exercised, rather than held and that does not have a central locus (1994: 7). This conception of power invites us to wonder less about the origin of power or what it is, and more about its manifestation (how power operates) in the context of our on-going relations with each other (1994: 9).

Thinking More about Ethics and Identity

The Fall of the Hero

Since 1986, I have been involved in the formal consideration of clinical bioethics through membership on various ethics committees. For six years, I was a research associate with the John Dossetor Health Ethics Centre, where I was part of a research team that considered relational ethics as a foundational concept in clinical bioethics. The question that drove my interest in clinical bioethics was whether it was possible for healthcare providers to practice ethically with patients when it often seemed they were patently unable to manage ethical relationships among themselves.

My central concern with ethics became inextricably linked to my concern with how people interact together in teams, or for that matter in any circumstance. There seemed to me to be a profound ontological and epistemological significance of our on-going human relating that could be expressed and experienced in the language and processes of ethics. Griffin characterised ethics as being *"concerned with the structures required to sustain identity"* (2002: 177) and suggested there has been a tendency to view ethics (as I think I have tended to do) as both a stable pool of universal principles and a theory of leadership as everyday interaction. Griffin suggested that this dualism has caused us to think that we can have experience and detach ourselves from it to change, manipulate, or observe experience objectively. Griffin denied that one can stand outside of and observe experience and instead

understands human interaction as necessarily participative and self-organising as we make sense of our experience together.

Thus, while the hero no doubt has a legitimate (if rare) place, s/he should likely more often give way to interaction with others in a way that discovers and defines a co-created future. For me, this involves an on-going journey of learning and relearning how contrary my interest in the relational nature of ethics, leadership, and organisational change has been with my heroic efforts to bring the world into 'alignment' with what I know to be right. Surprise and reaction are gradually giving way to curiosity (what is going on here?) and interaction (how do we understand what is going on and move forward together?). I have been slow to respond to the call for action in the narrative because I have been unsure of how to proceed. This is also the dilemma of the hero: What shall *I* do? A different question, a relational one, would be more likely to engage staff in discussion that could lead to a new future, one more closely resembling shared and discovered ideals. Such a question might be: What is going on here and how do *we* want to proceed?

Who is 'In' and Who is 'Out'

I have discussed values and the ethical actions that holding values tend to invoke, that in turn inform the continued shaping of values. However, another dynamic also seems to be at play in the narrative and the stories of my early experiences—this is the idea of insiders and outsiders. In the narrative, staff identified several elements of their experience that made them feel like outsiders, by which I think they meant that they feel 'less than' those who feel to them like insiders. As outsiders the RCAs felt they hold less (or no) power and status. They perceive nurses as having power and status that is denied to them, those from the Philippines as having more status and power compared with those from elsewhere, and full-time 'regular staff' as having power and status not available to part-time or casual staff. I was the most powerful and was clearly expected to use my power to resolve this sense of unfairness they were experiencing. This perceived ordering of people, practices, and power parallel other structural hierarchies in the organisation such as that reflected by traditional organisational charts.

That such a hierarchical ordering of the world of work may be neither natural nor necessary began to be considered seriously in the 1980s as concepts of employee

empowerment and self-directed teams gained momentum. Tom Peters, in his book *In Search of Excellence*, said

> *Regardless of whether or not the fit is perfect, organize every function into ten- to thirty-person, largely self-managing teams. Eliminate all first-line supervision as we know it.* (1987: 296)

DuPree (1989) supported the popularised notion of inverting the organisational pyramid and inspired leaders to see themselves as actualising the potential of people around them, setting the possibility for our true 'being' to lead us to the right 'doing'. DuPree urged organisations to be transparent and inclusive, which continues to be a common call to ethical leadership. For DuPree, *"an inclusive system requires [everyone] to be insiders"* (1989: 67), which he thought included certain marks of inclusiveness such as being needed, involved, and cared about as individuals, and having a piece of the action. Moreover, inclusive leaders owe their followers a space where people can be who they are, have an opportunity to serve and feel challenged, and feel a sense of meaning and deep and permanent worth. Finally, DuPree thought inclusive capitalism required something from everyone, such as being faithful, having a redemptive purpose, being vulnerable, willing to take risks, and a willing to be intimate—to not be a spectator, and making a commitment to learning together (1989: 66-70). Sociologist Norbert Elias (1970/1978: 131) would dispute that it is possible for everyone to be insiders, and instead refers to figurations—habitual patterns of acting—that cannot generally be perceived directly due to the interdependent nature of our relationships. In these patterns individuals are not statically in one role, but contextualise their experience in the on-going patterning of power relations.

Authors like DuPree (1989) and Handy (1991; 1995) interested me because they were popular but just outside the mainstream and thus could draw attention to the value of uncertainty and the importance of people and values, where mainstream authors drew attention to numbers, quality improvement formulas, or sophisticated process modelling to reengineer the corporation. Arguing for a more human, holistic perspective, Handy pointed out the danger of reductionism, calling it the *"sin of modern life"* (1995: vii); he wanted to turn things upside down, to say that the only prediction that would hold true is that no prediction would hold true, that corporations of all kinds needed more unreasonable people who wanted to change the world, not adapt to it, who wanted to challenge orthodoxy, not rationalise it (1995: 201). These

ideas had strong appeal to me. I knew I was dissatisfied with the emphasis on numbers and systems of the dominant organisational theory, and I suspected that progress had more to do with who we are and how we interact, including how we defined who was 'in' and could fully participate in creating the organisations they worked in.

My early encounters with complex responsive process theory (e.g., Stacey, 2007) were exciting because it addressed power in what was for me a whole new way, including involvement and participation as well as exclusion and destruction. I will explore this theory briefly in the concluding section, but for now I want to explore further what was happening in the 1980s and 1990s. In the name of empowerment, organisations were flattened, meaning that there was a reduction in management layers, staff were to be self-directed—the idea being to bring decision-making closer to the bedside and reduce bureaucratic 'red tape' (a term that disparages management interference in decisions better made by frontline staff). At the same time that this ideology was introduced to healthcare, many organisations began a shift to program-management. This shift was in effort to reduce the fragmentation thought to result from organisational structures that centred on disciplinary silos and to replace them with interdisciplinary teams that were structured around the needs of a particular patient population. Patient-centred care was thus established as both a principle of care and an organising principle to improve coordination and collaboration among diverse professionals and simplify decision making. Staff in the narrative clearly did not feel the sense of belonging and empowerment that was hoped for in the writings of these authors.

Thinking About How Organisations and the People in them Change

At the root of the narrative and stories of my early experience lies a struggle to understand how people and organisations change. In particular, I have been interested in understanding how people who represent different healthcare disciplines can work together in ways that support the health-related goals of patients as well as their own personal and professional growth. As I moved through progressively expanded leadership roles these experiences of surprising intensity and fervent reactions that I described began to give way to more relational and emergent approaches and (ironically) also to a move away from humanist methods that valued affect, toward

methods that valued numbers, represented by the emergence of total quality management (TQM) and business process reengineering on the other. TQM was popularised by H. Edwards Deming (e.g., Deming, 1986; Walton, 1986) in manufacturing and was taken up in healthcare through the creation in 1991 by Don Berwick and others of the Institute for Healthcare Improvement (IHI). The IHI remains an important organisation in the continued evolution of TQM in healthcare. Amazon.ca currently lists over 3,000 titles under the search words 'Total Quality Management'. Peters (1987) referred to the *"quality revolution"* and suggested it requires *"management obsession"* about measurement and improvement strategies to continuously improve quality of services or products (1987: 70).

Such cybernetic approaches that rely on measurement and control to organisational management and development shifted my thinking toward believing that clearly defined goals and strategy, constancy of purpose, process mapping, and statistical process control would achieve the right results. In other words, principles of engineering control were applied to human systems as if human systems behaved mechanistically (Stacey, 2007: 46). Through taking up TQM, healthcare was thought to became more business-like—it became an 'industry' and turned toward patient-centred care (following industry's customer or consumer-driven thinking), adopted business units, even profit centres (an oxymoron in Canada, where not-for-profit socialised medicine is a defining part of Canadian culture), and began to move away from command-and-control of people to continuous process improvement. In healthcare, this also represented a shift away from care that was thought to be based more on the whim and convenience of the professionals to more scientifically valid 'evidence-based' and patient-centred medicine. The complex interaction of multiple human factors (biological, physiological, psychological, social, spiritual) was, and often still is, considered to be a distraction. People were being driven out in the quality equation, and this set the stage for an important aspect of systems thinking—namely that systems, not people, are to blame for inefficiency.

Senge's (1990/2006) influential text *The Fifth Discipline* introduced the learning organisation and systems thinking to corporate America and was quickly adopted into healthcare practices. For me, and for many others, Senge's notion that systems, not people, were to blame for failures or inconsistent performance was seductive. It permeated the TQM movement precisely because processes (an expression of 'the system') could be broken down, examined objectively, and fixed.

Not only did we not need to blame people, there was really no need to even consider the human component. (This is admittedly a caricature of Senge's contributions, but my experience was that many people were thinking along those lines.) The first chapter in *The Fifth Discipline* is titled *"Give me a lever long enough … and single handed I can move the world"* (1990/2006: 3). This reference to the hypothetical Archimedean point—a vantage point outside the thing being observed such that an observer who stood at that point could see the thing (in this case, the system) in its totality. It is a sensible analogy if one believes that it is possible to step outside and observe one's own experience.

In this emerging organisational world of whole, but blameworthy systems, and innocent individuals buffeted by out-of-control processes, there was a strengthening in academic medicine of dual competing hierarchies—one medical and one administrative. These hierarchies dominated academic health centres and were sometimes not just competitive, but openly hostile (Gustafsson, 1989). Contrary to Senge's (1990/2006) belief that people were not to blame (and despite feeling seduced by having some*thing* to blame), it was clearly people, not 'systems' who were hostile. Individuals sabotaged those with perceived competing interests, and I had growing doubts that this new emphasis on systems, particularly in a highly structured and mathematically modelled cybernetic framework, could either explain or transform organisations.

The Patient Care Project: Reengineering Healthcare

From 1993 to 1995, I was the project leader for a hospital-wide business process reengineering project. Reengineering promised breakthrough improvements (where TQM promised incremental improvement) based on process analysis, widespread consultation with staff and physicians, and the application of complicated mathematical modelling to prove the value of identified improvement opportunities. Thirteen teams consisting of up to 25 people supported by an external consultant ('methods experts') and an internal consultant ('context experts') laboured for two years to develop an integrated strategy that we proved mathematically would improve patient care and the quality of staff work life and significantly reduce cost. Hammer and Champy (1993) and Champy (1995) inspired our work. At the end of this multimillion dollar project our recommendations were put on the shelf. The hospital

had become part of a large regional structure and our recommendations could not be implemented.

During the project, I remained disconnected from the methodology, which used a highly structured cybernetic approach to diagnose opportunities for change and develop plans to control the future (Jackson, 2003: 88). I was more interested in how the teams worked together—how they formed, how they handled conflict, whether in their work together they achieved goals that were important to them, and whether each person felt they grew personally or professionally through their involvement with the project. These issues drove my interest and day-to-day function with the teams. Block's (1993) *Stewardship* and Wheatley's (1992/1994) *Leadership and the New Science* were two very influential works for me at the time.

Block (1993) argued that leaders and followers alike colluded in the establishment and continuation of patriarchal organisational structures and processes and encouraged empowerment of local action through the free flow of information, active resistance of what he called parentalism (which he felt lead to helplessness and reduced creativity), and a fundamental reconsideration of power that favoured local action over centralised control. Part of what intrigued me about Block's writing was a notion fundamental to the reconfiguration of power, namely that he felt organisations should stop separating management of work from the work itself. Block felt that everyone should manage and that while some would have a wider or longer view of managing work, management prerogatives should disappear—there would be no privileged class (1993: 65). Wheatley (1992/1994) took this idea of local action even further based on theories of complex adaptive systems. She argued that 'control' in complex organisations could not be achieved and argued instead that 'order' would be a more realistic goal but even that could only be achieved temporarily. She cautioned that order itself *"hid the processes that venerate life"* (1992/1994: 77).

As Senge (1990/2006) had done, Champy (1995), Hammer and Champy (1993), Block (1993), and Wheatley (1992/1994) all argued that organisations and their environment—internal and external—are inseparable parts of a single whole. Hammer and Champy made that argument to promote consideration of end-to-end process management; Block thought it important in terms of encouraging local action and interaction between suppliers and internal or external customers to build personal relationships that empower local solutions; and Wheatley promoted this view arguing that corporations are open systems that both influence and are influenced by their

environment. I was both intrigued by and suspicious of the systems approach, despite the shift toward a complex adaptive systems view. Welsh poet and management consultant David Whyte (1994) expressed another part of what I was feeling. Whyte said,

> *The wish for unity, for a system, becomes a burden in itself. Before we have looked up from our elaborate Daytimer [i.e., business calendar], the elements with which we grapple have divided around us and joined up to form a world from which the Daytimer itself excludes us.… Without the constant and chaotic reordering necessary for adaptability, [an organization becomes] a house of the living dead.* (1994: 251-252)

Whyte also described the

> *San Andreas fault in the modern American psyche: the …* ***wish to have power over experience, to control all events and consequences, [versus]*** *…* ***the*** *…* ***wish to have power*** *through* ***experience****, no matter what that may be.* (1994: 17, original emphasis)

This I think expresses a sense of what the RCAs are feeling—they find themselves in a world that excludes them, a world where others have power over them, which further denies their ability to have power through full participation in their own experience.

Sociologists Elias and Scotson (1994) studied a community in which some members of the society were well-established in the community and other newer members of the community were new and considered 'outsiders'. Elias and Scotson suggested that the tensions between these groups did not arise because one side was wicked or overbearing and the other weak, but because they were actively created and recreated in the fluctuating power relationships between people. He suggested that gossip has a principle role (1994: 156). The established create a heroic 'we' identity as a way of distinguishing their group from another. They denigrate the outsiders, and the outsiders come to understand themselves in the way they are being viewed by the established. There is no natural or imposed order that would inevitably lead to RCAs feeling like outsiders to the established privilege of nursing, Filipina, or full-time staff. Rather, Elias and Scotson would suggest that the patterns they all engage with in the day-to-day negotiation of their work together contain and produce the tensions they are feeling. Hiring practices and contract provisions regarding internal job transfer mean that teams have very little, if any, choice about who is hired. In fact, because of contract seniority provisions, employees have more choice than employers

or teams in deciding where they will work. This may lead to reluctance on the part of teams to accept staff they have not had the opportunity to select and disappointment on the part of staff whose expectations may not be realised on joining a team. Since staff are necessarily interdependent, according to Elias and Scotson, they inevitably constrain and enable each other and rely on each other for recognition (1994: 156). Antagonism, and the feeling of being an outsider, would be unexpected in a context in which teamwork is so critical and the surprise of encountering it might understandably have induced the strong and unexpected reactions they experienced.

Complex Responsive Process Theory – A Brief Exploration

I encountered the work of Stacey and his colleagues in 2008 toward the end of my Master of Arts (MA) in Leadership program through Royal Roads University (RRU) in Canada. The Appendix found at the end of this report provides the program description currently on the RRU website. The MA program promised, among other things, to

> *provide new competencies and insights that clearly demonstrate how inspirational leadership can deliver exceptional employee and organizational performance ... while helping to lead and manage change under dynamic conditions.* (Royal Roads University, 2011: para. 3)

I found it puzzling that leaders might be expected to deliver exceptional employee and organisational performance. 'Systems thinking' was a frequently mentioned focus throughout the program. As previously noted, I was suspicious of systems thinking in the way it seemed to virtually eliminate the vital contribution of human interaction to both positive and negative experiences. This suspicion likely arose from reading such authors as Gliek (1987), Capra (1996), Capra and Steindl-Rast (1992), Gregory Bateson (1972), Mary Catherine Bateson (1994), Grof (1990), and Prigogine and Stengers (1984), who were proposing quite different ways of thinking about such things as what constitutes ethics, truth, and reality, and how learning, innovation, and change occur. Most of this literature made more sense to me than mainstream systems thinking, common notions of scientific method or mainstream organisational theory, but this body of work did not represent a single coherent philosophy, and I struggled to put ideas

together and make sense of them, especially in relation to organisational development theory.

A paper by Ralph Stacey was included the reading list for one of our 'Systems Thinking' seminars. I approached the paper reluctantly, assuming it would be another take on the same old approach. Instead, he seemed to rebel against the systems thinking and to suggest that it was simply another form of command and control. Stacey presented an intriguing alternative that accepted much of the complex adaptive system theory but interpreted it in the context of sociology and human behaviour. His theory of complex responsive processes of relating is not easy to grasp, but it felt close to putting into words some of what I had been feeling. Stacey et al. wrote:

> *At one end of the spectrum is the dominant voice in organization and management theory, which speaks in the language of design, regularity and control. In this language managers stand outside the organizational system, which is thought of as an objective, pre-given reality that can be modelled and designed, and [controlled] ... at the other ... there are voices from the fringes of organizational theory, complexity sciences, psychology, and sociology who ... argue that humans are themselves members of the complex networks they form and are drawing attention to the impossibility of standing outside of them in order to objectify and model them. With this intersubjective voice people speak as subjects interacting with others in the co-evolution of a jointly constructed reality.* (2000: ix-x)

The theory of complex responsive processes rejects the notion that a series of nested systems exists, some of which operate independently from the individuals who, as a subsystem, make up the system. In such systems approaches, leaders it is thought, can imagine then enfold vision and mission and values into the human matrix and then cause it to unfold and be realised as the desired future through operationalising the pre-planned strategy (Stacey and Griffin, 2006: 29). In the narrative at the beginning of this project, staff seemed to be calling for me, their leader, to develop and execute a plan that would 'unfold' with certainty and precision.

Staff themselves identified the existence of a power struggle between those who hold more power (those who they see as the established) and those who hold less (themselves, as outsiders). Complex responsive process theory draws in part on the work of sociologist Elias, who said in discussing *"figurations"* (1970/1978: 15)—by which he means groups of interdependent people caught up in power relations—that sociologists often fail to acknowledge the *"central part played in every social*

development by tension and conflict ... tension and conflict will never be banished from society" (1970/1978: 172-173). Shaw suggested that the way we experience power relations at work is in the way we are *"always acting to include some and exclude others and how we experience ourselves as included and excluded"* (2002: 74).

Complex responsive process theory seems to me to be suggesting that at least three common mainstream management assumptions are fallibilistic: objectivity (a correspondence theory of truth that fails to take into account social construction of meaning), design (which, along with objectivity, presumes one can stand outside the present reality to design a desired future), and control (that fails to take into account the fundamentally emergent nature and unpredictability of organisational life). In what I am sure is still a very naïve way, it made such good sense to me to question these issues, but how are we to move forward, if it is not through planning and controlling, inspired by a grand vision of an ideal future? If indeed the rational is not to be found within an individual, but only in community (Townley, 2009: 127), how might community be understood as process that continuously co-constructs the future together?

Shaw suggested that the answer lies in a willingness to *"stay in the movement of communication, learning and organizing … to think from within our living participation in the evolution of forms of identity"* (2002: 20). Changing conversations in organisations (also the title of Shaw's book) is what, according to complex responsive process theory, changes organisations. Reflecting on his experience of conversations in the Doctor of Management (DMan) program at the University of Hertfordshire, Fonseca offered his perception that innovation is

> *essentially a conversational process ... of communicative interaction ... characterized by redundant diversity experienced as misunderstanding ... all of which seemed to be requirements for the emergence of novelty* (2002: 53)

The notion that redundant diversity—repetition and duplication of previous conversation (2002: 52)—experienced as misunderstanding could be the thing that provokes the search for new meaning sheds an interesting light on organisational conversations. Much like the situation I was presented with by the RCAs, these conversations express similar concerns over time and suggest that the way forward

will include engaging in continued conversation, even though we do not yet know how our future will emerge.

Moving into the Unknown

I entered the Doctor of Management program hoping for answers about how, as an internal consultant, I lead teams to successfully adopt style of practice widely known as Interprofessional Collaborative Practice, a practice I have passionately promoted and had a very clear and idealised perspective about what it would look and feel like when done 'right'. Influenced by a still naïve understanding of complex responsive process theory, my thinking and question have changed dramatically. The question I now want to explore is how people working in healthcare teams negotiate the conflict in and complexity of their daily work together and how an internal consultant can be a partner in the emergence of novel team practices in a way that supports achievement of outcomes that are important to them and to the patients they serve. The contribution of complex responsive process theory to innovation in healthcare practice and how an internal PC can engage with teams in a process of practice innovation has not been widely reported in mainstream healthcare literature. My research will contribute to filling this gap in current thinking through a focus on how change happens in the presence of conflict, including thinking about how conflict can be both problematic and transformative at the same time.

The challenge of this process is that both the process and its outcomes are, according to the theory itself, largely unpredictable. They emerge in unpredictable ways in the lived experience of a group of people interacting together on an on-going basis in a particular circumstance. Nevertheless, reflection on the specific circumstances that will unfold and be considered in the body of work for this Doctoral program may provoke recognition by others in similar circumstances. The narrative approach offers a rendering of experience that will be unique and which may also offer readers multiple resonances with their own experience. Thus readers may derive further unique interpretations of this work in their own contexts.

PROJECT 2: INTERPROFESSIONAL COLLABORATIVE PRACTICE – EXPLORING THE 'TAKEN FOR GRANTED'

Introduction

In Project 1 I explored the development of my thinking about my own practice as a leader in Canadian healthcare contexts. I saw that how I understood concepts such as leadership, organisational structure, and processes changed over time. For example, I recognised a shift from understanding leadership as a question of "what *I* should do" (which assumes that the solution to a problem could be identified in advance and then enacted through the intentional work of an inspired leader) to understanding leadership as a quest to understand what is going on and how *we* go on together. Implied in this question (consistent with complex responsive processes of relating) is a particular theoretical position, namely, the need take seriously the moment-by-moment interactions between people as they negotiate the power relations and multiple interests inherent in their interdependency.

Project 1 ended with the observation that my focus on entering the Doctor of Management program was on how, as an internal consultant, I could support the implementation and widespread adoption of IPC. As I began to engage with the ideas of complex responsive processes of relating and research, my thinking started to shift. I saw that my conviction about what IPC is and what it would look and feel like if 'done right' emanated from an idealised systems-based logic that conceives of the model of IPC in very specific terms and abstracted from practice.

I also started to question the notion that, as a consultant, I could design, implement, and support the widespread adoption of this practice (Stacey, 2010). Without wanting to imply planning is always ineffective, the question still arises for me about how organisational change (specifically professional practice) does happen—and what is the role of an internal consultant in organisational change?

Thus, by the end of Project 1, the focus of my research shifted from how an internal consultant could support the implementation of IPC, to an exploration of the nature and role of conflict in IPC among new or established teams, and how my own practice develops as I work with and in team conflict. In this project I will explore how IPC is understood in the current literature, what might be taken for granted in these works, and whether there are alternative understandings (particularly in the

body of knowledge described as complex responsive processes of relating) that would be helpful to explore. To begin, I present a narrative about a recent in-service education session I was invited to give about IPC.

Narrative Part 1:
An Invitation to Talk About Interprofessional Collaborative Practice

I was invited to give a one-hour in-service education session to an interprofessional leadership group for the Acute Care for the Elderly (ACE) unit at Grace Memorial Hospital. I chose this narrative because I had taken a new role as PC for Interprofessional Practice, Education, and Research. The PC position was new in the organisation so no one, including me, knew how the role would emerge. Preparing this in-service for another hospital seemed like a good opportunity for me to think formally about how I would talk about IPC in this new role at my own institution. My organisation sought me out for this new role, based on their confidence in my expertise in interprofessional practice, and while the role seemed like an opportunity of a lifetime, I found myself uncertain about how to go about my new work.

I wanted to be able to demonstrate the expertise implied by my new work title and by my new status as a Doctoral student, and felt I had something novel to offer arising from my engagement with the program. I was also nervous about speaking from this new role and new ways of thinking, as neither felt very concrete. Writing about change, Bridges (1981) pointed to a time of discomfort and chaos that he called the neutral zone—a time when familiar patterns no longer exist but new patterns have not yet been established. While his ideas about change have a very sequential feel that I take issue with, I can certainly relate to feeling disoriented in the emerging patterns of my new practice.

In the first part of my presentation I presented IPC as it is characterised in current healthcare literature. My purpose was to provide a common framework for later discussion. In what follows I summarise the first part of my presentation, drawing on the literature that currently informs primarily the Canadian and United Kingdom (UK) discourse about IPC—two countries that are leading this practice development. This discourse is closely linked with interprofessional education and while I do not intend in this project to address interprofessional education, I do want

to acknowledge the close ties between how professionals learn and how they subsequently practice.

Interprofessional Collaboration: The Widespread Interest in IPC

IPC is cited in nearly all current policy, health services, and health human resource literature as an essential component for developing patient-focused care and a sustainable health system (Canadian Health Services Research Foundation, 2006a; 2006b; Canadian Nurses Association, 2005; Curran, 2004; D'Amour and Oandasan, 2004; Health Council of Canada, 2005; 2006; Oandasan et al., 2004; Orchard et al., 2005; Romanow, 2002). The Health Council of Canada identified four areas of focus for healthcare renewal in Canada. The first recommendation stated, *"Sufficient numbers of health care providers* ***trained in teams*** *... must be in place;* ***otherwise all other efforts [will] flounder****"* (2006: 1, emphasis added). The World Health Organization recently published a major work on interprofessional education and practice in which it declared, *"After 50 years of research, there is sufficient evidence to indicate that effective interprofessional education enables effective collaborative practice"* (2010: 7). In the same month, a national competency framework for IPC was also released by the Canadian Interprofessional Health Collaborative, the result of nearly seven years of work on this project (Canadian Interprofessional Health Collaborative [CIHC], 2010). Interest in IPC in the United States can certainly be seen in powerful organisations such as the IHI. Most of the developed world at least, is calling for attention to collaboration among different health professionals.

The Advantages of IPC

Improved patient safety is the most consistently cited benefit of collaborative practice. Major patient safety reports (Baker et al., 2004; Kohn et al., 2000) implicate lack of effective teamwork and poor communication as leading causes of medical error—leading in the United States to over 98,000 preventable patient deaths each year according to a landmark study by the Institute of Medicine (2001). IPC has also been associated with: improved population health and patient outcomes, improved access to healthcare, improved recruitment and retention of and communication among healthcare providers, more efficient and effective employment of health human resources, improved knowledge translation, enhanced workplace learning, and

improved satisfaction among patients and healthcare providers (Brown, 2004; Curran, 2004; Oandasan et al., 2004; Phelan et al., 2006; Zwarenstein and Reeves, 2006).

With the exception of studies relating effective teamwork to patient safety, most of these claims are only marginally substantiated, at least by the 'gold standard' of randomised controlled trials (RCTs). Studies that use qualitative methods, whether positivist, interpretivist, or both, more consistently demonstrate the benefit of IPC, but are not as well accepted by health services researchers who tend to hold a narrow, rationalist view about what constitutes acceptable evidence of benefit. Despite relatively weak evidence, the actual and theoretical benefits of IPC nonetheless have wide appeal in the healthcare community.

IPC Defined

IPC is a patient-centred process of communication and decision making that enables the separate and shared knowledge and skills of the providers and patient to synergistically influence care (Way et al., 2001). Nuances of that definition include: the notion of *partnership and shared decision-making* (Orchard et al., 2005); practice as a *process through which parties* who see different aspects of a problem, *constructively explore differences*, and seek solutions that go beyond their own vision of what is possible (Gray, 1998); emphasis on *blurring of practice scope* and *the highest level of unique scope of practice* (Gilbert, 2007); practice as highly *responsive, evolving and emergent* (Lahey and Currie, 2005); *no single right way* (Health Canada, 2006); *continuous interaction and interdependence* (Curran, 2004; D'Amour and Oandasan, 2004) and a *collective responsibility* for outcomes (CIHC, 2010). The italicised words are concepts that I highlight in presentations about IPC as evocative phrases from which a 'feel' for the practice in its ideal forms may be constructed.

I concluded this part of the presentation saying that IPC is like a dance in which a group of skilled and reflective practitioners understand each other's practice at the level of what Hurst (2008) called reciprocal literacy. Here practitioners know almost intuitively what needs to be done and with minimal need for communication, collaborate effectively together. Hurst also meant that practitioners have sufficient knowledge of disciplinary practices to critically analyse one another's practice. I also point to a taxonomy of interaction that distinguishes between *communication* (simple information exchange often through chart notes); *coordination* (disciplines agree to

work in a coordinated way, but still work independently); *cooperation* (greater interdependence in matters such as scheduling, resource sharing); *co-location* (thought to promote teamwork through proximity); and *collaboration* (overlapping scopes of practice and consistent, effective communication) thought to net the presumed advantages of ICP (Gilbert, 2005). Participants seemed to recognise in the description a desired and achievable ideal though for them, perhaps not achievable just yet.

Reflecting on the Narrative

I often present IPC as something teams should strive to do (implying they are not currently doing so). When people said they were already practicing this way, I would think, "You may think you are, but you're not", without actually knowing anything about their practice. By the end of Project 1 and with patient coaching to this conclusion by colleagues in the DMan program, I was beginning to realise the implications of the fact that my own view of IPC emerged from one day in my own clinical practice that happened in 1974 and from which I created an idealised version of IPC that no doubt only I remember at all, never mind with the reverence that I have attached to the experience. I have reified of the experience of that day, giving an almost physical reality to the theoretical ideal that I imagined, and have been trying to replicate the experience ever since, as if there were no other way it could be (hence the speed with which I reject the possibility that people are already practicing in this way).

Increasingly, I understood that IPC is not a 'thing' with particular rules and special ways of being together and was ready to believe my own (and others') rhetoric that IPC is different in each circumstance and even from day to day in the same setting. With this realisation, I must also conclude that I cannot stand apart from the practice situation and precisely define what it is or should be. The question then immediately arises about what that means for my practice as a consultant: What do I do instead? This question is highly anxiety-provoking for me, as it challenges not only a deeply held belief that I had the 'right answer', but that I could help others to 'see the light'. These are questions of identity; if ideal practice patterns cannot be identified and taught, coached, or coerced, then who am I as a PC, and what do I do in this role?

I anticipated declaring that 'interprofessional' and 'collaborative' are too often taken for granted based on believing that the declaration that 'we are practicing this way' was informed by naïve, taken-for-granted understandings of the terms interprofessional and collaborative. I thought that if these terms were understood, people would no longer claim they were practicing IPC—at least not in the way *I* meant. Instead, I see that these terms are quite well described in the definitions of IPC. The term interprofessional is certainly not difficult to understand—two or more professions working together; and collaboration is, at least on the surface, also quite easy to understand, notwithstanding the problem of the taxonomy of a communicative continuum. It seems more likely that all of those patterns of relating would coexist rather than moving from lower to higher order patterns of relating and that what I have in fact taken most for granted is practice. In modern health services almost all practice happens through the interactions of many people and is, therefore, de facto both interprofessional and collaborative. If I understand what practice is, I may come to different understanding of not only clinical practice, but also my practice as an internal consultant.

Stacey (2005) pointed out that everyday interaction between individuals as they go about their daily work together needs to be taken seriously if we are to understand how practice emerges in a complex, highly social context. Understanding practice as a social, emergent phenomenon would, I think, provoke high anxiety among healthcare leaders who tend to see practice as the logical application of theory through particular models and/or the correct use of evidence-based techniques, and see these qualities determinative in practice. I turn now to the questions that are forming for me—not how this practice can spread, or what the role of conflict is, but what does practice mean, how do patterns of practice change over time, and what is my role as in internal consultant?

Understanding Practice

I want to explore this emerging line of thought by inquiring into the term *practice* itself. Practice, as a construct, may be taken for granted when it is qualified by other terms such as interprofessional or collaborative. Suspending practice in a discourse about being interprofessional or collaborative may mask what is going on when we work together, because we are failing to grapple first with the critical

question of what is practice. Treated as a noun, practice is a 'thing' to be described, reified, and, in the case of IPC, perhaps even made a fetish. In its 'thingness' practice is abstracted from its dynamic, embodied experience. Understanding practice may open avenues to a more fruitful exploration of how multiple healthcare disciplines practice together.

I will explore first the ways in which practice is usually described and then explore an alternative discourse that identifies practice as a sociological phenomenon, with particular reference to theorists in the domain of complex responsive processes of relating. Healthcare identifies most strongly with the science of certainty and, therefore, tends to express theories of knowledge and causality that are consistent with certainty. Organisations in this domain are thought of in mechanical terms that can be easily controlled through efficient (predictable) causal mechanisms. Change it is thought can be predicted and planned (formative and rationalist causality) and neither history nor on-going interactions between actors have any real effect (Stacey, 2010: 47-48). In contrast, the theory of complex responsive processes of relating finds the philosophy of uncertainty to be more congruent with the experience of human behaviour, including organisational life. This theory explores epistemology in dynamic, embodied and relational terms, and understands causality as transformative. These concepts will be more fully developed as companion threads through the discussion that follows.

Practice as Application of Theory

Practice is often characterised as the application of theory. In this thinking, practice operationalises or applies the methods and techniques (viewed as competencies) that have been derived from theoretical models (Van Manen, 1999). The 'correct' translation of theory to practice is viewed as challenging, and it is common for researchers and clinicians to attempt to 'close the gap' between theory and practice, thus positioning theory and practice as dichotomous constructs (e.g., Cooper and Spencer-Dawe, 2006; Murray, 2009; Myers, 2008; Reed, 2009). Carson and Carnwell (2007) even suggested the possibility of 'working in the gap', a space between theory (understood by the academic) and practice (understood by the practitioner) in which the academician and the practitioner could somehow work together to bridge the theory-practice gap. The translation of knowledge into practice has become an important industry in healthcare and is closely associated with the

related evidence-based medicine (EBM) movement. The Cochrane Collaboration (2011) is a gold standard in the EBM industry that publishes the 'evidence' of best practice in hundreds of healthcare contexts. In healthcare, theory is transformed through scientific proofs to evidence, which is then thought to 'drive' practice—that is, to be the base for practice.

While I do not wish to impugn the value of theory, medical science, or evidence produced by it, I do wish to draw attention to the thinking underlying it and question how directly such thinking can be applied to or provide an explanation of practice. This 'evidence' prompts clinicians to see practice as the correctly applied, logical end point of the chain of scientific evidence. Science (in Aristotle's epistemic tradition) would prove a theory (often in conditions far removed from practice) through an efficient causality in which essential truth is revealed. This knowledge would then be translated to practice.

The PC in this view would plan the 'roll out' of the technique, ensuring that it is understood and correctly applied by clinical practitioners. Such thinking reflects a formative causality in which the consultant would embed the new technique in a carefully formulated plan, including perhaps a policy about the new practice and educational sessions to teach practitioners how and when to apply the new technique. The plan is then 'unfolded' (implemented) in clinical programs. While such a plan can be effective in limited technical contexts, it is common for organisations (and consistent with my experience) for the desired change to 'miss the intended mark' or not be sustained. In such cases, we tend to blame the 'system'—the education program was deficient or failed to reach enough people; insufficient resources went into the change strategy; or we blame people, believing they suffer from change fatigue and simply cannot, or will not, absorb the new information.

Some key issues are ignored in this scenario. The epistemic approach, underpinned by assumptions of certainty and control, does not account for the fact that the new technique generally works, but not always, and are ultimately applied in circumstances unlike the experimental conditions by many practitioners each of whom will interpret and apply the technique slightly differently. Scientific and efficient cause heuristics are too limited to account for the complex environment in which clinicians practice. The assumption that social systems can be understood in the same causal framework in which physical and biological systems are understood is common, and I believe flawed.

Practice is clearly not just the unproblematic application of theory. There are many *"tacit dimensions of the rules, precepts, codes, principles, guides, commitments, affects, and behaviours that one observes … within a domain of action"* (Van Manen, 1999: 1). The tendency to privilege the theoretical, as being closer to 'the truth' and to conflate the philosophies of certainty and uncertainty (Dewey, 1929) is problematic since causal mechanisms, and epistemological and ontological assumptions are quite different between these philosophies. I am not looking to present theory and practice, or the science of certainty and uncertainty, as dichotomous. Rather I argue that the epistemology and causality most congruent with the biological and physical sciences is insufficient for understanding causality, and change in a social structuration. Dewey suggested the failure to integrate what we know about the world and the intelligent direction of what we do resides in our

> *unwillingness to surrender two ideas formulated in conditions …different from those in which we now live … [one], that knowledge is concerned with the disclosure of the characteristics of antecedent existences and essences, and [two], that the properties of value found therein provide the authoritative standards for the conduct of life.* (1929: 71)

Dewey rejected essentialism—prima facie deterministic conditions from which we simply unfold in the only possible dimension contained in the antecedent conditions. Dewey would not deny that essentialist conditions exist in, for example, a tulip from a tulip bulb, a building from the architectural plans, or a baby from a human embryo, but he did reject that knowledge, causality, and experience in human interrelations emerge from an essentialist blueprint.

Stacey and Griffin (2005) hold that theory and practice are not opposite; they are paradoxical aspects of the same phenomenon. This has profound implications for both epistemology (our theory of knowledge—how we understand and interpret the world around us) and ontology (what we understand the nature of phenomena, such as practice, to be). Flyvbjerg (2001; 2004) drew attention to Aristotle's distinction of three kinds of knowledge: techne (or technical knowledge), episteme (scientific knowledge), and phronesis (practical wisdom), and pointed particularly to the value of phronetic knowledge. Understood as practical wisdom, Flyvbjerg suggested that phronetic knowledge accords importance to values, understands that power influences the construction of knowledge, privileges experience and narrative, and includes a dialogue with many voices (2001: 295), all of which eschew Newtonian science.

Flyvbjerg appeared to come close to denying a place for positivist science, and this would overstate the concern I am raising. I am arguing for reasonableness (neither absolute certainty nor absolute uncertainty) to our understanding of how knowledge is generated and changed in social contexts (which tend to greater indeterminacy) compared to biological or physical systems (which tend to greater determinacy). I do not see science or theory as distinct from practice, but scientific writers fail to consider the contribution of phronetic knowledge or take indeterminate conditions of indeterminacy into account. Phronetic knowledge is generated through and guides practice, offering new theoretical perspectives in conditions that include values and power relations. Technical or scientific knowledge should not be ignored, but we can neither understand practice nor understand how practice changes unless we include attention to practical wisdom in our methods. Practice is not adequately characterised only in relation to or as a separate construct from theory.

A Reflective Pause

In the first part of my in-service presentation, I did not discuss a theory of practice or speak directly to the relationship between theory and practice—an important oversight given the tendency for practice to be understood in rather narrow scientific terms. In fact, through frequent reference to 'the literature' and using phrases such as 'we think …' and 'studies have shown …' I gave the impression that IPC was a single and scientifically grounded truth. Presenting the definitions and descriptions as if it were a theory of IPC (and then forgetting the 'as if') was a paralogism to gain legitimacy and present myself as an expert.

Professional practice is not generally considered the rote application of scientific discoveries despite efforts to roll out the latest 'best practice'. We are not far from a time when most medicine was considered to be applied biology (Toulmin, 2001) and elements of this formulation of practice are certainly still evident. This is a gross over-simplification of the complex and interdependent mental, physical, and social processes involved in the moment-by-moment negotiation of practice. However, to avoid throwing out the baby of theoretical certainty in the bathwater of practical indeterminacy, a formulation of practice needs to understand practice as an aspect of theory and theory as an aspect of practice. This could be helpful to clinicians and leaders who struggle to understand the difficulty of implementing new practice

derived from science in emergent practice patterns that require their own practical wisdom and judgment under conditions that are often indeterminate. I will pick up this theme in the concluding sections of this project. I want to turn now to another common formulation of practice, particularly in nursing, and that is to consider practice as a model.

Practice as a Model

Clinical practice is also described as a model of care or schematic to explain how things work. Practice models take key variables or elements such as structure, processes, purpose, and values, and explain the relationships between them (Hoffart and Woods, 1996; Wolf, 2007). Through defining these elements and the relations between them, models of practice are thought to serve as kind of navigational map for clinical processes and relationships, provide the basis for comparative analysis—for example whether one practice model is superior to another—define how people work together, and establish the basis for designing changes in evaluation of practice for over time (Leathard, 2003; Wolf, 2007).

Models of practice emerge from systems thinking and define processes and relationships among the elements or parts that interact over time to produce (or project) a bounded, coherent whole. Subsystems like communication, assessment, treatment planning, documentation, and discharge planning are said to exist inside the system and interact in predictable ways to produce the system as more than the sum of the parts. Time is thought to be linear from past to present to future, and causality is viewed in formative and/or rational terms—that is that managers can at one time stand outside the system to rationally plan it, and then step back in as a participant to lead the unfolding of the enfolded intentions (Stacey, 2007: 261-263).

Different kinds of healthcare teams (e.g., multidisciplinary, interdisciplinary, and transdisciplinary) are often taken to imply particular models of care (Barker et al., 2005; Curran, 2004). There is often an implied continuum between the conventions most commonly used; for example, the term multidisciplinary describes practices in which professions work cooperatively but in parallel, in contrast with IPC teams that collaborate to develop common goals and work together in ways that blur professional boundaries (McCallin, 2001). However the teams or practice models might be described, a team is still considered a system. For Stacey,

> *In systemic process thinking, practice means the system of routines, cultural traditions and so on that individuals use as tools in their practices or praxis. From the system view, experience is the formulation and testing of hypothesis about an objective world understood in terms of systems, where the system is outside of experience, a hidden reality or given categories such as mental models … and places thought before action.* (2007: 263-264)

Stacey (2007) interpreted the 'system' as a spatial and temporal abstraction from interactions between individuals. Statements of goals, mission, values, and rules of engagement are thought to be deterministic in that they precede and dictate what action occurs in a process that (in Stacey's view) falsely puts thought before action, which he argued paradoxically arise together (2007: 264).

In the previous section, I discussed the distinction made between theory and practice and suggested that one problem with this is the tendency to oversimplify practice—to see it as a simple deterministic extension of the scientific process. In this section, the points I want to emphasise are how models depict organisations as statements of culture that define vision, mission, and values; and structure that define relationships, policies, and processes, all of which are seen as deterministic. In other words, the designed model is what determines practice.

Most models define values, which I will explore as an exemplar of thinking of practice in terms of a model of care. Our organisation is a faith-based (Catholic) health system reputed (internally and externally) to 'live' the values it espouses. Recently, corporate values have been defined in terms of competencies and related behaviours. Interview questions are identified that can be used to identify prospective employees who 'fit' and performance appraisal mechanisms are developed to determine if employees are 'living' the values. This approach presents values as something a person has that the organisation can provide and that they are deterministic in human agency. While it is legitimate (and necessary) for managers to articulate values they believe the organisation should stand for, I find it questionable as to whether it is either possible or desirable to insist that employees adopt the values wholesale and show how they are living them.

Mead expressed the view that cult values (such as we find in corporate value statements) are *"useful only when they express a hopelessly ideal state"* (1923: 243). By cult values he meant collective idealisations that become functionalised in the interaction of the living present (Griffin, 2002: 116). Clearly, value statements that

embody what is possible, rather than what is ideal, would be ludicrous. For example, there are times when a choice between honesty and compassion or reasonableness would favour what could technically be seen as dishonest, even if only by omission, but a value statement suggesting "honesty unless something else would be better" would be absurd. Toulmin suggested that the *"abstract generalization of theoretical ethics is no substitute for a sound tradition in practical ethics"* and referred to what he perceived as a revival of absolutism as a *"tyranny of principles"* that *"evades all firm stands by suggesting that we [can] choose our 'value systems' as freely as we choose our clothes"* (1981: 31). The assertion of objectivity in ethics leads (problematically) to absolute moral principles that cannot be mediated by practical judgment in the context of particular real-life cases.

Mead argued that if we view human society as no different than the natural world, it would make sense that human agency is limited and cult values could be inculcated individually so that everyone would be 'good'—that is, people could be constrained to *"living by certain absolute … values housed and hallowed by institutions"* (1923: 246). On the other hand, if we understand society (as Mead did) as made up of social individuals with free will, values are not expressed in ideal, absolute, universal, terms and then 'lived'. Values emerge in lived, conflictual experience. Society *"gets ahead, not by fastening its vision upon a … distant goal, but by bringing about the … adjustment of itself to … [that which] the immediate problem demands"* (1923: 247). This is more congruent with what I experience each day at work. The articulation of corporate or team values emerge from valuable conversations that imagine an ideal world and we can usefully make agreements about how we would be together if there were no constraints. However, following Mead's view of agency, such statements are not and cannot be determinative and, in my view, should not be considered absolute or used to evaluate staff performance.

Even if we accept the possibility that a person could choose or be made to adopt the cult values of an organisation, the cult values are ideal and thus remain some distance from our lived reality. Attempts to coerce employees to live the corporate values would diminish human agency and prevent free agents from choosing behaviours that are fitting under the specific circumstances they find themselves in. Moreover, nothing leads faster to employee cynicism than occasions when leaders fail to live by the idealised values or fail to act decisively when others fail to (as they inevitably will). Some have even compared the coercion of employees

to internalise and live certain values to a totalitarian state (Alvesson and Willmott, 2002; Willmott, 1993).

Habermas (1984/2001; 1987) used the term 'lifeworld' to draw attention to the unproblematised background of our interdependent lives—the shared, but mostly tacit understandings and values—that develop through interdependent interactions and help us to live successfully together. Habermas argued that to make the lifeworld explicit is, in effect, to destroy it. He thought cult values form part of the lifeworld, but only if they remain unproblematised. He argued that influence and value-commitments could only be enacted in our relational living and which he thought the lifeworld would be 'colonised' if value-commitments are made a matter of institutional authority. Taken out of the private realm, the sense of oneself is lost, since everyday life would be purely rational and utilitarian. Shaw (2002) offered a similar interpretation, calling the behaviour that we expect from coercing employees to live the corporate values *"designed behavior"* in a misguided effort to control employee action (2002: 131). Coercing employees into aligning their values with those of the organisation and believe the aligned values will be determinative of 'right' action requires that we accept the totalitarian thrust. It also suggests a formative causality, in which values are enfolded into the organisation and then unfolded (or lived) through a carefully crafted plan. Furthermore, we must believe a rational actor can independently choose to align with and then live the corporate values (rationalist causality). All of these seem problematic to me.

I have focused on the issue of aligning individual and corporate values as an exemplar for understanding the limitation of thinking of practice as a model. Models, including the model of IPC, are usually defined by mission, vision, and value statements, as well as structure, rules of engagement, and policies and procedures that collectively represent an ideal state. I do not wish to imply this is bad or wrong—just that it is insufficient on its own to understand practice as it is lived and experienced by engaged actors, and to point out that models and representations alone no not direct practice. Models are abstracted from lived experience and can become reified—taken as if the model *is* practice. While models may be helpful as a way to conceptualise work they become problematic if we conflate the ideal conceptualisation with our lived reality in practice, since these ideals will not translate directly and universally to practice. Formative and rational causalities predominate, leaving the impression that practice is objective (evidence-based), logical (based on a

concrete model that relates parts of the system to each other), and rational (practice can be understood in theoretical terms and decisions made which lead to 'correct' practice). Failure to achieve the ideal state in systems theory is blamed on inadequate formulation of the systems and its subsystems, giving leaders a way to 'blame' the system, not the people (Senge, 1990/2006).

Systems thinking, dominant in healthcare, invites a relentless search for ultimate truth, blameless people, blameworthy systems, processes that can be mapped and then tweaked to gain safety and efficiency, and assumes that the natural sciences (mostly predicated on predictability and control) apply unproblematically to human social interactions (dynamic, uncertain, and unpredictable). The models, helpful as they are for thinking, do not help us to understand what is actually going on in our daily interactions in practice, since all are abstracted from the lived reality of practice.

A Reflective Pause

In the in-service presentation, I held IPC out as both a highly idealised and simplified model of practice that would, if we just do it 'right', improve patient outcomes, reduce errors, increase efficiency, improve staff satisfaction—quite literally, save the health system. I offered the seductive possibility that the 'right' way to achieve ideal patient outcomes and staff satisfaction could be known, planned, and implemented and implied a relatively conflict-free world where power is shared equally and discoverable right answers drive away conflict. Discussing IPC as this ideal experience that few would even recognise leaves little opportunity for discussion—and certainly did not invite reflection about everyday real-life experience. Participants felt excluded from the picture being presented and perhaps inadequate.

As I now reflect on the in-service and other similar talks that I have given, I can see that I am neither speaking from or to the experience of participants. It is very difficult for participants to engage with the idealisations I present. Audiences are polite, even inspired, but not really engaged. When I did note some of the challenges in the second part of the presentation, I noticed significant tension among the participants at that point. I wonder now if they already felt excluded from the ideal picture I had been presenting, and were then uncomfortable with the challenges, perhaps feeling them as blameworthy patterns of interaction that could and should be

avoided, rather than as natural and necessary phenomena in our experience of relating with one another. Struggle and harmony coexist. As I begin to formulate how my practice will develop, it seems it would be more helpful (and more reality congruent) to present practice as always involving struggle and conflict, harmony, and compassion at the same time. By first presenting the ideal state and then presenting the challenges, I set the ideal practice against the challenges and created the impression that disharmony and conflict can be driven out to make room for the ideal. This is far from the reality that I experience in my daily practice.

Before moving to explore how practice might be considered from the perspective of complex responsive processes of relating, I want to briefly explore one other way in which practice is often associated with tasks, seen as part of our professional identity.

Practice as Task-Related Competency

Professions have elaborate systems of education that include theory and apprenticeship; entry by examination; self-regulation, including definition of the 'exclusive' acts that only licensed members can legally perform; commitment to a professional code of ethics; and the admission to the study of the profession only those individuals the profession deems to have the right character and intellectual characteristics (Martimianakis et al., 2009). French sociologists Jamous and Peliolle (1970, cited in Traynor, 2009) described professional work as a combination of technical skill (technicality) and the formation of expert judgments that could only be made by individuals with personal qualities distinctive to that profession (indeterminacy). Indeterminacy is characterised by *"sloping frontiers"* rather than the *"sharp boundaries"* found in the determinate precision of positivism (Lubenow, 2002: 218). Lubenow said,

> *[Indeterminate frontiers] … refer to epistemic relations … [in which]we reopen and renegotiate … their meanings as we deploy new evidence, or … deploy old evidence in new ways … indeterminacy … [involves] oblique standards of conduct … [not] explicit rules of behavior … [and] from its own internal complexities, [produces] its own innovations.* (2002: 226)

Indeterminacy is about the tacit knowledge gained by professionals as they progress through training and gain the practical experience to know, for example, when not to apply the rules. Indeterminacy is invoked to explain why techniques that

seem possible for anyone to learn cannot simply be taught, since it is not possible to teach, only to know phronetically, when and how to apply the technique. Indeterminacy is challenged by patient-centred care, which includes a key (some argue equal) role for patients in decision-making about their health (thus threatening the power and pre-emptive knowledge of the professions); and evidence-based practice, which tends to establish the 'right' course of action based on generalised and static information derived from the scientific method and leaving less room for knowledge arising from indeterminate elements of practice (Traynor, 2009). Ironically, the evidence-based practice movement in nursing and allied health disciplines strengthens their perceived legitimacy as scientific disciplines, and at the same time threatens their position as practitioners skilled in decision making in the indeterminate milieu of unpredictable circumstances. Techniques and clinical pathways, cannot fully account for the complexity of professional judgment and interdependent relationships or the dynamic and unpredictable nature of the practice environment, including the physical 'environment' of the patient.

It is beyond the scope of this project to fully explore the relationship between practice and evidence-based practice, professionalism, or the concept of evidence, but these are complex questions relevant to emerging practice patterns. Paley (2006) argued that what counts as valid evidence is too narrowly defined and needs to take into account the 'patterns of knowing' that professionals use to make clinical judgments. In a seminal article on patterns of knowing in nursing practice Carper (1978) suggested empirical, aesthetic, personal, and ethical domains as distinct patterns of knowing and thought each needed to be considered in nursing practice. Drawing on Carper's taxonomy, Paley (2006) argued that evidence largely developed from statistical measurements (the empirical pattern of knowing) cannot be indiscriminately applied to particular patients, and it is here that the 'art' of practice (aesthetic, personal, and ethical knowing) gains ascendancy over evidence created by science in practice.

While I can understand the attraction of determining contexts in which each kind of knowing would apply, this suggests different and incompatible worlds, so that in one context (accurate measurement of fluid intake for example) nursing could legitimate practice in science, and in another (e.g., understanding the patient's experience) use a more hermeneutic approach. Clinicians rarely draw on intellectual traditions sequentially, but in the same moment draw on technicality *and* aesthetic,

personal, ethical, and political considerations. Any of these on their own provide an important but partial picture of practice that makes little sense abstracted from the interdependent interplay between them all.

Task-based descriptions of practice fail to account for the significant indeterminacy associated with professional practice. Attempts in IPC to differentiate between tasks that only a particular discipline can do, and tasks that can be done by more than one discipline are rarely helpful. Efforts to do so mask the significance of local interdependent conditions by seeking formulaic taxonomies that are then thought to drive practice.

Efforts to precisely define professional competencies may do more to reproduce conventional practice than ensure consistent standards (often the explicit intention of developing competencies and standards) or promote interprofessional work (Reeves, Scott, et al., 2009; Talbot, 2004). When we think about practice in terms of competencies, standards, or tasks we are abstracting these constructs from our lived experience, and as Mead (1923) suggested about cult values, they are ideal constructs that can only be functionalised in particular circumstances of practice. Barnett (1994) also suggested that competence, which he characterised as having both operational (technical) and academic (epistemological) components, is not sufficient to inform our thinking. Barnett offered a Habermasian view in which he suggested that what lies beyond competence, is 'lifeworld becoming', in which constructs such as reflective knowing, open definitions, dialogue, critique, and practical discourse compliment more competency-based thinking.

Narrative: Part 3

To this point in my presentation, I had suggested that 'practices' among the collaborating disciplines are unique and overlapping and that the 'boundaries' between professions are not clear and distinct, meaning that overlapping legislative and practical scopes of practice make it possible to more fully integrate day-to-day practice through collaboration. This thinking linked practice with application of theory, tasks, models, and competencies, which are grounded in rational and empirical intellectual traditions and in understanding skill, knowledge, and competence as individual traits.

By turning to ‘IPC 501’ in the in-service, I meant to imply that the information would be new, advanced, and provocative. I discussed the propositions that: IPC exists in contexts that are increasingly complex, specialised, and interdependent; conflict is inevitable and can be both destructive and transformative at the same time; interdependence puts power dynamics as a central concern; and IPC challenges professional and personal identity. I intended to acknowledge and normalise how complex and difficult IPC is and through that to invite the group to a deeper engagement with their own struggle. I sensed audience discomfort about these concepts and concluded that they were difficult and worthwhile topics to explore. These ideas were emerging for me through the DMan program as important to understanding practice as a complex responsive process of relating, and I will next explore the concept of practice from that perspective.

Practice as Complex Responsive Processes of Relating

As previously noted, practice is often used as a noun—as if a thing existing independently from its own enactment in the on-going interdependent interactions of the actors. The body of ideas that constitutes the complex responsive processes of relating theory eschews organisations as a ‘thing’, and argues instead that organisations inhere in patterns of on-going interaction between people (Stacey and Griffin, 2005).

> *Organizations are …processes of human relating … in …simultaneous cooperative-consensual and conflictual-competitive [patterns] … understood as acts of communication, relations of power, and the interplay between people’s choices arising in acts of evaluation.* (2005: 3)

This denies a determinative character for organisational mission, vision, values, hierarchy, and policies. Drawing on Mead, Stacey and Griffin (2005) argued that constructs such as purpose and values are only functionalised (i.e., meaning can only be adduced) through the patterns of relating that arise in on-going human relating. Moreover, since they are human processes, there are necessarily relations of power and choice arising in acts of valuation. While professional knowledge (including theory) models of practice and techniques exist and influence what practitioners do, they do not provide an adequate understanding of practice as a dynamic, social construct, and are not by themselves determinative.

Organisation (practice) emerges in the moment-by-moment interactions among actors in both stable and novel patterns at the same time. In other words, the emergence of something new and the continuation of what is familiar happen together through the process of human relating. The characterisation of an organisation as something that learns (Senge, 1990/2006) is anathema to proponents of complex responsive processes of relating, since that characterisation requires us to imagine the organisation as a system that is separate from the people who make it up and anthropomorphise it in a way that is simply not congruent with reality.

This sense of relating with others in unpredictable and emergent ways is congruent with how I have experienced practice notwithstanding that accumulated technical and scientific knowledge and experience contributes to the process of relating. Stacey and Griffin (2005), in effect, made no distinction between organisations and practice. We could say that organisations are practice experienced as complex processes of relating and that it is impossible to separate organisations from the micro-interactions of interdependent people as they engage in their daily work. This has profound implications for how we form and carry out intentions (ethics), who we are and how we recognise ourselves and each other (identity/ontology), how we make sense of our world and negotiate together in light of our inevitable differences and interdependence (knowledge/power), and how we understand time and causal relationships in the process of change. These are all crucial to understanding healthcare practice as processes of human relating in the provision of healthcare services.

Stacey and Griffin (2005) argued that an iterative, circular understanding of time provides a reality congruent explanatory framework for understanding human experience, including how practice (for example) changes. A rational positivist framework sees time as linear and presumes that reality is a trajectory from an unchangeable past through the present to a future than can be carefully planned. Drawing on the work of sociologist G.H. Mead, complex responsive processes of relating understands time as iterative and reality as existing only in the present moment. Mead wrote:

> *Reality exists in a present … [that] implies a past and a future, and to both these we deny existence … for that which has passed would not have ceased to exist, and that which is to exist would already be in that inclusive present … for that which marks a present is its becoming and its disappearing.* (1932: 1)

In this concept Mead argues that the past continues to exist in the present moment and it does not suddenly cease to exist or become fixed. At the same time, our action in the present moment anticipates a future state, and in this anticipated future, something novel could arise—hence the circularity of time. Of course not everything is novel. A degree of stability is critical to going on together and making sense of our world. When novelty does arise it may not be as we expected and could be better or worse. This is what Stacey and Griffin mean when they say that transformation is paradoxically predictable and uncertain at the same time (Stacey and Griffin, 2005). This conception of time is important to understanding transformative causality and how radically distinct it is from the formative and rationalist theories of causality referred to in earlier parts of this project. Transformative causality is unavoidable if we take seriously Mead's (1932) thought about the present moment.

Drawing on complexity science, Stacey and Griffin (2005) asserted that the potential for transformation in on-going human interaction arises from the capacity for spontaneous individual responses and the amplification of small differences in ways that repeat existing patterns of behaviour and amplify spontaneous changes in unpredictable ways. Those who have developed the theory of complex responsive processes of relating in organisational development and change reject the notion that the complexity sciences can be directly translated to human systems as some other complexity thinkers tend to (e.g., Olson and Eoyang, 2001; Zimmerman et al., 2001), who tend to emphasise that a small number of simple rules is all that is needed for a (predictably better) future to emerge. The key difference between natural systems and human interaction is that humans make evaluative choices. Accordingly, interactions have dimensions of identity, ethics, and power not present in physical or biological systems. Therefore, complex responsive processes of relating integrates complexity science with sociological inquiry into subjects such as mind, self, and society (following Mead, 1934); theories of values and reflexivity (e.g., Dewey, 1934; Joas, 2000); and theories of power and identity (e.g., Arendt, 1970; Bourdieu, 1977; Elias, 1998).

Stacey and Griffin made the unusual claim that the purpose of research in an organisation is

> *not to solve a problem or make an improvement in the organization, but to develop practitioner skills in paying attention to the complexity*

> *of local, micro-interactions [they are] engaged in, because it is in these [interactions] that wider organizational patterns emerge.* (2005: 24)

In paying attention to what is happening in these on-going interactions, the consultant participates in, observes, and interprets human action in groups, drawing attention to the importance of *on-going interaction and interpretation* as the mechanism of organisation change. For Stacey and Griffin, wider organisational patterns emerge in the moment-by-moment micro-interactions between actors, whether or not there is a blueprint. This does not happen in a system in which the consultant can stand outside of to design, observe, and manipulate, but within interactions the consultant is involved in as a participant.

Practice, then, is the

> *simultaneous cooperative-consensual and conflictual-competitive processes of human relating … understood as acts of communication, relations of power, and the interplay between people's choices arising in acts of evaluation.* (Stacey and Griffin, 2005: 3)

Emergence of new practice patterns is best understood through transformative causality and in the context of the philosophy of uncertainty, because what arises cannot be fully predicted or controlled and on-going interaction between actors is the vehicle for practice transformation. The experience, knowledge, and techniques that practitioners bring to these interactions will vary as will the purpose. Practices are emergent processes of human relating that is informed by and further informs experience, knowledge, policies, tools, and guidelines. Stacey and Griffin (2005) argued that in the context of organisational change new patterns of practice could only emerge through the continued interactions, which only lead to further interactions.

In the next section, I want to explore briefly the possibility that if practice is the continued interaction of actors, the indiscriminate application of empirical methods in practice may in fact collapse practice in a Habermasian sense. I do not mean to suggest that empirical methods have no place in understanding and informing practice. Rather, I mean to suggest that exclusive or indiscriminate use of methods grounded in rational positivist paradigms cannot adequately explain or express practice. If the complex, dynamic processes of human relating are the phenomena of interest through which practice evolves, strictly applying a rationalist scientific method alone will neither explain nor change practice and may explain why reliance

on methods such as Deming's "Plan-Do-Study-Act (PDSA) cycles often fail to achieve or sustain the anticipated benefits (Walton, 1986). While it would be possible to apply positivist methods to understand the outcome of practice, understanding and changing practice can only be adequately approached through also including a sociological framework such as complex responsive processes of relating. The process of a PDSA cycle, for example, requires that at various points that clinicians stop their clinical practice to attend to the scientism of the cycle, and at that point, they would be considering practice from a distance. This is what Stacey (2007) referred to as first order abstractions (in which observers seek general rules to explain how a system operates) and second-order abstraction (in which observers then seek to change how the system works). If we are interested in the phenomena associated with practice understood as a process of on-going human relating, using rationalist models to understand and change practice could collapse practice since how we think about practice becomes abstracted from practice and no longer makes sense out its self-referential context.

The Collapse of Practice

A long-standing hegemony of positivist science undergirds thinking among health professionals. While this tradition is strongest among physicians and scientists, nursing and allied health professionals have sought to gain legitimacy by subjecting their own theories and practice (and theory of practice) to 'scientific scrutiny'. It is the belief in objective truth, if/then causality, and one right way that drives positivist research whether in qualitative or quantitative methods. Critics of positivist science call into question whether facts are ever interpretation-free and theory-neutral, whether knowing (subjective) can be separated from the knowledge (objective) and whether there is a finite truth (Alvesson and Skoldberg, 2009). Qualitative traditions based on hermeneutic and phenomenological interpretations take into account the living experience of an actor, but do not take into account objective or internalised structures that might explain its own condition of possibility (Bourdieu, 1980/1990). Bourdieu suggested, *"Of all the oppositions that artificially divide social science, the most fundamental, and the most ruinous, is the one that is set up between subjectivism and objectivism"* (1980/1990: 25). Bourdieu insisted that the object of social science is not the individuals but what he calls the 'field'. *"To think in terms of field is to* ***think relationally****"* (Bourdieu and Wacquant, 1992: 96, original emphasis). In other

words, to think about individuals one must include the network or configuration with multiple dimensions such as the distribution of power (1992: 96-97).

To explore further the possibility that positivist science applied in a social context might collapse the phenomenon of interest, I want to comment on a paper by Landerfeld (2003). Landerfeld, a geriatrician at the University of California, reviewed the 'evidence' of sustained benefit in three approaches to managing care for older adults in hospitals. These commonly used approaches are known as ACE units, Geriatric Evaluation and Management units, and the Elder Life Program, all of which Landerfeld referred to as *"microsystems of care"* (2003: 422). Landerfeld found that *"efforts to demonstrate the efficacy [of these programs] are remarkable for their paucity"* (2003: 422). In some cases, initial improvement in measures such as cost, functional outcome, and patient satisfaction were seen, but he was surprised that the studies did not demonstrate sustainable effects. Since these clinical programs offer care that is specifically designed for the unique needs older adults, one would expect such care to be more beneficial.

If practice is the emerging patterns of interaction between practitioners, it seems likely to me that developing specific models of care (like an ACE unit model) *and* subjecting them to RCTs might be less successful than anticipated since the very essence of practice (emerging patterns of stable and novel interactions) is lost in the superimposition of a controlled scientific experiment onto a social process. The more tightly the process of human interaction is controlled, the more difficult it is to sustain practice. Practice, in effect, becomes mechanical—the stable and predictable application of theory and technique and cannot take into account indeterminacy, phronesis, or emergence, and renders irrelevant the relational context of care provider relationships with the patient and each other. It is possible that ideas that seem so good and sensible (like those of an ACE unit) do not achieve the desired result, not because the ideas are faulty, or even that they do not in fact achieve what they set out to, but that how we study them—especially with the rigor of the RCT—simply collapses practice which cannot function in the interactional forms that the research method calls for. Similarly, a highly structured plan to integrate evidence into practice relieves the practitioner of the need to think and ignores the primacy of the social dimension of knowledge. I am exploring here more than just a disconnection between positivist science and social science—I am exploring the possibility that practice actually collapses and can continue only individualistically and only with a profound

loss of the necessary human freedom to act responsively into circumstances as we find them (Niebuhr, 1963).

In my experience, when large projects are implemented through a carefully orchestrated strategy, staff often seem to 'grin and bear it' or to 'wait it out' and do the best they can to carry on until the initiative is over and they can 'get back to normal'. If even change has been adopted, there seems to be a sense of relief when the project is over and staff sense a return to 'normal'. I wonder whether highly structured changes to practice, including the formal application of PDSA cycles and the involvement of RCT methods to the 'helplessly' social process of practice actually damages practice. The tightly controlled research protocols of RCT studies would reduce the complexity of human relating more than PDSA cycles would, which by their nature preserve a degree of interaction and emergence not typical of RCT trials. PDSA cycles can be a potentially powerful change strategy if we do not take too seriously their claim to be based on a strictly scientific method, and if we are creative, rather than prescriptive, in how these cycles are documented. Change as a relational, emergent process can be supported by PDSA cycles and even formal planning, but and plans should at best be held loosely and changed frequently.

The Narrative – A Final Reflexive Turn

Although this in-service was a brief, one-time event, I provided little opportunity for participants to engage with me or each other except to ask questions for clarification. There was one brief discussion about the concept of power—during which participants expressed their discomfort with and denial that power had any real effect in their day-to-day relationships. Participants pointed to amicable relationships in which differences were misunderstandings mostly resolved through respectful discussion. One person stayed behind after my presentation. She presented a different view of team relationships and discussed concerns she had that various members of her team were stuck in what she described as unhelpful habits of interaction that involved blaming, shaming, and denial of personal responsibility. She was worried that the ACE unit team was a team in name only and that everyone just hunkered down and did their own work with limited communication and less collaboration.

Reflecting on this session, I recall feeling that there was very little engagement by most in attendance with what I was presenting or with each other. As people arrived there was very little conversation—no sense of a team that knew each

other well and enjoyed being together. They were not overtly hostile, but a sense of camaraderie, as one might expect with a team that worked together closely, was lacking. Many seemed distracted and were perhaps attending more out of obligation than interest. There was almost no engagement with the experience of the team. While I had prepared my remarks using a power point presentation format, I did not use a projected version. Instead, I provided copies of the presentation and sat with participants in a circle. My intent was to not follow the slides in a formal way, but to use them to guide discussion, but I became oddly shy when participants did not engage in conversation as they gathered, and in response I resorted to a more traditional presentation.

I presented an idealised picture of a systems-based notion of IPC that they may have felt they 'should' be able to achieve and an abstract, non-contextual description of challenges. Nothing about this invited the team into a meaningful dialogue about their practice or experience. The presentation was impenetrable, that is, it would have been very difficult for those who wanted to raise their own concerns or express another point of view to do so, since I presented a coherent and complete treatise, backed by literature to be taken 'as if' a finite truth. On further reflection, I see that my turn toward the more familiar format for presenting an in-service was a mechanism to reduce my own anxiety about how the team had gathered, and how they engaged with each other and with me. A more reflexive approach that included sharing my observations and sense-making about how participants gathered would likely have changed the whole texture of the meeting and would at least have invited a conversation that sought to understand the meaning of their own experience.

Reflective practices in organisational research and consulting assume that observers cannot reliably articulate observation of the social context of which they are a part (Alvesson et al., 2008). With the cautionary note that there is no point completely outside the context studied from which a consultant could observe and report objective findings, reflexive consulting practices could provide one type of textual information to participants that it would be difficult for them to see themselves. Moreover, knowledge and learning are social and cultural phenomena, and in practice-based theories about learning it is assumed that

> *knowing precedes knowledge, both logically and chronologically … [where] the latter is … an institutionalized version of the former … acquired through some form of participation … continually*

> *reproduced and negotiated; that is, it is always dynamic and provisional.* (Nicolini et al., 2003: 3)

The specific concerns and experience of this team were ignored and there was no opportunity for reflection by the team about their own experience. I also remained silent. As a result, my own experience was also not shared; we were left with descriptive images of ideals and challenges that may have been congruent with people's experience, but may equally have been irrelevant and forgettable.

If I take seriously that my own practice as an internal consultant, and that of teams I work with, is understood best as a dynamic process of human relating, then one implication for my practice is that I need to be cautious of presentations and be at ease with more unstructured, dialogical processes that engage with the wisdom and experience of clients, and also my own experience. I now argue that practice is a participatory, relational phenomenon and while my experience and interpretation of it is informed in part by knowing relevant literature, my engagement with clients must remain sensitive and open to the experience of those clients. Knowledge will at times support, inform, modify, or affirm the knowing of those whose practice and environments I am entering into as a 'temporary resident' in longer term consulting arrangements, or as a visitor in short-term arrangements such as the in-service that I have been reflecting on in this project.

I am expected to develop practical tools that teams can use to become more interprofessional and collaborative in their local practices. Stacey described tools and techniques as generalised and idealised abstractions. While tools and techniques can at times be useful for exercising limited control, they can also be a rational cover for the less orderly interaction of ordinary politics in everyday life (2010: 229). Armed with rational tools and techniques managers may miss, as I did, opportunities to *"provoke and evoke richer, more complex forms of conversation that become immanently practical from the perspective of complex responsive processes"* (2010: 229). The trend to rational idealism expressed for example in the evidence-based practice movement is pervasive in healthcare and it is tempting to polarise rational and reflexive stances, but this is not necessary. Humans relate in a robust, multifaceted, complex reality that contains but does not resolve the paradox of rationalist and reflexive processes occurring at the same time. Stacey suggested that the role of the consultant

> *becomes one of participating in the local interactions of organizational life with the purpose of aiding the development of more fluid conversation in which the potential for both continuity and change emerge.* (2010: 220)

Transition to Project 3

This project marks a significant shift in my thinking in two critical areas. First, I am more concerned about understanding practice as constantly emerging in the on-going interaction among actors than I am about promoting a particular kind of practice. That said, modern healthcare practices inevitably involve interactions between multiple disciplines, and the literature on IPC continues to be helpful to understanding practice in the context of these complex communities. Reflecting on the social construction of knowledge in practice and how healthcare organisations make use of rationalist knowledge and generate new knowledge and new patterns of practice through taking seriously the micro-interactions of everyday practice will add a dimension to thinking about collaboration in practice that is currently under-represented. Here I will look to authors such as (Bourdieu, 1980/1990; Flyvbjerg, 2001; Nicolini et al., 2003; Toulmin, 1976; and Van Manen, 1999), in addition to further inquiry into complex responsive processes of relating.

The second and related critical shift is seeing my own practice as situated in and needing to be relevant to a healthcare environment that holds tightly to rational idealism. This is not wrong—it is too simplistic in a complex environment for which efficient, rational, and formative causality provide an incomplete explanatory model for change. Too often, even seasoned managers are unable to participate in complex conversations and reflexive practice and attempt to control rather than understand and interpret the phenomena. It is rare for managers to stay engaged with questions and more common to rush to answers. Staying engaged with questions may seem frivolous and ‘soft’, but it is in open conversational space and diversity that new practice patterns are likely to emerge.

PROJECT 3: "YOU DID WHAT?" AN EXPLORATION OF POWER AND KNOWLEDGE AT WORK

Introduction

In Project 1 I explored how my thinking developed about leadership and how organisations change in the context of publically funded academic healthcare organisations. I explored my experience and the literature that informed it at various stages of my practice. Project 2 explored my primary interest in how professionals representing different disciplines work together collaboratively, a practice commonly referred to as Interprofessional Collaborative Practice or IPC. While I expected to explore 'interprofessional' and 'collaboration' as concepts, this shifted to 'practice', as the concept more likely to be taken for granted by healthcare providers. Thus, practice became the focus of Project 2. I examined some traditional views of practice (e.g., as the application of theory, as a model, or as skills and techniques) and concluded that these descriptions reified practice, rendering a fundamentally social process flat and lifeless. Instead I proposed, following the work of Stacey and Griffin, that practice could be understood as,

> *Processes of human relating … in …simultaneous cooperative-consensual and conflictual-competitive [patterns] … understood as acts of communication, relations of power, and the interplay between people's choices arising in acts of evaluation*. (2005: 3)

Stacey and Griffin (2005) were not in fact proposing a theory practice, but a theory of action or agency. Nevertheless, their description provided a resonant starting point for me to begin to understand practice as temporal, active, embodied, and immediate—a complex and emergent social phenomenon. In day-to-day interaction people necessarily negotiate and make choices within the on-going paradoxical presence of cooperation/consensus and conflict/competition, and do so through acts of communication. However, it would be a mistake to co-opt a theory of agency/action as if it were equally a theory of practice. In this project, I want to deepen my exploration of practice through an account of some challenging interactions I have recently had with my Director, Margaret. I have taken on a role that is new to me and to the organisation titled PC for Interprofessional Practice, Education, and Research. Margaret and I continue to negotiate how this new role will emerge and what it actually means to be a PC: What should I do and resist doing? At

the heart of our discussion lie the questions of what is practice and how the practices of the point of care staff and the PCs are related.

Background to the Narrative

Recently, our Nursing Practice Office was reorganised; one reason was the recognition by healthcare leaders (including nursing) of the need to provide explicit support for the emergence of IPC. Six new or reconfigured PC positions were added, one of which is the position that I hold. I report to Margaret, the Director of Practice Education and Research. I am the only non-nurse.

Each of the PC positions has a particular focus; the explicitly understood focus of my consultancy is to help the organisation develop collaborative clinical practices that take advantage of having diverse disciplines who work together in clinical teams. The complexity of individual and population health issues and increasing specialisation and differentiation among healthcare providers are cited as reasons why IPC is considered to be so important (Curran, 2004; D'Amour and Oandasan, 2005). While health and healthcare systems are complex and it makes sense that it would be better, not worse, if members of different health professionals worked and collaborated well together, emphasis on the terms 'interprofessional' and 'collaborative' has resulted in a glossing over of the question of practice itself. What is happening when individuals 'practice' together and how are teams to be supported by positions such as the one I hold? The tendency is to reify a particular ideal of IPC 'done right' (as I have often done) and then evaluate 'live' practice against this idealised notion. In the following narrative, I recount aspects of how my Director (Margaret) and I began to understand and negotiate my new role as a PC. Two key themes emerged: power, which I will explore with primary emphasis on the work of Foucault; and the associated theme of knowledge and the relation between power and knowledge. Throughout this project, I will continue to build an understanding of practice as the overarching animating theme of my research and before concluding I will again explore practice and action.

Narrative: Initiating a New Role

First Impressions

Early in the development of the new Practice Office, a discussion about the disbursement of some funds that were available to support nursing education created some discomfort in the group since these funds were only for nurses. I felt the need to reassure everyone that I understood and supported the decisions that were being made. However, I also took the opportunity suggest that we might begin to think of continuing professional education differently so that individual professionals would be accountable for their own discipline-specific continuing education and corporate funds would be made available only to support engagement with educational programs that had some element of interprofessional education.

A very brief and uncomfortable silence followed, broken by Margaret issuing a very clear and firm one-word response, "No!" Her response was met with another silence, into which I finally said, "Of course we would never do that in one step or rigidly". I offered a quick and humorous apology for "causing trouble so soon", but added that other health authorities were developing these kinds of policies. Margaret reaffirmed quickly and without humour, "It is not going to happen here". She was not challenged by anyone (including me), and the previous conversation continued. This early exchange signals the first theme of this project: a consideration of relations of power.

Tethered

Over the next weeks, my conversations with Margaret led me to believe that she viewed 'evidence', 'practice', and the role of the PC differently than I did, and that she intended to enforce her view. One day, she asked me to meet with a Program Director (PD) to discuss problems with how the teams in that program were functioning, and though she had little information about the problem, thought I could help with 'interprofessional'. I met with the PD and together we devised the beginning of a plan to understand the issues more thoroughly and discuss potential approaches. There were significant concerns regarding relationships among all staff and about the quality of nursing and medical care in particular. I felt it would be helpful to have one of the other PCs on the project and approached the individual I thought would be most appropriate. The PD asked that I consider working with an

internal physician consultant whom she had found helpful previously, so I also met with him to discuss the possibility of working together. Finally, I discussed the issues with an operations leader in the area.

I felt it would take a team to assist this group, so was pleased with getting positive responses from the people I had already contacted. In a regular meeting with Margaret, I provided an overview of the meetings I had held. Margaret was clearly alarmed and incredulously asked, "You did what"? She felt my actions were more operational than practice-related and believed that involving the other PC and the physician was unwarranted. While these people might have roles to play at various points, for Margaret, the roles were very distinct and she felt it would be wasteful for us all to work together. I saw significant overlap and the idea of working sequentially was anathema to the very idea of collaboration. Margaret and I acknowledged our disagreement, I agreed to 'back off', and we agreed to stay in conversation. The essence of this scenario arose several times in different contexts.

I felt like I was tethered to a bungee cord—I would start an assigned project and she would pull me back. In our discussions Margaret indicated repeatedly what she expected was that I would define clinical tasks and best practice based on evidence, create short-term contacts with clinical programs, primarily for the purpose of laying out best practice, and that operations and clinical leaders to enforce practice as it was defined. She felt that attending to relationships (particularly conflicted relationships) was beyond our scope and belonged with those who had specific training in psychology. Their work would precede ours. I argued it was neither possible nor desirable to simply identify professional tasks, tell everyone what they 'should' be doing, and expect someone else to make it happen. Moreover, I felt that I could not know independently what 'best practice' was for any given area, and I viewed relationships and communicative interaction among team members as a central concern both in team-based practice and services we offered from the Practice Office.

I felt frustrated and curious about the tension between us. Nearly everything about how Margaret viewed my work felt wrong or at least incomplete: the idea that I could define best practice, practice could be universally applied, the near complete separation between thinking (developing evidence-bases standards) and doing (applying those standards), and that consultants should not work together but should define separate reasons for their involvement and work in sequence, all these felt

worlds apart from my own ideology and sense of practice. From this sense arises the second (and related) theme of this project—exploring knowledge and knowing in the context of practice.

Reflexive Pause

Initial Reflection

The situation was new to all of us. What had been the *Nursing* Practice Office was now the *Practice* Office, with a broader mandate and six experienced staff in new PC roles. As the only non-nurse, my presence introduced an element of diversity that, while welcome, also raised a degree of reflexivity about practices that were taken for granted and that was at times uncomfortable for all of us. Prior to joining the Practice Office, I was an operations and site leader with over 200 direct reports and accountability for everything that went on in two stand-alone facilities—from light bulbs and parking lots, to care delivery and relationships between staff and with patients and families. I was used to a high degree of independence and was well received as a leader. It seemed that in this new role I would have considerably less independence and felt uncertain that I wanted to work in the framework was being imposed by Margaret. Certain conversations had been rapidly silenced and the assent to that silencing by the group felt stifling.

The first theme I want to explore is power, which I will turn to next, emphasising the philosophy of Michel Foucault. Foucault is a scholar in the humanities, often associated with poststructuralist and postmodern philosophies—but labels that he himself rejected. Foucault classified his thought as a critical history of modernity rooted initially in Kant and later in Nietzsche. Foucault published a retrospective of his work that was later used as the article for the entry 'Foucault' in Huisman's (1984) *Dictionnaire des Philosophes*. In it, Foucault said this regarding his interest in power:

> *It is a matter not of examining "power" with regards to its origin, its principles, or its legitimate limits, but of studying the methods and techniques used in different institutional contexts to act upon the behavior of individuals taken separately or in a group, so as to shape, direct, modify their way of conducting themselves.… These power relations characterize the manner in which [people] are "governed" by one another.* (1984: 942-944)

Thinking about Power

Introduction

In Project 2, I proposed (following Stacey and Griffin, 2005) that practice could be understood as,

> *Processes of human relating … in …simultaneous cooperative-consensual and conflictual-competitive [patterns] … understood as acts of communication, relations of power, and the interplay between people's choices arising in acts of evaluation*. (2005: 3)

Notwithstanding that Stacey and Griffin did not intend this definition as a theory of practice, they put clear emphasis on processes of relating, stressing their necessarily consensual and conflictual nature through relations of power. I will first briefly explore how power tends to be characterised in the dominant discourse about IPC. I will then take up power presenting the views of French philosopher Michel Foucault, who defined power as *"a way in which certain actions may structure the field of other possible actions"* (1982: 791), and finally, offer brief commentary on Elias's views.

Power as Conceived in the IPC Discourse

My relationship with Margaret can be thought of as a fractal of interprofessional relationships in clinical practice, so it makes sense to consider first how authors who discuss IPC take power into account. Orchard et al. (2005) are considered leading researchers in this field. In identifying the culture necessary to support IPC, they cited power relationships as a key barrier to effective IPC and identify power imbalance as an issue of concern. Some members of the team have little ability to influence decisions compared to others. They attribute this to professional socialisation that impairs shared decision making and leads to frustration for everyone. Orchard et al. (2005) suggested a four-stage change process (sensitisation, exploration, intervention, and evaluation) to transform this inequality so that everyone has an equal chance to influence decisions. Through this process, team members clarify their own and each other's roles, learn to value everyone's input, develop trusting relationships, and become willing to share power. Others make similar points (e.g., Abdel-Halim, 1983; Gummer, 1994; Heller, 1998; and Krackhardt, 1990), but what is of interest is that power is not explored conceptually, so it is impossible to discern how they are thinking about power. The implication seems to be that power is a 'thing', a possession, held by an individual who can then

choose to influence situations in ways that limit others' ability to have influence. The solution to the 'problem' of power is for those who have 'more' to voluntarily limit their influence and for those who have 'less' to use what they have to the fullest extent possible, thus balancing power equally. This formulation of power as a quantifiable possession earned through professional socialisation and then voluntarily shared in the interests of equality seems to me naïve and incomplete.

The authors cited above have a largely logical positivist orientation, even though they are sympathetic toward a social view of human relating. I want, therefore, to also briefly introduce how authors who are interested in IPC but are oriented more toward a complexity view consider power. The literature exploring complexity is, of course, not homogeneous, so I want to point to some intriguing differences in how power is considered among authors, again focusing only on those in a healthcare context. For some (Plsek and Greenlaugh, 2001; Holden, 2005; Paley, 2007), the concept of power all but disappears. It is as though concepts associated with complex adaptive systems such as the property of emergence, the few simple rules, and sensitivity to initial conditions so diminish the influence of power that, at least in the articles cited above, power is not mentioned. Cooper et al. (2004) wrote specifically in the context of interprofessional education and appeared poised to offer a complexity view of power since in their introduction they referred very explicitly to the 'problem of power'. They articulated four principles of complex adaptive systems (self-organisation, paradox, emergence, and edge of chaos) and showed how these apply to interprofessional education, but beyond the introduction said nothing about the influence on the power dynamics that they positioned as so problematic in their introduction. Kernick (2004) drew substantially on the works of Stacey and Griffin in his edited book *Complexity and Healthcare Organizations: A View From The Street.* Kernick articulated a view of power as *"the constraint that excludes some communicative actions and includes others",* but this is immediately followed by the features of emergent decision-making which, among other things, calls for *"reducing professional hegemony and power differentials"* (2004: 138), thus negating the communicative acts from which he claimed future actions would be constrained and enabled.

The nursing and feminist literature has significant depth in exploring concepts of power and influence, clinical processes, knowledge, and identity from a

Foucaldian perspective. Rather than summarise that literature, I will turn instead to explore Foucault more directly.

Power and Foucault

Foucault's project was to disrupt ideas emanating from the humanist movement relating to power. When Foucault discussed humanism, he was generally referring to conceptions about what human beings are by nature proposed in the Enlightenment period (Pickett, 1996: 452). Following Nietzsche (and contrary to the humanist view that humans have a 'true' self), Foucault considered human nature contingent and arising from continuing social practices within a particular context and time. Foucault was particularly concerned about how humanist thought interpreted power: *"Humanism is everything in Western civilization that restricts … [or] … prohibits the desire for power"* (1980: 220). Foucault wanted to disrupt the categories and central concepts of humanism that considered power as situated in an individual, unidirectional, hierarchical, negative, and generally oppressive—even inherently evil (St. Pierre, 2000, as cited in Davies et al., 2002). Power in the humanist tradition is *"a force that challenges the natural and political liberty of the individual"* (Pickett, 1996: 589); as one's agency increased so did one's power and the potential to abuse it. Foucault interpreted humanism as saying that only those who keep their distance from power could discover or know truth and that truth could, therefore, only be found in power-free (and therefore uncorrupted) 'zones' (Foucault, 1980: 51). Foucault rejected these assertions outright. Interestingly, current notions in healthcare associate truth as arising in the context of 'evidence-based' practice, in which positivist science is the 'zone' uncorrupted by power. As I discussed in Project 2, critical theorists such as Alvesson and Skoldberg (2009) stand with Foucault to argue it is impossible for knowledge or truth to arise in value-neutral, power-free contexts, since 'objective truth' is always at the outset shaped by power- and value-laden decisions about issues such as what phenomenon is worthy to be studied and how it is to be studied.

Foucault shifted away from a humanistic view of power in several ways (Davies et al., 2002). Foucault argued that power has no essence—it is not a thing or attribute that exists and can be held by some and not others. Instead, he argued that power is a motion or an action. Foucault explained, *"Power is … a way in which certain actions modify others … which is to say that something called Power does not*

exist … Power exists only when it is put into action" (1982: 788). This explains Foucault's emphasis on 'relations of power' that arise in action between people in which one person structures the range of possible responses of another. This idea of action-limiting response is different than Mead's (1934) notion of the social construction of mind, self, and society, in which Mead suggested that global patterns that we think of as society or culture arise through and further inform the inescapable interdependence of human interaction. Foucault argued that relations of power structure the range of possible responses, which Mead saw as more emergent in the co-constructed meaning between actors in continued interaction. Foucault considered human nature as contingent and arising from continuing social practices within a particular context and time, suggesting a kind of separation of individual and social with the social being deterministic, assertions Mead would disagree with.

Foucault did not deny that the effects of relations of power could be in some circumstances perceived as 'bad' (i.e., constraining desired or promoting undesired actions), but he did not believe that power was inherently evil or corrupt, as the humanists did. Foucault argued that power relations could well be enacted as a positive force.

> *What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse.* (Foucault, 1982: 119)

This provides an important clue about how Foucault saw the relation between power and knowledge, which I will address later. Foucault distinguished power, which he argued can only be exercised in conditions in which interlocutors had at least some measure of freedom to resist the action upon further action, from violence in which resistance is either not possible or the choice to resist would exact such a high cost that the choice to resist is not realistic. *"The relationship between power and freedom's refusal to submit cannot … be separated… slavery is not a power relationship"* (1982: 790). Arendt made a similar point when she said, *"Under the conditions of human life … violence can destroy power … [but] it can never substitute for it"* (1958/1998: 202). For Foucault and Arendt, the exercise of power can only happen between free agents in the process of their interacting.

Foucault also rejected the humanist view that knowledge is absolute, pure, and not subject to influences of power. To his amusement, Foucault's use of 'power/knowledge' led some scholars to believe he saw these terms as coterminous:

> ***When I read—and I know it has been attributed to me—the thesis 'knowledge is power' or 'power is knowledge,' I begin to laugh, since studying their*** *relation* ***is precisely my problem. If they were identical, I would not have to study them.*** (Foucault, 1983, cited by Keenan, 1987: 210, original emphasis)

Foucault believed that power presupposes knowledge and, at the same time and through the same processes, also actualises knowledge (Davies et al., 2002: 298). Early in Foucault's career, he studied psychopathology and experimented extensively with common psychoanalytic tools (e.g., the Rorschach)—his interest was in knowledge in the context of human sciences, *"which pertained to psychological theories of human behaviour, capacity, and normative functioning"* (Alcoff, 2005: 211). Alcoff noted that Foucault was not widely quoted in the philosophy of science literature and thought this was because he shifted his focus from natural to human sciences. Alcoff thought Foucault tended to be anti-rationalist because he wrote so extensively about power—in particular about the relationship between power and knowledge—since that relationship denied by rationalist science. My reading of Foucault does not support that. The contexts for Foucault's work were social (e.g., prisons, mental institutions, and hospitals). Foucault referred to these bodies of knowledge as disciplines and considered how disciplinary knowledge was developed through relations of power, and at the same time, how disciplinary knowledge shaped relations of power. (Here Foucault is closer to a Meadian idea of paradoxically 'forming and being formed by' in a continuing dialectical process.) Foucault considered, for example, the issue of madness and how the perception of madness reflected the

> *intelligibility within discursive relations at a given time… consecutively rendering the mad as excessive (grouped with drunkards, debauchers, etc), as the unfortunate (grouped with the poor and the homeless), and as the sick (grouped apart from all others so that a specific kind of "cure" can be administered.* (1983: 214)

Thus Foucault's project took a significant step away from the notion of objective, value-neutral knowledge, and instead, directly related power and knowledge.

Finally, Foucault challenged the humanist notion that the interests of a just and democratic society are served by reducing or eliminating power (Davies et al.,

2002). Foucault's project was not to reduce or equalise power, but to understand the rationalities that make any particular power relation seem reasonable or inevitable. For example, the power relations between men and women more often constrain the actions of women. In the context of a particular place and time, Foucault studied the rationality that would make this particular power relation seem reasonable or inevitable and thus seem to fit within the ideal of a just and democratic society. Foucault deliberately suspended the problem of legitimacy, which enabled him to look at power in a way that brought new light to modernity (Fraser, 1981).

This discussion has so far focused on some of the key features of Foucault's thinking about power that distinguish it from the notions of power proffered by humanism. I want to turn now to the question of interpretation—how does this discussion help to make sense of what was happening between Margaret and me as we negotiated my new role in the Practice Office?

Reflexive Pause II

Making Sense of my Experience

Foucault asserted that at *"the very heart of the power relationship, and constantly provoking it, are the recalcitrance of the will and the intransigence of freedom"* (1982: 790). In other words, power (reciprocal incitation) and the freedom to resist (mutual struggle) act together in human relating. Foucault suggested the neologism 'agonism' to describe relations of power that are *"less of a face-to-face confrontation which paralyzes both sides, than a permanent provocation"* (1982: 790). Mouffe (2005) used the term agonism as well and distinguished antagonistic relations (between enemies who hold irreconcilable views) from those in agonistic relationships (in which there is no rational solution to differences and conflicted parties recognise the legitimacy of their opponents). This is very similar to Foucault's permanent provocation but more clearly identifies the possibility of mutual respect and recognition within on-going conflict. In suggesting that *"the exercise of power is … elaborated, transformed, organized … [endowing] itself with processes which are more or less adjusted to the situation"* (Foucault, 1982: 792), Foucault offered the view that relations of power emerge in particular contexts and shape the rules of the game in which the on-going participation of the actors elaborate and transform the

context. Thus context and relations of power arise in and form one another. Following Mead and Elias, Stacey (2005; 2010) offered a similar view.

To consider the system of differentiation in which Margaret and I act upon the actions of the other, I want first to restate that for Foucault, participants in relations of power mutually act upon each other's actions in ways that enable some and constrain other possible responses. As noted previously, this is quite different to Mead's understanding, which sees agency not as issuing from one person to another, but arising in the context of their on-going relations. Margaret and I each act to constrain one another—if this were not so, power would be situated in one person or the other, not in the relationship, and this is precisely the view of power that Foucault disputed. Healthcare, including nursing, is deeply rooted in hierarchical relationships and the differentiation between Margaret as 'boss' and me as 'subordinate' implies that Margaret can legitimately shape my role and how my work will proceed. The degree to which she exercised this right was unexpected and aroused strong resistance in me, which (and this is critical) I was free to offer. However, while I explicitly invited continued discussion about our differences, at times I distanced myself from her in ways that precluded the very conversation I had invited. For example, I withdrew from engagement with several projects in which she and I disagreed about what my legitimate role was (rather than adapting my role to her expectations), and at times I worked from home. After nearly eight frustrating months without reaching agreement about what I should be doing, I began to discreetly expose our differences to others. In doing so, I sought to legitimise and recruit others to my view of the situation and provide a context for my colleagues about why progress in my portfolio was limited. It was also a potentially destructive act.

Following Foucault's assertion that power is enacted in systems of differentiation that enable one person to act upon the actions of another, my effort to invite others into the game would only have invited the enactment of further relations of power, without necessarily adding weight to my own ability to be more influential in my relationship with Margaret. Margaret's ability to influence actions available to me will always include her differentiated position as 'boss' in a hierarchical organisation. However, her power was in no way absolute. It was limited, for example, by our organisation's explicit committed to democratic and egalitarian ideals. My differentiated opportunity to influence Margaret's actions lay in the organisational interest in promoting IPC and my positive reputation within the

organisation. This limited Margaret's ability to act as she might have wanted to in her frustration with the fact that I disagreed with her and refused to simply 'see things her way'. Times when I avoided the conflict by withdrawing from projects and working from home simply left both of us impotent.

Margaret had been part of the Practice Office for a number of years, and understood the history and tradition of what was considered legitimate activity and what was avoided in terms of its role, scope, and function. Among the historically legitimatised roles of this office was the identification of 'best practice' based on evidence. Among the activities excluded from the scope of the office was responsibility for overseeing the implementation and sustainment of the defined best practice at the point of care. Margaret's objection to my involvement of other internal consultants in one project reflected her longstanding concern with the efficient use of the limited resources of the office. In addition, the roles of the six PCs, those who worked with teams experiencing interpersonal conflict (psychologists working in another department – the Centre for Practitioner Renewal) and those responsible for supporting organisational change (Change Initiatives Team) were very clear and distinct for Margaret. For me, there was significant overlap. Margaret argued that I was not qualified to work with teams in distress or if I was qualified, it was not my job. I argued that conflict is experienced by all teams, and that a PC needed to be qualified, willing, and able to work in difficult circumstances *and* know when to refer specific situations to others with different qualifications. I did not believe that I could, independently and far from the bedside, determine what evidence-based best practice might be and package it in a way that operations leaders could unproblematically implement. These disparate objectives for my work were in important ways irreconcilable. For Margaret, the goal for my work was to develop a quick, pre-planned, knowledge-driven consulting intervention that would provide clear direction for the local leaders. My goals were to establish on-going relationships with leaders and staff, to determine with them what solutions might best fit their needs, and remain involved as a participant in refining initial ideas. Since I could not foresee future workload, I had no answer for Margaret's concern that I would soon find myself gridlocked if I worked the way I was suggesting. Significant differences in our understanding of constructs such as 'evidence', 'best practice', and 'knowledge' in general were emerging.

So far, I have considered how our relative positions in the organisational hierarchy influenced the ways each of us had to influence the actions of the other, how our objectives were at odds and how our worldviews were largely irreconcilable, Margaret's grounded in certainty (that science can develop right answers that are more or less true for most circumstances); mine grounded in uncertainty (that truth and knowledge are political, partial, contingent, and evolving and that practitioners need to be guided by epistemic knowledge but rely on phronetic knowledge). Margaret's views about 'how the Practice Office works', what weight the 'evidence' should be accorded, and what is to be done with the evidence (i.e., it is to be 'translated' into 'best' practice) were all problematic for me. To stress a point that Foucault underscored about relations of power, my resistance could only happen because we were both free to choose how we would continue to act in this situation. For months, we remained in this lunge and parry, enabling and constraining each other, at times finding common ground, other times frustrated by oppositional views.

Foucault (1980; 1982) argued that the means used to bring power relations into being is an important consideration. In this, Foucault was being somewhat self-contradictory, since, like Elias, he claimed that relations of power were an inherent aspect of human relating and, therefore, always present. Nevertheless, I interpret Foucault as seeking to understand the mechanism(s) by which relations of power become explicitly understood as such. Relations of power are unavoidable even if the interlocutors are unaware of them. Recall the early conversation when Margaret strenuously rejected my suggestion about continuing education funding. In another situation, she found a proposal I had developed involving nurse educators in a research project to be 'insulting' since I had not discussed it with her first. All this felt like a tightening of even what I could talk about without explicit (and prior) permission.

I became aware of how our relation of power was being enacted—what called it into explicit play—through this series of small comments, which I took to be Margaret clearly stating not just views that opposed my own, but that closed down further discussion. I have experienced these encounters in a variety of ways: surprising, frustrating, embarrassing, humiliating, and amusing. Some have been linked for me to a deep sense of self-doubt. Am I who I think I am if in conversation intended to explore ideas I invoke responses such as those I experienced from Margaret? Was there a cultural or linguistic gulf created by my not being a nurse that

complicated our ability to even understand one another? How could I make sense of this emerging pattern? Foucault's interest was in exploring the relation between power and knowledge, but these questions raised another relationship between power and identity, which was of interest to Norbert Elias. Elias and Mead were both influential in the body of work comprising complex responsive processes of relating, and in the next section I will briefly turn to them to further explore the question of the relation between power and identity.

Thinking About Power with Scott, Mead, and Elias

Mead (1934) identified three stages in the development of self: children's role play, which enabled one to take oneself as an object to oneself; the self as constituted by an organisation of the attitudes of others; and self as influenced by the social attitudes of the generalised other (the social group within which one is relating). These mechanisms operate together throughout life, according to Mead, so that we form and are formed by our interactions with others in social groups, which are also formed by and form the interactions between individuals. I developed a proposal that I planned to present to Margaret and asked one of the other PCs to review it. She thought the proposal had merit, but advised that the best way to work with Margaret was to ask questions (not present ideas) so they would think that the ideas were theirs. On one hand, I was surprised by the need for this complicated, covert strategy. On the other, I recognised this pattern of communicating as a longstanding one in the relations of power between nurses and physicians, so it should not have been surprising that it also operates within the nursing hierarchy.

It would be virtually impossible for Margaret to be explicitly aware of this pattern, since its pattern of operation resides in what Scott (1990) called the *"hidden transcripts"* (1990: 14) or patterns of speech and complex behaviours in which both the dominant and subordinate groups collude to perpetuate patterns of oppression (Scott was writing in the context of anthropologic exploration of oppressed peoples). Hidden transcripts, according to Scott, are: specific to a given social nexus, selectively elaborated by some and hidden from others, and represent *"a zone of constant struggle between dominant and subordinate groups"* (1990: 14). Scott argued that the dominant group prevails (though never totally) in defining and constituting what remains hidden and what becomes the public transcript and believes this unremitting struggle over this boundary as *"the most vital arena for ordinary*

conflict" (1990: 14). As a new member of the team, the only non-nurse and holding the portfolio (interprofessional practice) that could threaten the hegemonic caste of nursing, my presence could potentially expose hidden agendas, mostly unintentional, since I am not aware of the rules that articulate the boundaries of what can be thought and talked about in what context. Expressing ideas that question conventional patterns would tend to invite precisely the defensive responses I was experiencing. Considered in the broader context of interdisciplinary teams, this exposing pattern of communication between Margaret is paradigmatic, a fractal image, of the challenges teams will experience as interdisciplinary team members work together more closely.

Foucault believed that where there is power, there is resistance, and I have certainly resisted what I perceived to be the confining exercise of Margaret's power. For Scott (1990) these behaviours reflected aspects of hidden transcripts. Arendt (1958/1998) observed:

> *Whoever, for whatever reasons isolates himself and does not partake in … being together … forfeits power and becomes impotent, no matter great his strength and how valid his reasons.* (1958/1998: 201)

Just as Foucault argued that power is a relation and can only be exercised in relation, Arendt made the point even more strongly by suggesting that the result of complete withdrawal (as is the case, for example, when I chose to work from home), I forfeit power altogether and become impotent.

Mead made a similar point but from a different perspective. He argued that because individuals develop through relations with others, the development of the self and the social nexus in which relations are occurring are linked. Thus, he postulates that the full development or organisation of the self is possible only in the context of organising the individual attitudes of others.

> *There is a definite end to be obtained; the actions of the different individuals are all related to each other with reference to the end ... in a unitary, organic fashion … which is introduced into the organization of other selves.* (1934: 158-159)

In finely nuanced arguments, Arendt pointed to the impotence of isolation, Mead to the necessity of individual and the group as mutually defining, and Foucault to power as an enacted phenomenon in human relating—all would see my decision to simply withdraw from the relationship as unhelpful.

Foucault made the following observation with respect to the rationalisation of power:

> *The exercise of power is not a naked fact, an institutional right, nor is it a structure which holds out or is smashed: it is elaborated, transformed, organized; it endows itself with processes which are more or less adjusted to the situation.* (1982: 792)

As an aside, the frequent reference to power as an 'it' with some determinative capacity ('it endows itself with processes'), demonstrates Foucault's linguistic tendency to reify power in a way that contradicts his own thesis that power/knowledge is not a thing, but an action of human relating.

Margaret and I continued to meet to discuss how my role should be developed. Our conversations tended toward a rather repetitive circular pattern, in which Margaret would restate her beliefs and I would restate mine. In a surprising turn of events, Margaret suggested at one of these meetings that she might be in my way. I agreed and said, "You need to get out of my way". Following a very brief pause, she said, "Okay". Neither of us clarified precisely what we meant by this exchange, but it inferred that the restrictions I felt were lifted. However, we had not reached any sort of meeting of the minds; despite being freed from Margaret's restricting views, I found myself continuing to act as if nothing had changed, like the prisoners in Foucault's panopticon who acted as if they were being watched even when they were not, in effect guarding (subjugating/oppressing) themselves (Foucault, 1977/1980). Taking Scott's (1990) view, this exchange simply expanded what was contained in the hidden transcripts of our power relations, but our differences continued to powerfully affect our acting upon each other's action. The value was that each of us could save face and carry on with our work.

Elias (1970/1978) understood relations of power as a feature of all human relationships, which Foucault also suggested, although Foucault saw the need to 'call them into being'. Whether called into being or simply always present, both Foucault and Elias resisted judging power as good or bad, but saw it as a feature of human interdependence that is both enabling and constraining at the same time. For Elias, this occurred through figurations (the name he gave to the shifting web of interdependent relationships) and our position in them. These shifting webs of interdependence may generate something new, but they also constrain action and exhibit stability, which means that not just anything happens. Elias stressed that whether specific actions within a figuration are enabling or constraining, the relationship is nonetheless functional. 'Functional' as Elias used the term is not

juxtaposed against ‘dysfunctional’, which would confuse *social beliefs* (in which function means there is harmonious whole and dysfunction means disharmony) with the *scientific theory* (in which each party—whether friend or enemy—performs a function for the other). For Elias, power was enacted in interdependent relationships, which constrain people to a greater or lesser degree in response to the (unequal) ability of each party to exert influence over the other. Elias explored relations of power through the analogy of game theory in which, for example, a game between two people with equal skills might be played differently than one between people in which one has greater skills, but still would want the game to be interesting. Whereas Elias was interested in understanding how power is exercised under various conditions, Foucault’s project was focused on understanding the conditions under which the exercise of particular relations of power were rational. The emancipatory thrust of each is thus quite different. In seeking to understand the conditions under which specific power relations are justified, Foucault provided clues as to how society might be restructured and thus change the relations of power. The thrust for Elias was on understanding how power relations are played given the game, rather than what the game is.

For Foucault (1982), institutionalised relations of power are expressed through predispositions to action based in the history of the social praxis within which they are occurring, legal structures, and customs, and arise in and form very complex subject/object and intersubjective relations such as might be found in a state or large organisation. In the narrative, I suggest a particular conception of knowledge and learning is implied by Margaret’s position that is widely accepted in healthcare and constitutes one of the most influential means of institutionalised relations of power in modern healthcare settings. I am referring here to the relation between power and knowledge that is implied in evidence-based practice. This does not require us to take our leave from Foucault or power, since his project in large measure consisted of exploring the relationship between power and knowledge. I will start with a brief exploration of the different views held by Habermas and Foucault, explore the ideas of complex responsive processes of relating in terms of knowledge and power, and conclude by returning to thinking about practice.

Exploring Knowledge (Remembering Power)

Thinking about Habermas and Foucault

The philosophies of Habermas (e.g., Habermas, 1984/2001; 1987), following Kant, and Foucault (e.g., Foucault, 1972; 1975/1995), following Nietzsche, have been important in the development of critical systems thinking (CST). CST critiques society and culture through the social sciences and humanities and develops the premise that *"the knowledge of our world, produced by the categories of the sciences, is inevitably partial and systemically distorted"* (Brocklesby and Cummings, 1996: 742). The CST research perspective embraces emancipation from these distortions as a key commitment. I want to start this section with a brief précis of the contributions of Habermas and Foucault that were of particular interest to CST since they were critical of one another's views. Biebricher (2005) suggested that their argument amounts to a misunderstanding, particularly by Habermas of Foucault's work. Others authors have tried to reconcile the contradictions in Habermas's and Foucault's perspectives (Alexander, 2001; Flyvbjerg, 1998b; 2000; Flyvbjerg and Richardson, 2002), arguing that their perspectives are actually complimentary, even interdependent.

Both Habermas and Foucault sought to understand and disrupt the assumptions and behavioural patterns that promote domination. Habermas' fundamental question, *"What knowledge is required to emancipate people?"* (Brocklesby and Cummings, 1996: 742) is answered in part by proposing three knowledge-constitutive interests: technical interests (empirical-analytic) that serve to predict and manipulate the physical world, practical interests that serve the need to develop communication and common meaning among interacting agents, and emancipatory interests that aim to expose how empirical and practical interests have been distorted (Brocklesby and Cummings, 1996; Mingers, 1992). Habermas was concerned with emancipating groups of people from worse to better states by a more holistic framework of knowledge attuned to and free from the instrumentalism of science and the way in which power distorts communicative interaction (Brocklesby and Cummings, 1996). For Habermas, power was not a central theme; instead Habermas tended toward an idealist, systemic stance that held individual reason as *"'inescapably situated' in history, society, body and language"* (Healy, 1997: 142) in which (more or less) universal presuppositions (truths) support communicative action

and consensus. For Habermas, the emancipatory thrust of communicative action is derived from *"free, open, participative, consensual—and, of course, rationally motivated—decision making in all areas of social existence"* (1997: 145). Habermas remained optimistic about the liberating potential of human reason.

Foucault was critical of Habermas for accepting that reality and rationality were adequately defined by the state and for his tendency to seek universal truths as a basis for rational consensus. By putting power at the heart of the emancipatory project, Foucault stressed that since power influenced how knowledge was constructed, demonstrating any kind of ultimate truth would at best be an elusive and unproductive goal. Brocklesby and Cummings (1996) argued that Habermas sought human emancipation by linking the three knowledge-constitutive interests (Habermas named this 'complementarism'); Foucault rejected the possibility that one can arrive at or derive from collective effort any sort of ultimate truth, and instead sought self-emancipation through deconstruction of power and knowledge. Flyvbjerg (1998b; 2001) suggested that the tension between Habermas and Foucault represents an important tension in modernity between *"the normative and the real, between what should be done and what is actually done"* (2001: 210). The CRG theorists would argue that the normative is also real and reject the dualism suggested in Flyvbjerg's wording. I agree, yet this description resonates with aspects of the tension with Margaret, when she pushed toward normative and ideal states, while I tended toward understanding what is actually going on in day-to-day practice and participation the emerging patterns. Moreover, our struggle was not only a fractal representation of practice between professionals at the bedside, but was also similar to the broader tension in modern medicine between evidence-based practice (issuing from epistemic traditions) and practice-based wisdom (issuing from phronetic intellectual traditions). It is to these questions and to the theory of complex responsive processes of relating that I now turn.

Exploring Knowledge (Remembering Power)

Returning to the Narrative

I want to acknowledge that the normative stance can certainly represent one (static) expression of reality (so avoid suggesting that normative and real are necessarily opposite), but argue that the 'real' to which 'normative' is often

juxtaposed consists in the multidimensional and continuously emerging reality of practice and action/agency as a temporal process. Margaret's wish for me to establish best practice based on evidence is a common and rational request (in the Foucauldian sense). That is, it makes good sense in the context in which she is making the request. It is a way of thinking about evidence and science that is endemic in healthcare—that there is a right or best answer to the complicated questions of providing healthcare and that science can and will define what that answer is. It is certainly not unthinkable that the scientist could accept knowledge as *"inevitably partial and systematically distorted"* (Brocklesby and Cummings, 1996: 742), yet science almost immediately forgets that possibility to confidently care for the lives of others. Margaret reflected an aspect of this stance in a phrase she used, 'The evidence is the evidence', by which she meant (or at least hoped) that there is a non-contingent 'right way'. It was simply not logical to her that point-of-care staff would be permitted to do anything other than what 'the evidence' showed. My reminders of the need to take professional judgment (phronetic wisdom) into account in clinical decision-making and pointing out that all knowledge is partial and distorted were frightening for her. We each took extreme positions: I argued as if I accorded no validity to scientific evidence, and Margaret argued as if all practice is a simple translation of the evidence. I do not discount evidence any more than she discounts professional judgement, but we clearly come at the matter of understanding practice from different points of emphasis.

> Nicolini et al. argued that reversing the
>
> *hierarchical privileging of theoretical, discursive knowledge over practical understanding … [places] knowing in practice [as predating] reflexive theoretical knowledge and makes [theoretical knowledge] possible.* (2003: 9)

Thus, rather than choosing between normative (temporarily fixed, static) and existent (as in the embodied knowledge of this moment in practice), the effort is to understand how knowledge—discursive or reflexive—comes about. These comments link to Project 2, in which I explored the concept of practice and in that project concluded with Stacey and Griffin (2005) and Stacey (2007) that practice is, in fact, not application of systemised routines created through the scientific method, but is rather local embodied interaction between cooperating and conflictual people who need to communicate, negotiate in relations of power, and make evaluative choices. Here I

want to return to complex responsive processes of relating to first explore knowledge and then to revisit the question of practice.

Revisiting Complex Responsive Processes of Relating

A popular view of knowledge in organisations is that knowledge is a commodity that takes up residence in the heads of 'experts', such that individuals holding it need to be protected by the organisation (e.g., through incentives or empowering elite employees). Knowledge, in this way of thinking, needs to be 'managed' through elaborate strategies in which ideal knowledge or right practices are indiscriminately 'rolled out' (giving rise particularly in healthcare to the development of implementation science). Furthermore, it is thought that tacit knowledge (what employees know from experience) arises in individuals and is stored there alongside rational knowledge. Individuals can be articulate and codify this tacit knowledge, which can then be stored (using information technology) to assist in the spread of individual knowledge to others performing similar functions (Stacey, 2001; 2010).

This way of thinking about knowledge is largely based in a cognitive understanding of human psychology and the formative causality of systems thinking. Stacey (2001) on the other hand, argued:

> *Knowledge is not stored ... then retrieved to form the basis for action … it is continuously reproduced and transformed in relational interaction between individuals. …* ***Knowledge is the act of conversing and learning occurs when ways of talking and therefore patterns of relationship change****. … The knowledge assets of an organization … lie in the pattern of relationships between its members and are destroyed when those relational patterns are destroyed. This begins to suggest very different ways of thinking about what it might mean to "manage" knowledge in organizations.* (2001: 98, emphasis added)

I will elaborate on several specific ways in which systems thinking and complex responsive processes of relating view knowledge differently and explore in each case how this might be playing out in the situation with Margaret. In systems thinking the sender-receiver model of communication is dominant. Since knowledge resides in the mind of an individual, one party must first think about the idea to be transmitted and formulate that idea into language, the content of which is then transmitted to the receiver and translated, following accurately the intention of the transmitter. Social structure emerges through repetition of these structured sender-

receiver dyads, and develops independently as culture, which now acts back to influence future interactions. From a complex responsive processes perspective mental models or inner worlds as the basis of their actions is rejected. Each individual (self) acts toward others (the social) and itself (mind) in emergent patterns made unpredictable by simultaneous cooperative/consensual and conflictual/competitive acts of evaluation in the context of relations of power. Biological correlates of the action of the mind are experienced as feelings and emotions, which also influence communicative acts (Stacey, 2001).

In the context of communicative acts, the sender-receiver model seems to me far too simple to account for human behaviour. It is the model suggested by Margaret's insistence that I develop standards of interprofessional practice, which can then be implemented unproblematically by others. Moreover, her prior assumption that I could design, distant from practice, what the right way to practice is, suggests a view of practice as the correct application of 'real' (objective, essential) and universal knowledge. I do not dispute the value of empiricism (although I take seriously that it is always partial, distorted, and therefore open to interpretation). I do argue that even as empiricist knowledge is important to the technical aspects of practice, practice as an embodied, relational, and temporal process cannot be adequately understood in empirical terms alone, nor designed in advance and applied formulaically. Systems thinking splits thought from action (planning in advance how actors will behave), and emotion from thought (in the service of objectivity/impartiality) in ways Stacey (2001: 198) found highly problematic. He pointed out that the human brain does not represent or store memory in the mechanical and reproducible way of that camera would store a picture so that the same picture is seen every time it is viewed. Following recent findings in the neurosciences, particularly Freeman (e.g., Freeman 1994; 1995), Stacey (2001) asserted that human memory is not static, but rather is biologically altered as new neural stimuli are experienced (2001: 199). It follows that practice both precedes and continues to shape received knowledge. If I stand apart from practice, I cannot participate with others in understanding or shaping knowledge and practice. In systems thinking, for example, Margaret's position that dealing with difficult emotions and troubled relationships is someone else's role might make some sense since emotion and feeling are split off from and have no place in practice. From the perspective of the CRG, emotions and feelings are not split but form an integral part of the rich tapestry of human interdependence.

Rethinking the Relationship between Practice and Action

In this section I want to revisit practice. In Project 2, I conflated practice and action/activity and gave no account of practice theory. This section will continue to build toward understanding practice, including the distinctions between practice and action, primarily following Foucault (e.g. Foucault, 1972; 1975/1995), Shaw (2002), and Schatzki (2010).

For Foucault practices are where *"what is said and what is done, rules imposed and reasons given, the planned and the taken-for-granted meet and interconnect"* (Faubian and Rabinow, 1994: 225). Foucault noted that in traditional formulations, practice was considered an application or consequence of theory or as an inspiration to theory. In either case, practice and theory are separate and, he argued, the relationship adduced a process of totalisation. Against that, Foucault believed the relationship to be partial and fragmentary: a theory is always local and limited, and it is applied in another sphere distant from it that is also local and limited, but not in fully overlapping ways. The moment theory moves into its practical domain, it experiences obstacles and what Foucault called 'relays' are needed to develop new theory; practice then, is a set of relays from one theoretical point to another, and theory is a relay from one practice to another. In this system of relays within a larger sphere and a multiplicity of parts that are both theoretical and practical, *representation no longer exists; there is only action*—theoretical action and practical action. So Foucault connects practice and theory calling both action—theory does not express, translate, or apply practice: it *is* practice. As theory is privileged over practice in Western society, the struggle over knowledge involves relations of power, and a theory, for Foucault, is the regional system of this struggle. Theory does not totalise, it is in the nature of power to totalise (Bouchard, 1977).

Two things come to mind in how Foucault wrote of practice. First, in my struggle with Margaret the difference between how we each understood knowledge, practice, and the role of the PC was linked to the hegemonic privilege of theory (knowledge, evidence), the related tendency to see practice as the translation of theory through codified representations (such as policies and guidelines), and the coercive use of authority (such as audit strategies). This is an example of the conjunction of power/knowledge so central to Foucault's thinking. Second, I note a similarity between Foucault's 'relays' between theory and action and the dialectic process that

grounded Griffin's (2002) theory of experience as the unity of thinking and action. Patricia Shaw was instrumental in developing the body of work associated with the CRG, and while Stacey and Griffin did not write about practice, Shaw did, so I will turn to her work to explore practice.

For Shaw (2002), practice is the patterning of sense-making (which is theorising) and, therefore, she links theory and practice in a paradoxical way. Systems of accountability and policies do not determine the practices that emerge; designed roles cannot construct the identities that will be developed in their enactment; and while affordances can be developed for negotiating meaning, they are not meaning. Practice, Shaw believed, follows a temporal logic that distinguishes and relates concepts as emerging in a continuous flow of present experience, rather than a spatial logic that places concepts in relation to one another as a conceptual map (2002: 120-121). *"Our learning"*, Shaw said, *"as the experience of engaging day-to-day in sustaining and developing meaningful activity is practice"* (2002: 166). How Shaw linked theory and practice is not dissimilar to how Foucault presented them. Recall Stacey and Griffin's definition of action as:

> *A process of human relating … in … simultaneous cooperative-consensual and conflictual-competitive [patterns] … understood as acts of communication, relations of power, and the interplay between people's choices arising in acts of evaluation*. (2005: 3)

While a degree of intentionality is implied, Stacey would I think agree with Weber who said that action is *"very often simply a dull reacting to familiar stimuli that proceeds according to an already lived-into disposition"* (Weber, 1960, cited by Schatzki, 2010: 44). This disposition develops because practices have many largely unconscious repetitive patterns that feel natural, as if nothing else could happen—this is close to Bourdieu's notion of habitus. The introduction of unfamiliar actions dissonant to unconscious patterns of actions could disrupt our 'dispositions' and sense-making; unpredictably, the new action could be quickly extinguished or redefine practice.

Shaw (2002) argued the actions/activities of practice (she did disarticulate action and practice, but not starkly) are stabilised through repetition and evolve through sustained interaction. This is very close to MacIntyre's definition of practice:

> *Any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized … [with] a standard of excellence … appropriate to …*

> *that activity … [and] the result that human powers to achieve excellence … are systematically extended.* (1984: 187)

For MacIntyre, the institution is a critical requirement for sustained interaction and development and evolution of internal standards. Both scholars emphasise a complex social nexus extended in time and the historicity of practice (i.e., people enter into an existing practice and through continued practice participate in its continued evolution).

Shaw (2002) pointed out that the discourse of practice comes to police the terms in which we argue retrospectively about what has happened and prospectively for what we should do, and serves the on-going constitution of different forms of social relations (how we organise ourselves). These social relations are always political and become rationally invisible: *"a certain kind of voice is literally unable to speak"* so that we sometimes have a sense of *"being constrained in a prison which one is helping to sustain"* (2002: 96-97). This is resonant with Foucault's (1977/1980) panopticon and with the conversations that seemed entirely off-limits for me to have with Margaret.

Shaw (2002) commented on the tendency to map patterns of activity and the historical, cultural, and physical 'contexts' of practice as wholes distinct from the people who are acting in particular times and places. In healthcare, this mapping takes many forms (practice guidelines and models, policies and procedures, job descriptions, and professional competencies) all taken 'as if' the collective maps are or are determinative of practice (rather than ideal representations). Theory, in this view, drives practice, and I see this in Margaret's stance.

For Shaw, organisational continuity and change emerge over time through the continuous interaction of interdependent agents as they engage in sense-making. For her, the logic and method of sense-making is stories (narratives).

> *The paradoxical nature of narrative is that it makes sense of what we can draw on (the past) in such a way that shapes our experience of a meaning present (now) which includes where the story can go from here (the future). At the very same time, the way the narrative is opening up the future acts back on how the past leads towards it, and so further shapes our present experience. … This is the paradoxical, iterative, non-linear movement of narrative sense-making.* (2002: 121)

Drawing on Wittgenstein (1969), Tsoukas (2005) also emphasised the importance of narrative to practice and noted that stories are needed to state what rules cannot.

Wittgenstein wrote, *"Rules have loopholes, and the practice has to speak for itself"* (2005: 145). Tsoukas suggested that practice speaks for itself in two ways: actively (through its actions), and gnosiologically (through narratives) to articulate self-understanding and historically shaped identity. Tsoukas used the term gnosiological (from the Greek word *gnosis* meaning 'knowledge') to evoke the concept of discourse on knowledge in general, as opposed to cognitive or formal knowledge.

Shaw's (2002) writing about practice had a very different emphasis than Foucault's. She was concerned about the process of sense-making and recognised practice as an embodied, social, temporal, and emergent process. She acknowledged and was interested in relations of power, but she was concerned primarily with the understanding of relations of power in terms of sense-making in local interactions. Foucault (1980), on the other hand, was very interested in power. He sought to understand relations of power and the contexts in which particular relations of power were viewed as 'natural'; his intent was emancipatory, whereas Shaw's was not. Shaw and Foucault agreed that it makes little sense to distinguish practice and theory dualistically, and while Foucault was not as clear as Shaw about the paradoxical tension, both presented a compelling account of practice and theory as inseparable aspects of a single phenomenon.

Schatzki (2010) is a social philosopher and Wittgenstein scholar who has written extensively about practice. Schatzki summarised the scholarship of practice pointing to philosophers such as Wittgenstein (e.g.1969), Dreyfus (e.g. 1995), and Taylor (e.g. 1985) who contended that practices simultaneously underlie subjects and objects, rely on nonpropositional knowledge, and illuminate the conditions of sensibility; social theorists and ethnomethodologists such as Bourdieu (e.g., Bourdieu 1980/1990; 1997/2000) and Giddens (1979) sought to disrupt action/structure opposition and individual action as the building blocks of social phenomena, and cultural theorists such as Foucault (e.g., Foucault, 1972; 1975/1995) who argued that practice is a discursive activity, and oppose practice as structure, system, or abstract discourse. Schatzki defined practice as,

> *An organized, open-ended array of doings and sayings … organized by action understandings, which combine abilities to perform actions and recognize [and respond to] others' actions; rules, which are formulated directives, instructions, admonishments …; a teleological affective structure … germane to the practice involved.* (2010: 140)

Schatzki suggested that in the flow of activity what a person does next is the action that makes sense under the specific conditions and circumstances of the activity. His arguments about what goes into actions were very similar to what Stacey and Griffin suggested. Although he did not refer specifically to transformative causality (explored in Project 2), Schatzki argued that *"action and its motivation … span past, present and future dimensions of time"* (2010: 115).

Beginning to Disarticulate Action and Practice

Schatzki et al. (2001) and Tsoukas (2005) made a very clear distinction between practice and action or agency (Foucault did not distinguish them, and Shaw's and Stacey's distinctions were weak but similar to Schatzki's in nature). Schatzki et al. thought:

> *Practices are the source and carrier of meaning, language and normativity. The generation, maintenance, and transformation of these phenomena are achievements … realized in the public realm of actions and interactions that practices open up. Individuals instead of effecting and sustaining norms, meaning and language out of their own resources, are integrated (to varying degrees) into the ways of proceeding that characterize extant practices, where these matters are conserved and novelty and transformation take their start.* (2001: 12)

In Project 2 I made no distinction between action and practice, and took Stacey and Griffin's (2005) theory of action/agency to be a definition of practice. They saw action and experience as aspects of a single phenomenon (one physical and one cognitive/emotional, but inseparable as embodied experience) and agency as the ability to act in the context of interdependent relations of power. To simply substitute practice for action, as I did in Project 2, is to ask the same dialectical process to account for two distinct things—practice and action—a leap I now find difficult to justify. Stacey and Griffin remained largely silent about practice, which they did because practice and theory are so often seen dualistically (R. Stacey, personal communication, January 23, 2011). Stacey (2007) did, however, offer a definition of practice as, *"The local activity of bodily interaction as communication, power relating and evaluative choice"* (2007: 263), which of course is very similar to Stacey and Griffin's (2005) definition of action. This, I think, shows how easy it is to fuse these distinct concepts, since both Stacey and Griffin emphatically denied that their theory of action could be taken up as a theory of practice (D. Griffin, personal communication, January 22, 2011).

Gherardi (2009b) suggested that practice is too often confused or thought to be synonymous with routine or the generic equivalent of what people really do. She drew on Cohen (1996) to distinguish theories of action and theories of practice in which action theories privilege the intentionality of actors, from which meaningful action is derived (in the tradition of Weber and Parsons), and in which theories of practice

> *locate the source of significant patterns in how conduct in enacted, performed or produced (in the tradition of Schultz, Dewey, Mead, Garfinkel and Giddens). Hence theories of practice assume an ecological model in which agency is distributed between humans and nonhumans and in which the relationality between the social world and materiality can be subjected to inquiry*. (2009b: 115)

Gherardi asserted that while theories of action start from individuals and from their intentionality in pursuing courses of action, theories of practice view actions as *"'taking place' … through a network of connections-in-action, as life-world and dwelling"* (2009b: 115). Stacey would disagree with this characterisation. There is clearly a plurality of semantic fields through which to explore action, practice, and the distinctions, similarities, and interaction between them. As previously stated, this will be taken up in more detail in subsequent work in this portfolio.

Conclusion and Implication for my Practice

Moving to Project 4

In this Project, the narrative I presented suggested the first and second theme of this project: power and knowledge and the relation between them. I focused on Foucault's conception of relations of power as an aspect of all human relating and his interest in the emancipation of self through the relation between power and knowledge. Power/knowledge for Foucault are inseparable aspects of a relational, enacted phenomenon that is a part of all human relating in which each agent is to some extent free to choose a response.

In interpreting my own relations of power with Margaret, the emergence of practice as an animating theme for this body of work was continued since it was clear that disparate thinking about practice and knowledge influenced how our relation of power was enacted. We both set unarticulated rules around not exposing each other beyond certain limits acceptable to the continuance of our particular civil society and not bringing irreparable harm to our relationship; this aspect points to a Foucauldian analysis and emphasised the context in which how we were both acting was rational

and pointed to our mutual ability to choose how we enabled and constrained one another's actions. A Habermasian analysis emphasises Margaret's identity as part of social group whose principles and normative behaviours are part of the hegemonic order, and where mine tends to veer away from it without abandoning it altogether. Habermas felt that in groups, the inter-subjective rationality was emancipatory, since normative behaviours change over time through on-going interaction. From an Eliasian perspective, I am still an outsider to the more established members of the office, and my views reflect perspectives that are different than the hegemonic order. Foucault criticised Habermas for not taking into account the central role of power and the important relationship between power and knowledge; Habermas criticised Foucault for failing to take into account the critical role of normative theories developed through continued interaction in relatively stable communities. Some scholars (e.g., Flyvjberg, 1998a) saw this argument as reflective of a continuing tension in modernity between normative theory and day-to-day emergent experience, which holds resonance for me in my experiences with Margaret.

An important part of this project has been considering the distinctions between practice and action/agency. Charles Taylor argued, *"Social theory arises when we try to formulate explicitly what we are doing, describe the activity which is central to practice, and articulate the norms which are essential to it"* (1985: 93). This brief sentence succinctly describes the important relationship and makes clear some of the distinctions between theory, practice, and action or activity. Authors that I have briefly discussed in this context (Shaw, Stacey, Griffin, Schatzki, Tsoukas, MacIntyre, and Gherardi) would, I think, find common ground between this statement and their own philosophies, notwithstanding the nuanced differences.

I have not considered sufficiently a number of important practice scholars (Bourdieu, Wittgenstein, Gherardi, Tsoukas, Turner, and Cohen to name just a few) and will do so in subsequent parts of this portfolio. Understanding theory, practice, and action as paradoxically different yet inseparable aspects of interdependent human experience crucially informs my own relating at work. The differences between Margaret's views and my own have been paramount, but are unexpectedly reduced, not because we have changed our general tendencies about practice, knowledge, action/agency, and change (which remain largely irreconcilable), but because I have a better understanding of the conditions and attitudes that make our disparate positions on issues rational. I am more willing and able to formulate conversations with

Margaret in ways that make sense to her and to develop representations of practice which are satisfying to her, but do not constrain my further actions or interaction with others.

In Project 4 I will present a narrative about current work I am doing as an internal PC with a tertiary in-patient psychiatry team. The team would like to work more into the philosophy and practice of IPC, but does not know what that might mean for their practice. This project was about my relationship with Margaret and about misrecognition in a sense; Project 4 will consider a context in which I am enacting the role of PC within a practice team. The narrative will present opportunities to continue to deepen an exploration of practice—both my own practice as an internal consultant and interprofessional practice among the members of this team—and to further compare and contrast the concepts of action and practice.

PROJECT 4: THINKING THROUGH PRACTICE – ON BECOMING A PRACTICE CONSULTANT

Introduction

In Project 3 I explored the development of a new role I took on as a PC for IPC, Education, and Research through reflecting on difficult negotiations with my Director. We were both uncertain about how this role would emerge, and our ideas were more opposing than complimentary. The process of 'feeling our way forward' to a common understanding was very challenging and is ongoing.

In previous projects, I noted descriptions and analysis of concepts related to interprofessionalism (Curran, 2004), how teams work or not (Herbert et al., 2007; Limieux-Charles and McGuire, 2006), why teamwork is essential (Leonard et al., 2004), and how collaboration occurs between disciplines (Garmen et al., 2006). Consulting about IPC is the specific remit of my PC role, so this literature is helpful. However, it seems to me remarkable that 'practice' is conceptually taken for granted, as if we all simply know what it is and how it happens. I find a tendency among healthcare providers that I have also experienced myself, to understand practice in highly abstract ways—*as if* the description or representation of practice (through policies, guidelines, competency descriptions, models, frameworks and so on) in some way *is* practice. Following Griffin (2002), it seems to me that forgetting the 'as if' quality of these representations covers over the highly social, contested, and processual nature of particularised local practices that simultaneously form and are formed by global patterns.

For this reason, I find it important to articulate and reflexively consider narratives of working with others in the *in-situ* context of their practices (as it happens in particular local conditions). In doing so, I acknowledge my sense that theory and practice are paradoxically in generative tension with one another, not separate processes that inform one another in a linear or sequential way. The following narrative describes my work with an in-patient unit that provides care to patients who live with eating disorders. The usual approach to requests for assistance from the practice office involves planning the goals and expected outcomes of the project and defining each step of the process with designated timelines and responsibilities—all in advance. Often, what actually happens is quite different. I will provide some

background to the request for my involvement with this team and describe some of our discussions together.

The Narrative

Background Context

I was asked to meet with in-patient Eating Disorders Program (EDP) team to 'build their capacity for IPC'. The team had experienced significant challenges over an extended period that, in part, involved a senior physician who had significant memory impairment and diminished capacity for critical thinking due to a tragic car accident. Despite the serious consequences of this tragic accident, he continued to practice. Nursing and other staff were intensely loyal to this beloved leader and essentially ran the program, often making decisions normally made by a physician. This covered over the competency issue of the physician and put the staff in an unusually powerful (if legally dubious) position. About half of the nursing and allied staff had been with the program for many years, and turnover among that group was very low.

Turnover was high among new staff. They often felt excluded from the tight-knit inner circle and were perceived by the 'old guard' as marginally competent. New staff were more likely to question the competence of the psychiatrist and the decision-making structure in the program, and were, as a result, treated with caution, even suspicion, by the more senior staff. When the physician left the program, serious disagreements immediately emerged between the new physician and the rest of the staff, particularly, the nurses.

Explicitly, the disagreement related to the philosophy of care in the program, specifically, whether clients would experience harm or benefit from medical interventions if they were not psychologically and emotionally ready to change their unhealthy behaviours. Following long-established philosophy and protocols, staff felt that client readiness for change was a primary concern; if a client is not ready for a structured approach to care, such care was thought to actually be harmful and thus unethical on the grounds of the foreseeable possibility of harm and the related grounds of client autonomy. The new physician argued an unconditional duty to care for patients and that patient interests are best served in an environment that understood the complexity of eating disorders and offered a full treatment program,

not just medical stabilisation. Moreover, the new physician reclaimed and exercised the sole right to make admission or discharge decisions.

Tension around this disagreement was fierce. Each group launched written charges against the other for unethical practice, which evoked strong denial and defensive responses from everyone. Nurses felt unable to directly question the new physician's philosophy of care because of the shifting power dynamics and retaliated with charges of unethical conduct based on alleged violations of professional boundaries with patients. In response, the physician launched formal complaints about some of the nurses for insubordination (failing to follow doctor's orders) and unethical conduct related to interference with her relationship with patients. These serious complaints were ultimately resolved, but the memory of these events was very much alive.

A decision was ultimately made to adopt the philosophy of care proposed by the new physician. Although her perspective was adopted, the new physician left the post soon after. Her successor supported the previous physician's decisions, which were then implemented.

Starting out with the EDP Team

Given the months-long rancour between the staff and physicians, staff were remarkably accepting of the decision regarding the new philosophy and most tried to be helpful as the new physicians found their way into this very complex program. There was a sense of optimism that a new level of cooperation was possible. The leaders acknowledged there were difficult topics that needed to be discussed, but I was asked to shape my work to this new optimism. The program had always had a strong focus on working as an interprofessional team, and the goal of my work was to further strengthen their working relationships and support IPC. The team committed to attending a one-hour discussion twice each month to that end. In the introductory meeting I talked about IPC and the intentions that had been outlined by the program leaders for these meetings, but also drew attention to the possibility that we were together beginning a different conversation in the continuing story of this team and that no one could know, including me, how their story would continue to evolve.

In the next few meetings, I introduced topics for discussion and invited people to break into groups of three or four and then summarise their discussion for the

whole group. I hoped the topics would elicit ideas that felt worthwhile exploring in more depth. The ideas were recorded on flip charts, which were typed and circulated to the team prior to the next meeting. One reason for working this way was that because of shift work and patient care needs, it was never possible for all members of the team to attend the meetings. I hoped the typed summaries provided an opportunity for those not able to attend a meeting to feel they were important and involved in the discussions. I thought the small group format might make it easier for the team to raise sensitive topics and induce a wider variety of ideas. Boundaries emerged as a topic that felt worthwhile exploring, and I want now to present some of that discussion.

Thinking About Boundaries

This team had a tendency to attribute disagreement about the practices of another discipline around patient care or treatment philosophy to 'violation of boundaries'. It was, therefore, not surprising to find 'boundary issues' as a topic of interest. Over several meetings, we discussed what the term 'boundary' meant to participants; how they thought boundaries were formed or defined; how boundaries 'worked'; and whether the boundaries were rigid or contextual so that the same behaviour in one circumstance might be acceptable and in another inappropriate. We discussed whether patients could violate boundaries, since the patients in this program often form strong bonds with each other that are sustained outside the hospital. Communication between the patients (often on Facebook) sometimes involved how to 'manage' certain nurses or which doctor was more likely to grant an overnight pass. Nurses described feeling "left to clean up the mess". One nurse said (referring to other disciplines such as doctors, pharmacists, or dieticians), "They leave orders and then leave the building". Nurses also felt they were left to explain treatment approaches to (sometimes angry) patients and families that the nurses might not understand the rationale for or necessarily agree with.

Thinking About Ethics

Explicitly about boundaries, I argue that ethical discernment is at the heart of this discussion. The team was trying to build a process of reasoning about what ought to happen in the situations they were exploring. A preeminent Canadian ethicist

referred this move to more systematic ethical reflection as a movement from *is* to *ought* (Dossetor, 2005). The team's discussion was pointing to categories of decisions or behaviours (such as whether, or under what circumstances, personal relationships between patients and staff would be acceptable) as well as specific decisions and behaviours (such as a nurse who wondered if he could order an unhealthy meal in a restaurant if his server happened to be a former patient).

One of the small groups drew a diagram to explore how boundaries are formed (Figure 1). The diagram represented a normative ethics framework in which agreements and rules dominate ethical choice and judgment. Two of the best known are deontology or the ethics of duty (*deos* is Greek for 'duty'), in which action is judged by whether rules or laws that help us to meet those duties have been followed, and teleology (also known as consequentialism), in which action is guided and judged by the consequences or ends—often expressed in terms of the greatest good for the greatest number (utilitarianism), although this is not the only end to which right action may be directed (Beauchamp and Childress, 1989). When, in the absence of any other discussion, staff accused one another of ethical misconduct based on violation of boundaries they were implying that a law-like rule had been violated and as long as the rule remains unquestioned, decisions about whether the rule has been violated may seem straightforward.

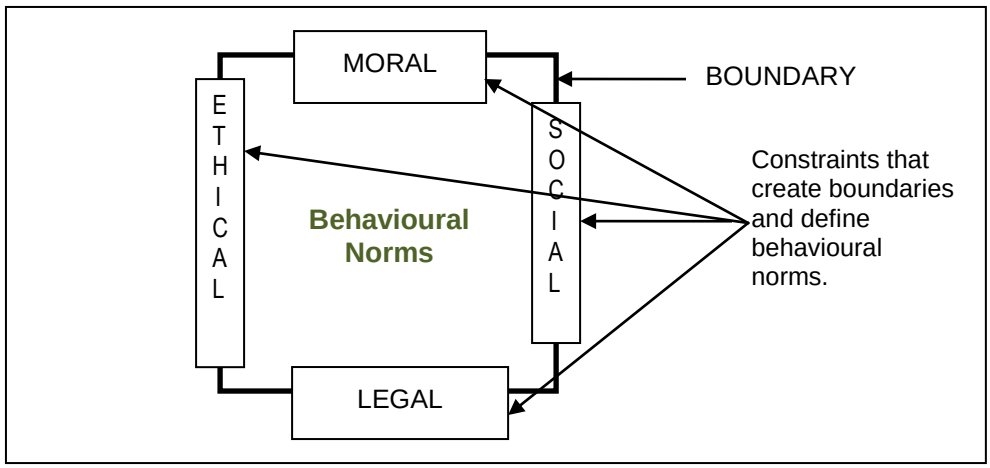

Figure 1. A depiction developed in a small group discussion of how moral, social, ethical, legal constraints form boundaries and create behavioural norms.

When the diagram was discussed in the large group, there were initial nods of agreement. It seemed to me that the group was quickly deferring to this very articulate image, and I was worried their quick agreement would prematurely close the conversation. I commented that while I found the image helpful, I also found myself

reacting to the rigid shape and heaviness of the boundary line—that something about it made me want to 'escape'. The discussion then turned toward the idea that boundaries could not be rigidly articulated and that few, if any, absolute or universal rules applied. Some suggested that the dark line representing the boundary be drawn irregularly or hatched to show that context matters in terms of judging whether an action is fitting or not. The conversation was radically disrupting the idea that judgment of right and wrong had no context other than individual choice to follow a rule or not.

Circumstances that challenge healthcare teams often contain ethical dimensions that I believe are best explored through a relational ethics framework. Relational ethics do not exclude normative considerations, but consider the wider relational context of the circumstances as an important and legitimate focus for ethical discernment (Bergum and Dossetor, 2005). Although often attributed to feminist formulations of ethics, theologian and philosopher Richard Niebuhr was one of the first to articulate a relational ethics framework. Niebuhr (1963) described the ethics of duty (deontology) as an ethic formulated based on what is 'right' (what the rule or law says), and teleology as focused on the 'good' (the desired end). He suggested an alternative, an ethics of responsibility, in which action may be judged 'fitting' if it makes sense in the context of on-going interactions of interdependent humans in particular contexts. Niebuhr's ideas were based on his interpretation of Mead (1934) and on what was, for Niebuhr, the Christian theological principle of taking the place of the other (this thinking is, of course, not exclusively Christian). Niebuhr argued the social self exists as 'members of a group' (the use of the plural 'members' denotes that the social self is not an isolated individual) and fitting action is not something to be decided through the approval and disapproval of other individuals, but through understanding *"the ethos of society"* in interpersonal interactions (Niebuhr, 1963: 78-79).

Potential Changes in Understanding Experience

Similar ideas were emerging in the team, namely that actions and practices could not be understood in individualistic terms—the social (as well as the ethical, moral, and legal) context in which individuals acted both constrained and enabled individual actions and everyone contributed to the context of the group through their

interactions with each other. When the discussion turned to the question of what would be helpful when questions of boundaries arose, most felt that talking together about how everyone was experiencing the situation would be the best way to start because no one's intentions could be easily seen and multiple interpretations and experiences of the same situation were likely to be in play. I pointed out to the group that where the question of boundaries and their violation had in past encounters seemed straightforward, they were now seeing the possibility of multiple interpretations and outcomes. They acknowledged the complex interplay of intentions, actions, and interpretations in any given situation and how challenging it was to understand those 'in the moment'. By interrupting the discussion periodically to ask, for example, about potential 'backstage conversations' (Goffman, 1959), what they were taking for granted, or whether this conversation was different from usual discussions, I was inviting the team to detach sufficiently from their immersion in both practice and reflection on practice to be able to reflexively consider alternate understandings of their experience. The team was exploring differences reflexively and in doing so, also developed their ability to discuss differences in their usual interactions.

A Shift in the Conversation

One of the nurses unexpectedly drew our attention to the summary of a previous discussion about 'things that frustrate me around here'. She had associated the discussions we were having with a patient whose care had recently challenged the team. She read aloud some of the issues that had been raised: feeling unsupported or disrespected, going back to problems that had been 'fixed', not working as a team, not feeling acknowledged or appreciated, feeling like 'no matter what I do, it's never enough', and putting personal ego ahead of patient care. This recital of what was wrong seemed to invite the opposite view and comments quickly emerged about how good it is to work on the team, how the disciplines work 'better together here than anywhere', and how supportive team members are of each other. This response (like the quick agreement about the boundary diagram) seemed to risk shutting down the conversation, so I pointed out that in response to an 'all bad' list, they had responded by developing an 'all good' one and shared that in my experience good and bad often co-existed.

The nurse clarified that she had raised the list of concerns because it and what we had just been talking about reminded her about a challenging patient, Lisle. There were nods of recognition and over the next three meetings we engaged in a reflexive discussion about Lisle's last admission. To the team's surprise, there was no substantive disagreement about the philosophy of care or specific decisions regarding Lisle's care. Instead, the discussion quickly centred on how difficult it had been for each of them to deal with this extremely ill woman. Lisle was near death on admission. Her mother seemed unable to understand how sick she was and actively resisted care, frequently pitting staff against each other and interfering with the crucial therapeutic relationship between her daughter and the staff. Over Lisle's three-month admission, staff had not discussed their own feelings, and blame started to surface as a defence against the fact that everyone felt helpless—it felt, they said, like nothing anyone did made a difference. Tasks and roles, decision-making authority and processes, and friction over patient assignments were all tacitly sanctioned topics of conversation. Speaking about their feelings and how this was affecting them was somehow not permitted by the same tacit rules consented to by the community. It was difficult for the team to stay focused on concerns about their own coping with this difficult situation and easier for them to continue to problem solve the 'clinical case'. I pointed out these shifts in focus, which often occasioned an apology from the 'offender' and provided grist for further reflection!

Reflecting in More Complex Ways

The team was considering their experiences in a much more complex way than they had previously. Their 'practice' included, but was also understood as more than, the tasks that they did, the roles they had, and the competencies they brought to the team. The team described practice as: "the game", "it's what we do", "a set of skills a practitioner has", "what we do and how we learn together", "something that evolves and changes through experience and reflection", "intuition or going against intuition to serve the clients best interest", and "professionalism can be used to dominate or put down others who are not members of that profession" (from discussion notes dated December 2010). Experiences that had previously seemed straightforward, including, for example, how interactions between patients, families, and staff could complicate care and polarise practitioners, were being considered in

more nuanced ways. The sense of ‘something more’ with respect to how they understood their practice(s) was expressed by the pharmacist, who said, “I knew this was a complicated environment, but these conversations really show that”.

I began to see in more nuanced ways that I was interacting with the team in ways that were both involved with and detached from their interactions. There was no particular plan with respect to what topics emerged—the conversation about boundaries came out of conversations about practice experiences and the sense that people were making of them; that discussion moved tacitly into the domain of ethics. I was ‘attending’ to different things than the team members were. For example, I noticed and pointed out subtle shifts in conversation or to what was being taken for granted, and I noticed when it seemed particular points of view were missing and asked about what or who was silenced. I explicitly acknowledged how difficult particular situations had been for specific individuals and invited them to reflect on how they had been impacted. These conversations affirmed some long-held assumptions and challenged others.

I want to turn now more formally to themes arising from the narrative. Healthcare is steeped in scientific thinking, and it seems that trying to impose the logic of science on issues such as understanding how people practice/interact together or how practices change in the highly social context of the practice environment is both common and problematic. This leads me to reflexively consider the narrative in the context of articulating the differences between the logics of practice and science and to see if understanding the differences and generative tension between them will be helpful to frame an understanding of becoming a PC.

Themes Arising from the Narrative

Introduction: Explaining the Interest in the Logics of Practice and Science

Many themes arise from this narrative, including boundaries as ethics in the complex contexts of clinical practice; figurations of power; interactions between established and outsider groups; processes of recognition and misrecognition in the struggle to (re)form the group; and the sense of shame and helplessness expressed by people feeling that no matter what they do, it is never enough. In addition, staff seemed to be exploring this sense of ‘something more’ with respect to understanding their practices through encountering a suspicion that concepts they had taken for

granted might be more complex than they thought. I also continued to develop a more complex picture of what I do as a PC.

Part of what underlies this awareness of complexity can be usefully explored through understanding the difference between the logics of science and practice. Scientific traditions of thought have been and remain crucial to many of the important advances in our understanding of disease, injury and healing processes, and to organisation and change. However, in the context of understanding and modifying patterns of practice, the logic of science is likely to lead to attempts to simplify and codify human behaviour as if it were no different than the biological behaviours of cells. The logic of science may articulate evidence for a ('universal', statistical) best *practice*, but I suggest that it cannot render intelligible the (complex, particularised) social *practices* in which best practice must ultimately be enacted or the multiple, interdependent discursive and non-discursive elements that make up the practice context.

Schatzki (2005) argued that practices provide the conditions of intelligibility for action. That is, the practices of particular communities (Gherardi, 2009a; 2009b) explain why certain actions make sense and others do not. In the narrative we see that the conditions of intelligibility for the EDP team were changing. For example, where it had made sense in the past to swiftly allege boundary violations, boundaries were now being discussed differently—a change in what Foucault (1977/1980) called discursive practices—so that the team's teleological sensibilities of practice and affective responses to observed behaviours were becoming more nuanced (i.e., the team was rethinking their experiences). Foucault felt that this idea of returning to or rethinking something was quite significant since he felt that it literally reinitiates action; that is, thinking about past experience can lead to the initiation of present actions in an importantly different way (1977/1980: 135). The French philosopher Deleuze said of the relationships between theory and practice:

> *From the moment a theory moves into its proper domain, it begins to encounter obstacles … which require relay by another type of discourse.… Practice is a set of relays from one theoretical point to another, and theory is a relay from one practice to another. No theory can develop without eventually encountering a wall, and practice is necessary for piercing this wall.… Representation no longer exists; there is only action – theoretical action and practical action which serve as relays and form networks.* (Deleuze, as discussed with Foucault, 1977/1980: 205-207)

Deleuze was suggesting practice produces or moves theory and theory produces or moves practice through these relays; but importantly, he did not suggest a relay *between* theory *and* practice, which would split the two. This underscores theoretical and practical action as different elements of a single phenomenon and the generative tension created in the relays and networks that form. I see this relay in how the EDP team was creating the possibility for different ways of making sense and going on together to emerge. For example, in our discussions, practice 'pierced' the theory that strict moral, ethical, legal, and social rules govern behaviour and began to form a different theory of ethics that was more resonant with their experience (i.e., Niebuhr's [1963] theory of what is 'fitting'). There is, of course, no reason to think that relational ethics would not also at some point be pierced as it hits the wall that only (further reflexive) practice can pierce. This is why I think Deleuze (1992) considered that representations become relatively impotent—they simply cannot keep up with the practice/theory relays.

It is important to be clear that the purpose of distinguishing the logics of practice and theory is not to split them or privilege the logic of practice, but to point to the generative tension between them. If the distinctions are hidden, it seems to me the generative tension between them is obscured, and it is more likely that leaders and practitioners will collapse the paradox to a dualism in which the hegemony of the logic of science will continue to crowd out the equally important (and distinct) considerations of clinical practice. This concern is easily observed in the near singular effort in the healthcare industry to accomplish organisational development through refining the dominant methods, for example, developing more precise definitions of best practice, better strategic and operation plans, improved measurement and quality control, and tighter targets (Chassin and Loeb, 2011; Langley et al., 2009; Lewis, 2010). Something in addition to methods of improvement based in the logic of science is needed since healthcare quality and cost continue to be issues of major concern. I am exploring whether the 'something different' may be found in the generative tension between science (which itself is also a practice) and practices in the clinical context (including IPC). Bjorkeng et al. pointed out that *"practice is everything—and thus nothing—as* ***nothing falls outside of practice and everything falls within it****. Hence the focus has to be on particular practices in order to have substantive specificity"* (2009: 146, emphasis original). The method of the DMan program is precisely about Deleuzian relays, in which reflexive engagement with the

researcher's own experience moves her from one theoretical position to another through an experience of sense-making in the context of particular experiences that are also considered in the broader related discourses in the literature. It is to the broader discourse that I now turn.

The Logics of Science and Practices

Introduction

In this section, I will rely heavily, though by no means exclusively, on an important paper by Sandberg and Tsoukas (2011). Jorgen Sandberg is an Associate Professor with the Gothenberg School of Economics and the University of Queensland Business School. His research interests include understanding what constitutes professional competence and its development in organisations, and knowing in professional practice. Haridimos Tsoukas is a Professor of Organisation Studies at the University of Cyprus and the Business School at the University of Warwick. Tsoukas has conducted pioneering research in the field of knowledge-based perspectives in organisations and the epistemology of practice. Tsoukas argued that a complex understanding of knowledge, inquiry, and action is needed to understand how practitioners carry out tasks and the relation of these micropractices with theoretical knowledge and meta-organisational practices (Tsoukas, 2005). I particularly appreciate that in thinking about knowledge and rationality (or logic) in organisations, these researchers do not place practice and theory in opposition to one another and that they identified the implications for organisational development of their careful distinctions between the logics of science and practice.

Sandberg and Tsoukas (2011) argued that scientific and practical rationality are equally concerned with both practice and theory, but differ in understanding how they are related. Practical rationality sees theory as a derivative of practice, which thus better reflects the richness of practice. Scientific rationality sees practice as derivative of theory, thus the practical relevance of theory developed through scientific rationality is more abstract and less rich. Sandberg and Tsoukas believed that most management theories, including theories of organisational development and change, are developed in the framework of scientific rationality and because they cannot adequately capture the logic of practice, have limited relevance to practice. Their arguments do not point strongly to the generative tension between the theory

and practice and tend, in my view, to privilege practical logic. I see this as a shortcoming of their work and will continue to point to how the body of ideas in complex responsive processes of relating uniquely sustains the paradoxical generative tension between otherwise competitive positions.

The Logic of Science

In scientific rationality, reality or 'being' is conceptualised as the '*is'* of things and is thought to exist outside the observer. This separation of subject (observer) and object (that which is observed) allows the observer to use his/her mind to capture and represent the object (Rorty, 1991). It follows that the most basic process of knowing is the subject/object duality and that the form of knowing is representational (Sandberg and Tsoukas, 2011: 340). A belief that fundamentally social processes such as patient care and team relationships have pre-given features leads to the conclusion that social processes can be depicted and become known through cognitive processes, including representations, and leads to the thinking that what matters most in terms of improving practice is how accurately what is outside the mind can be represented how accurately the evidence can be applied by the practitioner (Sandberg and Tsoukas, 2011: 340-341; Rorty, 1979). Due to the fact that practitioners (as opposed to theoreticians, although of course they too have a practice) are so close to practice, it is assumed that practitioners' knowledge is biased and subjective and thus imprecise and even nonrational (Bruner, 1990).

The diagram drawn by the small group in the narrative depicting boundaries (Figure 1) was an attempt to represent the concept of a particular practice experience. A diagram cannot express what it is like in time and in body to experience boundary. I have deliberately avoided using the term 'a boundary' to avoid objectification of what is, in fact, not an object that we can stand outside of to observe experience 'as if' we were a non-participant. The 'as if' quality is easily forgotten (Griffin, 2002). When we forget the 'as if' and take the representation to somehow be human experience, it flattens experience to two dimensions that we can only think about in what Bourdieu (1980/1990) called logical logic terms. We are left to think abstractly about embodied experience. This is what I think Sandberg and Tsoukas meant when they said that the logic of science cannot 'connect' with practice.

There were two philosophies of care described in the narrative. In one, structured treatment of patients was thought to be unethical if the patient was not emotionally and psychologically ready to change; there is 'scientific evidence' to support this point of view (e.g., Geller et al., 2004). Commitment to medical ethics and her legal duty to the patient supported the physician's perspective, as does other scientific literature (e.g., Watson et al., 2000). Contradictory 'best evidence' may be rationally justified within the logic of its creation, yet be unable to connect with particular contextualised clinical practice. Even if scientists and clinicians all agree the scientific evidence is trustworthy across the majority of possible contexts of its application, it still remains for practice to pierce the logic of science the moment theory moves into its proper domain (Deleuze, as discussed with Foucault, 1977/1980; 205-207), and this begins the movement to the next theoretical point.

The growth of EBM coincided with the explosion of information from the 1970s and the widespread availability of it facilitated by the World Wide Web (Claridge and Fabian, 2005; Wyer and Silva, 2009). Based in the logic of science, the EBM movement has also given birth in healthcare to implementation science (Stacey, 2007), the purpose of which is to discover how to ensure the proper translation of science into practice so that only what is best and right (according to the logic of science) is done (accurately and consistently) in practice. This way of thinking collapses the paradoxical tension and might, for example lead to the question of which evidence is more truthful. Whether the evidence of science is truthful would only be asked (and could only be answered) from the logic of science that developed it, so each contradictory study could only prove or disprove its claims by the same method that produced the claims in the first place. The question of which is more truthful is immediately tautologous and even if one answer seemed more correct than the other still cannot answer the *clinical practice question*: what should we do with this particular patient at this particular moment in these particular circumstances? For this reason, the studies were not helpful to the EDP team in deciding what to do and masked the difficult relations of power that were in such flux.

Sandberg and Tsoukas argued that by *"exalting knowledge generated through detachment from practice [the logic of science] disconnects knowledge from its social context and reduces human knowing to cognition"* (2011: 341). This leads to three problems: First, the logic of science cannot account for the meaning totality that practitioners are immersed in. Lave and Wenger's (1991) work on communities of

practice (CoPs) particularly points to the importance of immersion in practices (their term is situational learning) as knowledge-producing where knowledge emerges directly from practice rather than from representations and artefacts such as clinical practice guidelines or policies and procedures. (Here I experience my own tug toward separating the two as opposed to understanding the generative tension.) Gherardi's (2009a; 2009b) interesting reframe of Lave and Wenger's 'communities of practice' to 'practices of a community' emphasised practices as repeated actions by a community of practitioners that stabilise and sustain practices and also potentially transform practices because each situated experience is unique. Gherardi's reframe emphasised the heterogeneity of practices and the local context of community in a way that the original phrase does not. We simply do not experience work as serried rows of contingently linked variables that can be predicted and planned or captured and codified—we are immersed in the unpredictable flow of organisational life in which contingencies can become unlinked and new, unexpected patterns can temporarily emerge.

Second, taking EBM as an example, 'evidence' in science is constructed through epidemiological methods, which value averages and rules-of-thumb, counting as 'best' data gathered by the gold standard of randomised placebo-controlled studies. Evidence produced in this way clearly cannot account for the inevitable uniqueness of each situation in which it might be applied. Practices are always situational (unique, temporal, and embodied). Proponents of EBM (e.g., Wyer and Silva, 2009) have begun to object to critics (e.g., Murray et al., 2007), claiming that the EBM movement has long since understood the unique situatedness of practice and no longer holds itself out as the single source of truth (proclaiming this by conservatively defining EBM as the application of the best available evidence *in light of* professional judgement and patient values). In my experience, the sense that the evidence is somehow universally applicable (demonstrated in statements like those my Director has made, "The evidence is the evidence" [Project 3]) is still very common. We proclaim our understanding of the unique situatedness of practice, but continue to believe (or perhaps to hope) that the evidence is truth that can be universally applied as best practice. Simpson (2002) pointed out that situatedness, as it is often used in social theory, is linguistically humble as it acknowledges a limited, contextual view and aggressive since at the same time it points out that others' views are also limited. This is a useful paradox to keep in mind, since I want to emphasise again, the purpose

of understanding the logics of practice and science is not to dismiss either, but to acknowledge the generative tension between the two.

The third limitation of the logic of science is that it abstracts the dimension of time experienced by practitioners. Practice happens 'in time' not 'out of time'; in other words practice is an embodied experience that unfolds moment by moment in the on-going interactions. Scientific rationality cannot account for the logic that underlies the temporal flow of practice. Bourdieu pointed out that the flow and *"**directionality of practice** is constitutive of its meaning"* (1980/1990: 81-82, emphasis added) and argues that this temporal flow experienced by practitioners is excluded from traditional accounts of practice. The initial discussions of boundaries with the EDP team were interesting, but abstract from, not immersed in, the experience of practice; they were not situated in the very real and temporal context of conflicts that had recently challenged the team, and they were out of time in the sense of not relating to 'a time when …'.

These limitations of the logic science were clearly articulated by a nurse who was quite evidently frustrated with the conversation about boundaries. She said in animated tones, "I don't understand. Why are we talking about this? … It's all very interesting, I guess, but what does it all have to do with us?" I was taken aback by her frank commentary, but also recognised that a similar tension had been growing in me. I was not sure how to move from the safe (but less relevant) subject/object way of discussing boundaries, to the very real and potentially conflicted practice-based experience the group had recently gone through. I explained my understanding that when things got tense on the unit, it was often described as boundary violations, so I was trying to understand what we thought boundaries were, how they were formed, and how they worked. I acknowledged the abstractness of our conversation and invited discussion that would make this more real for the team members. The experience with Lisle was raised. The clinical nurse leader later acknowledged that she was "glad to see we were starting to 'get real'". These two nurses were commenting in very articulate terms on the difference (and the distance) between the logics of science (disconnected from the full relational meaning context, unable to connect with practice, 'out of time') and practice (for them, intense, real, conflicted, in time and body). I do not mean to imply that science is not real, or even less real, than practice; however, I do mean to suggest the importance of understanding the

differences and the generative tension between them and will later explore how this understanding informs my thinking about becoming a PC.

The Logic of Practice

Sandberg and Tsoukas (2011) believed that many philosophers, including Bourdieu (1980/1990; 1977), Flyvbjerg (2001), Giddens (1979), Schatzki (2002; 2005; 2010), and Shotter (1993) have effectively critiqued the adequacy of the logic of science as an explanatory framework for practice. They claim that Heidegger's social ontology offered an articulate view of the logic of practice (1927/1966: 342) and focussed on two aspects of Heidegger's work. First, they explore his notion of 'being-in-the-world' as our most basic way of relating (as opposed to subject/object). Heidegger stressed the importance of this reference to 'being in' as a sense of 'dwelling in', being inseparable from 'the-world' that we inhabit; implied by 'the-world' is the particular context we find ourselves in. Heidegger stressed this occurred in time; our being is embodied; and we dwell in, not outside of, our experience. He intended the compound term 'being-in-the-world' to express a *"**unified** phenomenon"* (Heidegger 1927/1966, cited by Sandberg and Tsoukas, 2011: 48, original emphasis) that, while it cannot be broken into parts and pieced together again, can nevertheless have *"several constitutive structural factors"* (1927/1966: 48-51). Following Sandberg and Dall'Alba (2009), Sandberg and Tsoukas referred to this 'dwelling in' as 'entwinement' and stressed, *"We are never separated but always already entwined with others and with things in specific … sociomaterial practices such as teaching, nursing, managing, and so on"* (2011: 349). Schatzki (1996) referred to this as 'attunement'. I believe that although it is a more awkward word, entwinement is more evocative of what Heidegger was trying to get at. 'Being', for Heidegger, is not a completely autonomous state, but a socially and culturally-bound (entwined) state in which the conditions of intelligibility arise that make it possible for practitioners to work in and make sense of the indeterminate (Lubinow, 2002; Traynor, 2009), yet still coherent, practices of a particular community.

In this way of thinking, the EDP team (as an example), is entwined in particular *sociomaterial practices* that include (i) a *specific teleological purpose*(s)—for this team these relate to quality patient care, being a tertiary referral service, and managing quality of work life; (ii) *already-defined distinctions about what matters*—

for example, how patient readiness to change impacts care, behavioural norms about boundaries, attendance, and participation in team and care rounds; (iii) the expectation of achievement of *certain standards of excellence* defined in job descriptions, human resources policies, and professional licensing boards enacted through the negotiated values and commitment of the community of practitioners; (iv) *performing certain actions* such as attending rounds and team meetings, providing direct care, documenting assessment findings, interventions and their outcome, offering group therapy, and so on; and (v) *the use of particular tools*, such as charts, computers, assignment boards, mechanical feeding apparatus, medication management systems, emergency equipment, and so on. The practices of this community in which each team member is entwined are complex, historical, evolving, embodied, temporal, and, to a significant degree, determinative of and shaped by continuing practices. The logic of science simply could not take this list of sociomaterial practices into account. Instead, inclusion and exclusion criteria would eliminate most of these experiences as confounding factors and thus eliminate the messiness of practice as irrelevant or inhibitory to the construction of valid and reliable knowledge that can spawn generalisable truths. For Heidegger (1927/1996, as cited in Sandberg and Tsoukas, 2011), as for Elias (1987),

> *There are several modes of engagement with the world, ranging from immersion to detachment. Revealing the entwinement logic of practice requires something in between: … a mode of engagement that involves both immersion in practice and deliberation on how it is carried out.* (Sandberg and Tsoukas, 2011: 344)

Most of the time, actors are immersed in the practices of their community without being aware of them, and spontaneous responses feel like autonomous choice, which the very fact of their immersion makes virtually impossible. Paley referred to this as *"unacknowledged conditions of further acts"* (1998: 819)—perhaps 'unacknowledgable'—when practitioners are fully immersed in practice. Heidegger (1927/1966, as cited in Sandberg and Tsoukas, 2011) showed:

> *It is only when we encounter some form of breakdown that we focus on and try to make thematic sense of sociomaterial practices … and thus "change over" to the epistemological subject-object relation.* (Sandberg and Tsoukas, 2011: 344)

In a breakdown, we shift from the usual state of 'absorbed coping' to 'involved thematic deliberation' (Heidegger, 1927/1996), or what Elias (1987) referred to as a

"detour via detachment" (1987: 3-4). We temporarily step away from our involvement and as a detached observer notice (or take into account) the meaning context we are immersed in. Dreyfus (1995) pointed out that in a severe breakdown, absorbed coping may be completely disrupted; we bracket immediate practical concerns either because we are too paralysed to act, or because we deliberately aim to discover the abstract properties of the situation through what Heidegger called theoretical detachment. Notice the aim to discover *abstract properties* of the situation through this stance—a cognitive rather than practical act. The paradox of thinking about practice in abstract terms soon pulls the detached observer back toward immersed practice.

Polanyi's (1966) work was helpful for developing an understanding of the paradoxical relationship between representations and practice. While he did not use these terms, he offered the view that the logics of science (as representational) and practice (as temporal, embodied, and immersed) are related through a process of indwelling.

> *Indwelling … [is a process of] … interiorization … To interiorize is … [to make the representation] function as proximal terms … [that are] applied in practice. … To rely on a theory for understanding is to interiorize it … for we are attending to things seen in its light … theory can only be learned by practicing its application: its true knowledge lies in our ability to use it … The declared aim of science is to establish … objective knowledge … But … tacit thoughts form an indispensable part of … knowledge, [and] the ideal of eliminating all personal elements of knowledge would … aim at the destruction of all knowledge.* (1966: 17-20)

Polanyi asserted that as we interiorise knowledge, we move from this proximal knowing to distal knowing-in-practice (1966: 18), thus emphasising the paradoxical relationship between what he called tacit and explicit knowing. The theoretical discussion that the EDP team had about boundaries did have practical value; it was not only abstract and impractical, it also had the potential to affect future practice through this process of interiorisation. However, the abstract discussion could not directly reach into the *experience* of practice, nor could insights achieved through abstract ideation be directly 'translated' into future 'ideal' practice as the only practice that would happen from that point forward. Instead, insights would become part of the sociomaterial practices, thus mutually transforming both theory and practice.

Interpreting the Narrative Further

The impaired memory and critical thinking skills of the physician recounted in the background to the narrative caused a severe breakdown in the function of the EDP team. The initial reaction was paralysis—staff were unable to detach sufficiently from their involvement to theoretically analyse the situation (which might, for example, have allowed them to see the legal bind they were about to set up themselves up for). Existing power relationships in which nursing and other staff made decisions more typically reserved for physicians were exaggerated, but now with the legal jeopardy tacitly apparent, the inner circle tightened with subsequent intensification of dynamics related to what Elias and Scotson (1994) described as the established and the outsiders. This was demonstrated, for example, by the stability of the established group and their tendency to be critical of newcomers, and by the fact that newcomers tended to leave the program after a few months. These newcomers questioned their own skills and felt concerned about the decision-making structure in the program. Further breakdowns occurred when the new physician not only changed the program treatment philosophy but also asserted her authority to do so independently. Unable to engage in involved thematic deliberation or theoretical detachment, aggressive posturing including formal allegations of unethical conduct deflected attention from questionable practices and a sense of helplessness.

When I met with the team, time had passed and there were key personnel changes, as previously noted. The team was more able to detach from absorbed coping and engage in discussions that also involved thematic and theoretical detachment. No doubt absorbed coping, thematic detachment, and theoretical detachment are all occurring simultaneously, so I do not mean to imply one is in or can instrumentally choose one or another. I am suggesting it is possible to notice what is happening by stepping back from immersion to a more detached stance.

The shift from the abstract discussion to a discussion of the concrete issues of Lisle's care was complex. The nurse who expressed her frustration with the abstract discussion of boundaries was partly responsible. However, our discussions had also created a context in which more reflexive discussions about practice situations that mattered to the team could take place with a sense of safety. When the first nurse challenged what was happening, another offered a different discussion (Lisle's care), which the group could have taken up or not. I recognise that as a PC I do not

independently determine what conversation will emerge. I (and others) can, however, point out emerging patterns of power and identity, how values and norms are showing up in the conversation, and what seem to be taken for granted. In the same way that team members move in the course of the emerging conversation between immersion, detached involvement, and theoretical detachment, I will also inevitably make those shifts with varying degrees of consciousness. None of these are better or worse and movement between them is both conscious and unconscious. Nevertheless, I suggest it is possible to choose to be more aware of how one is engaged. As a PC, it is helpful to maintain a level of detachment to be able to notice and draw attention to the group dynamics and assumptions that underlie the conversation. Drawing attention to what Goffman (1959) called 'backstage' conversation may be helpful to understanding differences between actual and idealised experience, and I want to turn briefly to what I think is a very important related article by leading authors in IPC, Lewin and Reeves (2011).

A Rendezvous with Goffman via Lewis and Reeves

Following Goffman (1959), Lewin and Reeves's (2011) ethnographic study explored how professionals present themselves on hospital wards and use 'front and back stage settings'. Their intent was to explore the nature of IPC and, in so doing, understand better how it could be supported. Lewin and Reeves's study is important to what I am thinking about in several ways: they pondered the same question Mowles (2008) did about why, if IPC is such a good idea, it seems so difficult to enact; they focused on acute hospital wards, which are often avoided because they are so complex; and they used Goffman's work, which is also important to the body of work of the CRG.

Lewin and Reeves (2011) concluded that the formal structures of teamwork, such as shared team identity, goals, formal agreements around rules of engagement, and formalised mechanisms of communication such as team rounds, do more to create the appearance of teamwork than to actually support its enactment. These formal practice and communication mechanisms tend to maintain hegemonic power relations and strong professional identities. Lewin and Reeves found greater collaboration and more equal relations of power in what Goffman (1959) called the backstage conversations that happen when the team is not 'performing' in its public role. This

study supported my decision to not follow the more 'usual' project-based Practice Office approach, which would have focused almost exclusively on defining goals and strategies in advance of this work, undertaking traditional team building; and defining team vision, mission, values, goals, 'rules of engagement' (behavioural ground rules) and the like. Following Lewin and Reeves's findings, the project-based approach would have been less helpful to the team's stated desire of understanding more about how to practice collaboratively. The authors concluded that interventions aimed at understanding these ad hoc communications as well as the more formal are needed. Such thinking resonates with what I have been exploring in this project, including the question of becoming a PC, to which I now want to turn.

Implications for Becoming a Practice Consultant

I will start by exploring aspects of the narrative that point to what we were doing together in the process of our discussions. I described in the background a breakdown in the team's ability to function that was so severe, all people could think to do was accuse each other of ethical misconduct. Detached reflexive discourse was impossible. Angry and defensive accusations and counter-accusations were a temporary solution to feeling powerless. In a less severe breakdown, a nurse expressed her frustration about the theoretical nature of the discussion we were having about boundaries, and from that, two important things emerged. First, I recognised in her comments elements of my own anxiety about how to bring our discussions closer to practice. She, in effect, created a breakdown, which invited a different approach from me and also from the team. Together we moved closer to practice through discussions of Lisle's case.

I have already discussed the surprising fact that staff had not previously discussed their own experience and feelings about managing this complicated case. Reflexive dialogue also occurred about a number of the team's practice tendencies (by which they meant less desirable 'habits'). For example, several people admitted that they were highly critical of the mother's attitude and behaviour. These team members acknowledged that their judgement might have influenced how they talked to the mother and invited some of the distressing behaviour. I related this discussion to an organisational priority around patient-centred care and asked what it means to them to practice in a patient-centred way in situations in which patients are often

treated involuntarily. Over the course of three sessions, ostensibly focused on Lisle and her mother, the team also discussed what mattered to them (tacitly implicated norms and values); what it was like to feel like you had failed a patient or a colleague or to feel unsupported by the team; and how they might approach things differently the next time Lisle, or someone like her, was admitted. I suggested a skill-building session and everyone participated in formulating and role playing different ways of 'Talking to Lisle's Mother', discussing how she might have respond to each. In that session, the 'play act' of talking to Lisle's mother evolved into discussing how they were reacting to each other. I want to emphasise that what happened was not planned except in very general terms. The team was making sense of their experiences and in the process, building a theory of communicating with difficult patients and their families and with each other in the complex and often difficult context of their particular context in mind. To follow Deleuze (as discussed with Foucault, 1977/1980), this demonstrated reflexive engagement with practice that was moving from one theoretical point to another.

I had a loose plan in mind as each session started, but beyond that, the discussion evolved in ways that I intended and in ways that I did not. These sessions created a forum for interaction and increased connectivity between team members and that, it seems to me, is what changes practice.

Implications of Differentiating the Rationality of Science and Practice

Sandberg and Tsoukas (2011) argued that thinking from the perspectives of practical logic requires two important shifts from the logic of science. First, they called for a *focus on the relational context (practices) that give rise to meaning* through interactions that both shift and sustain practices. This means that a consultant[2] could usefully focus on: (i) sociomaterial practices as the point of departure; (ii) people and what they do together; (iii) embodied action and the use of tools as means of enacting practice; (iv) standards of excellence that underlie practices; (v) what matters to people as they work together, for example how success and failure are understood; (vi) what kinds of actions and activities are normatively binding (e.g., policies, legal requirements for documentation, licensing boards and so

[2] While reference to consultants is used throughout this section, I intend for the term to apply in appropriate ways to how we also think about the practices of leaders, managers, teachers and researchers who also support practicing clinicians.

on); and (vii) the relationships between local practices and those in other related organisational contexts (2011: 346). These points of focus for a consultancy practice resonate with the experience I have described. They do not exclude aspects of a managerialist approach (e.g., raising the organisation priority of patient-centred care), nor is the approach isolated from the logic of science ('evidence-based practices' have merit). It is how we think about their enactment that is crucial.

Second, Sandberg and Tsoukas (2011) called attention to temporary breakdowns that occur naturally (first-order breakdowns), or that the consultant may induce (second-order breakdowns) that create detours via detachment (Elias, 1987). Breakdowns enable practitioners to consider their context reflexively, which is impossible when staff are immersed in absorbed coping. Breakdowns temporarily disrupt absorbed coping, thus the *"practice can reveal itself"* (Sandberg and Tsoukas, 2011: 347). In first-order breakdowns practitioners become aware of and can explore their response to thwarted expectations, deviations and boundary crossing, and differences that are ordinarily not noticed (2011: 348).

Second-order breakdowns are those induced by the consultant to create the opportunity for an Eliasian tour via detachment. The consultant could, for example, point out what is being taken-for-granted (what is a boundary) or what seems to be left out of conversations (the legal jeopardy of non-physicians making medical decisions); engage in role play (Talking to Lisle's Mother), do scenario planning or improvisational theatre; present or have participants present a narrative account of practice conflict (the story of Lisle); or express counter-intuitive thinking, for example, that thick square line representing boundaries made me want to escape (2011: 349). Such strategies may provide an opportunity for participates to step out of absorbed coping and consider their practices more reflexively.

Before concluding, I want to turn briefly to explore how what I have been thinking about through this project fits in the body of work of the CRG known as complex responsive processes of relating.

Complex Responsive Processes of Relating: Where/How Does Practice Theory Fit

Like Sandberg and Tsoukas, Schatzki (1997; 2001; 2005) and Bjorkeng et al. (2009) also followed Heidegger, arguing sociomaterial practices as the tacit resource

for sense making in the acts of practicing. Schatzki's (2001; 2002) earlier work suggested that practices provide the initially determinative thrust to action and agency, but more recently Schatzki (2010) claimed to have turned his previous position 'inside out', seeing action/agency as *"that through which practices, society, and history exist"* (2010: xi-xii). In other words, Schatzki now claims that is through activity that practices arise, where his previous position was that it is the social nexus of practices that determine practitioner agency/action. It seems inconsistent and unnecessary to me to claim on the one hand to overcome dualisms and on the other to argue primacy in a chicken-or-egg formulation.

Kemmis (2009; 2010a; 2010b) is a practice theorist who identified elements of practice that are *individual* with both objective (behavioural) and subjective (intentional action shaped by meaning and intention) aspects; and *social* with both objective (social interaction, ritual, social systems) and subjective (socially structured, shaped by discourses, tradition, interpretation) aspects. All of these elements are integrated for Kemmis in a reflexive dialectic view in which practice is *"socially and historically constituted, and reconstituted by human agency and social action"* (2010a: 141). This position sounds like complex responsive processes of relating, but in the end I think Kemmis resolved the paradox and refractures his carefully integrated reflexive dialectic stance by identifying separate research methods appropriate to each element. It may certainly be helpful to employ multiple research strategies, but by identifying how different strategies address different aspects of the dialectic integrative process, I think in the end Kemmis maintained the dualism.

I find the work of Stacey and his collaborators unique in how steadfastly they hold to paradox and to the generative tension of difference. The body of work through which complex responsive processes of relating is formulated sees no need to decide which is primary (practices influence practitioners who influence the further development of the nexus of practices they are engaged in together and so on and so on). Stacey (2001; 2007; 2010) repeatedly made the point that 'responsiveness' means that there is no need to think about starting and ending, as each response simply generates another.

While it shares some common ground with most practice theorists, complex responsive processes of relating also stands alone (through its unique commitment to holding onto the paradox of both/and at the same time) in taking very seriously the importance of the fact that the local and global mutually form and are formed by each

other in on-going patterns of interdependent human action and agency that are responsive to relations of power and emerging identity (Mowles, 2011; Shaw, 2002; Stacey, 2010; Stacey and Griffin, 2005). In the context of practice, individuals act interdependently and locally (i.e., in particularised situations) into-and-from the practices of their community. Professors Stacey and Griffin made it clear that neither had written about practice (Stacey and Griffin, personal communication, January 22–23, 2011). Professor Stacey said this was quite deliberate since the practice/theory dualism is so strong in the dominant discourse he felt it would too easily detract from the arguments they were putting forward, and because their interest was to think about how action/agency are enacted in relation to how organisation occurs.

I am not sure they have, in fact, avoided talking about practices. The logic of practices as developed in this project is very close to what Stacey (2001; 2007; 2010), Griffin (2002), Stacey and Griffin (2005), defined as the global, which itself has local and contextual implications—that is an organisation does not a have a single global structure, but many sites of organisation (Schatzki, 2005) or what I referred to earlier as a site of practices. I think what the CRG referred to as local interactions, already and always referred to the interdependent sociomaterial processes between individuals. When the CRG faculty talk about the global, they are referring to population-wide patterns or nexus of contextual practices, meaning contexts, standards of excellence, actions and tools, through which local practices are influenced. Action/agency does not just create but is responsive to (constrained by) global patterning. I suggest there are many sites of practices (a patient and her caregivers, a team a program or unit) within an organisation, and organising is 'global' in particular sites of practices and also in the organisation as a whole. Complex responsive processes of relating is very much about practices, and insofar as it seeks to constantly understand and sustain paradox and generative tension created by difference, it offers an important and distinct contribution to practice theory.

The Context of Practices

In this project I have described a narrative in which a group of practitioners experienced significant conflict over a number of months. I explored practices—those of the team, my own practice, and the practices generated through our work together—but in the end, distinctions between 'my' practice and 'theirs' are no more

easily sustained than sustaining a difference between theory and practice. I found myself theorising practices and practicing theory in ways that may occasionally have been confusing for the reader as it sometimes was for me. (Clarity, I suspect, is elusive and transient as *"life moves past us to the next question"* [Remen, 2000: 338]). Noticing differences between thinking about and experiencing practice led me to explore the *logics* of science and practice.

Sandberg and Tsoukas (2011) identified two shifts in focus in the logic of practice (whether one's practice is clinical care, consulting, or research): these shifts are from objects to sociomaterial practices, and from normative expectations, measurement, and control to temporary breakdowns, which make it possible for practitioners to detach from their involvement and reflexively understand their sociomaterial practices. I find these shifts critical, given that we are never separated from and are always entwined in the sociomaterial practices of our particular context (e.g., people and what they do together, what is important, how agency is exercised, how tools are used, how success and failure are understood, and expected standards). Gherardi's (2009b) reframe of Wenger's (1998; 2000) 'communities of practice' to 'practices of a community' portrayed this idea of entwinement in local, complex, heterogeneous sociomaterial practices that Schatzki (2005) claimed form the conditions of intelligibility of action/agency (i.e., understanding the sociomaterial context of practices is what explains why one action and not another makes sense).

The importance of this sense of *practices* is a key insight of this project. I find I have left off seeking to define practice as an exercise of logic in favour of understanding (following the CRG) the complex *context of practices* as a highly social and textured set of relations among interdependent actors with discursive and nondiscursive elements. There is a broad discourse to support and further explore this thinking in the synopsis of my work (e.g., Bourdieu's notions of field and habitus). Bourdieu called this

> *the almost miraculous encounter between the habitus and a field … which makes possible …the 'feel for the game' … what gives the game a subjective sense … a meaning … but also a direction, an orientation … and also an objective sense, because … the probable outcome …given by mastery of the specific regularities that constitute … the field is the basis of sensible practices.* (1980/1990: 66)

Foucault described something similar in what he called a *dispositif* (apparatus or social apparatus), which he described as:

> *A thoroughly heterogeneous ensemble … of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions – in short, the said as much as the unsaid … [and] the system of relations between the elements … that function as a means of justifying or masking a practice which itself remains silent, or as a secondary re-interpretation of this practice, opening out … a new field of rationality [in response to a need] …The apparatus is … always inscribed in a play of power … [and] … linked to certain … knowledge which issue from it but, to an equal degree, condition it ... the episteme is a specifically discursive apparatus, whereas the apparatus in its general form is both discursive and non-discursive.* (1980: 194-198)

Deleuze interpreted the dispositif as a *"machine that makes one see and speak"* (lines of visibility and enunciation) that define what is visible from the point of view of what can be enunciated (1992: 160). Lines of force proceed from one unique position to another in the lines of visibility and enunciation (like practices move from one theoretical point to another) through mechanism of power/knowledge (see Project 3). The *dispositif* (social apparatus) also involves lines of subjectivity that locate the production of subjectivity in social processes (1992:159-167).

Dewey (1958, as cited in Deleuze, 1992) wrote of the importance of habit and its tendencies to both stabilise (through history) and transform (through discourse) (1992: 279-281), and Elias (1998), like Bourdieu, talked of *habitus*, by which he meant that while our actions are constrained by the historical context of our social location, the civilising process inevitably includes transformation of the context not entirely through *"rational purposeful measures"*, yet also not without any kind of order (1998: 49). For Elias,

> *Plans and actions, the emotional and rational impulses of individual people constantly interweave in friendly and hostile ways … determines the course of change.* (1998: 50)

Many of these scholars are critical to the thinking of the CRG and in the synopsis I will turn more to their work to further explore the contexts of practice. For now, I want to turn to the implications of this Project for becoming a PC.

Implications for Becoming a Practice Consultant

Engaging with the Practices of a Community

The healthcare community, in my view, takes the term 'practice' very much for granted, and I believe this is to our detriment. Doing so masks for the need for practitioners (including consultants) to think about and consciously work within the complex influences affecting practices, expand our thinking about and approaches to how practices change, and identify the broader influences through which the challenges of interprofessional practice might be explored.

Interpreting Foucault's *dispositif,* Deleuze said that we act within a social apparatus that at any point has a particular actuality. The current actuality *"is not what we are but rather what we are in the process of becoming"* (1992: 164) and I suggest that it is the process of becoming within a particular dispositif that a PC is necessarily engaged with. If we fail to take that into account, there is an attendant risk of oversimplifying and codifying both our conception of the practices of a community and the nature and processes of our engagement with clients. This compliments Lewis and Reeves (2011) observations of the need to attend to the 'backstage' element of team function and the 'performance'.

I articulated the actions that I took in my role as PC throughout this project. I paid attention to the r*elational context (practices) that give rise to meaning* including what people do together and how they understand their actions and to temporary breakdowns that generate detours via detachment (Elias, 1987; Sandberg and Tsoukas, 2011). Pointing out the taken for granted, the impact of relations of power, helping the team to link their work with organisational priorities, referring to literature that may be helpful to putting words to feelings, provides opportunities for participates to step out of absorbed coping and consider their practices more reflexively.

Mowles explored the idea of consultancy as a form of temporary leadership. He found in his own work that he *"negotiates with [staff] what we should do next, how we might go on together … uncovering the different arguments for doing one thing or another"* (2009: 289). For Mowles, an important part of what he does is to *"keep alive the paradoxical and fluctuating relationships between the consultant and the people they are temporarily working with",* which he claimed enacts a form of leadership (2009: 290). In part, Mowles pointed to what Clegg et al. said is the first

character of consulting, that it is a discursive practice through which realties are enacted: *"changes occur through a process of contestation between old and new ways of thinking a thing into being"* (2004: 36). In the narrative presented in this project, I recognised the discursive nature of my interactions with the team and that I was often in a temporary leadership role. However, I also followed others as they introduced topics and led the discussion in directions of more interest and relevance to them and at times was peripheral to what was going on, listening only incidentally as small groups discussed topics and took unexpected directions. We all acted politically contesting power relations and, over time, I was a participant in both leader and follower roles; a learner and a teacher, both wise and ignorant, as were all the members of the team.

Stacey and Griffin (2005) described the research process of the DMan as one of involved detachment, and I suggest this is also true of the process of consulting. They argued that global patterns (what I am calling practices) emerge in local self-organised interactions. Thus practices can best be understood from within the local interactions in which these global tendencies to act are taken up. Whether developing practices as a PC or doing research, insights arise *in reflection on experience in interaction with others* through the paradox of involvement (the inevitable emotion aroused in interacting with others) and detachment (rational thinking in the positivist tradition).

Proceeding to the Synopsis

Through reflecting on the narratives presented in Projects 2, 3, and 4, my own thinking has moved most dramatically in three related areas. These are: understanding the contexts of practices as the conditions of intelligibility for action, exploring the implications of understanding differences in the logic or rationality of practice and theory, and exploring what this means for becoming a PC. These will be further explored in the synopsis, and I will show how reflecting on my experience with others demonstrates a key element of the DMan method (i.e., the paradoxical relationship of practice/theory).

SYNOPSIS

Introduction

In this synopsis I will (re)present the history and make further sense of my research as a whole. The point of departure, and key to the research method, is my own practice-based experience. I have been increasingly aware that while each project and the work as a whole begins and ends, these beginnings and endings do not point to essential proximal causes or final conclusions. Foucault noted that the world is a *"profusion of entangled events"* not an *"ultimately simple configuration"* where events possess *"essential traits"*, *"final meaning"* or *"initial and final value"* (1984: 89). This way of thinking invites the researcher to articulate tentative conclusions from which further reflection may be called from the life-world of people who struggle together in the *"interdependent webs of significance they themselves are weaving"* (Geertz, 1973: 5 [following Max Weber]). Bruner referred to his *"central ontological conviction … that there is no "aboriginal" reality against which one can compare a possible world in order to establish some form of correspondence between it and the real world"* (1986: 46). Thus, this portfolio seeks to make sense of and explain experience, not to discover ultimate truths or universal law.

The Structure of this Synopsis

I entered the DMan program with an interest in exploring how IPC in healthcare could be informed by the ideas of the faculty of the CRG at the University of Hertfordshire known as complex responsive processes of relating. I will provide a brief overview of the four projects that constitute the research to this point. I will then present and further explore the movement of my thought through three major themes that emerge from the projects taken together. First, as a PC with the specific remit to attend to collaborative practice among different health professionals, it became clear that my understanding of practice was very narrow and based almost exclusively in a positivist frame of reference. While I do not reject positivism, by itself, it felt inadequate for understanding how people practice together and what it would be helpful for a PC to concern herself with (Project 1, 2, and 3). This narrow understanding of practice was also reflected in the healthcare literature in which 'practice' is for the most part simply taken for granted as 'what we do' but is not a

topic of intense interest (Project 2). Theme 1 explores this movement of my thought from *Interprofessional Collaborative Practice* to *Practice as Inevitably Interprofessional, Cooperative and Competitive Lived Experience* (Project 1 and 2).

The second major theme is a movement of my thinking *Practice* to *the Practices of a Community*. I explore practices as social phenomena that are context specific and comment on relations of power as a feature of the practices of any community (Projects 3 and 4). Attending to the implications of these themes for becoming a PC is the focus of Theme 3. Here, my thinking shifted in terms of what it would be useful to pay attention to as I work with groups of healthcare practitioners in specific contexts. Theme 3 is titled *From Practice Consultant as "Expert"* to *Practice Consultant as (Temporary) Engaged Participant in the Practices of a Particular Community*.

Exploring my own experience as a PC *in situ* is a significant feature of the method. The penultimate section will more fully explore the method of this program of research, which is broadly consistent with hermeneutic phenomenology but, significantly, holds the researcher's own experience as the focus of interpretation and does not seek to articulate an essential nature of the experience being considered. The methods section includes commentary on the distinction between reflection and reflexivity and issues of reliability and validity. Finally, I will summarise the contributions of this research. Finding answers remains for me in creative tension with continuing to make sense of everyday experience through on-going reflective and reflexive engagement with the various communities in which I and others are continuously renewed and reshaped.

Brief Overview of Projects

Entering the Program and Project 1

As I came into the program, I was interested in exploring how, as an internal PC, I could understand and support IPC as the model of practice in healthcare organisations. In Project 1, I explored my own development as a leader and consultant, including significant milestones that influenced my understanding of leadership and IPC. I concluded that understanding how to support IPC through my role as a PC required a closer look at how teams understand and negotiate the conflict that is inevitable in the complexity of their daily work together.

The more surprising (to me) conclusion at the end of Project 1 was that, with the patient and persistent coaching of colleagues in my learning set, I began to see that my ideas about IPC were highly idealised and based largely on an experience early in my career that I had since tried to replicate. Surprise and struggle have been companions throughout this work. Bruner suggested that surprise is *"a response to violated presupposition"* (1986: 46), which resonates my experience in the program as I struggled to let go of long-held beliefs. I took new beliefs up naïvely and let go of 'old' ideas before fully understanding what I was letting go of or what I was taking up. A particular methodological strength of the reflexive research process is that it challenges this naïve way of thinking.

Projects 2 through 4

Projects 2, 3, and 4 explored narratives from current work experiences. In Project 2, I explored a presentation about IPC that I was invited to give. I began to understand that I had been taking the idea of practice for granted and, subsequently, understood this is also largely true of the dominant discourse on IPC. Thus, quite quickly in the process of the DMan work (and again, to my surprise), I shifted my attention from IPC as an idealised *style of practice* to understanding practice as an embodied and *emergent social experience*.

In Project 3, I discussed the challenges of negotiating my new role as a PC with my Director. Her ideas were radically different from mine, and the fallout from this difference led to a careful examination of relations of power as one thematic focus. One key difference was how each of us understood practice and the role of a PC, and this set the theme of understanding practice as central to this whole body of work. In Project 4, I reflected on work that I was invited to do with an in-patient interprofessional team whose members wanted to work together more collaboratively. In this project, I described work that I was undertaking quite differently as a result of my engagement with the program. In this synopsis, I will continue to reflexively engage with the projects and now turn to the first major theme.

Theme 1

From the *Idealisation of Interprofessional Collaborative Practice* to *Practice as Inevitably Interprofessional, Cooperative and Competitive Lived Experience*

Introduction

For most of my years in healthcare, I have been interested in IPC and have often described a single day early in my career that exemplified the experience and benefit of this style of practice. At that time (early 1970s), concerns about the fragmentation of care and efficient use of resources resulting from professional silos were not part of the dominant discourse in healthcare, so it made sense to organise the delivery of health services to convenience the professions. In the mid-1980s the healthcare industry started thinking about patient-centred care, one element of which is to organise service delivery (including all the involved disciplines) around clusters of patients with similar care needs. This ultimately became part of the justification and method for IPC. Through the engagement of my supervisor and learning set colleagues with early iterations of Project 1, I understood that I had idealised the experience of that one day and despite promoting the highly contextual character of IPC, I had reified the ideals of that experience. In other words, I had unconsciously started to think about the process of that day as if it were a physical entity that I could objectively and precisely describe and reproduce in any context. Moreover, I believed doing so would achieve predictable and helpful outcomes.

The beginning of a movement of my thought away from this tendency to idealise and reify was evident in the conclusion in Project 1, namely that it was important to understand how people negotiate conflict in the complexity of working together in interdisciplinary groups. I had not entirely left behind the idealisation of IPC, but understood its enactment as a more complex undertaking than simply developing the right representations (e.g., definitions, vision, mission and goals, and models), processes (e.g., agreed upon rules of engagement and communication), competencies (e.g., shared leadership or role clarification) and metrics to measure the predicted outcomes (e.g., reduction in adverse events for patients, improved staff engagement, and retention). It seemed less likely that perfectly describing an ideal notion of IPC would be helpful to supporting how people actually work together in

another context, and certainly did not help to understand how the practices of particular communities change.

This unexpected shift in the focus of my interest was more challenging since I had just taken on a role as a PC for Interprofessional Practice, Education, and Research. IPC is a topic of major interest in healthcare generally, and these 'sudden' shifts in my focus of interest seemed to risk prematurely or too completely dismissing IPC as a topic of interest. Thus, choosing an in-service presentation I was invited to give about IPC at the narrative for Project 2 was in part to reflexively consider and articulate how I was thinking and talking about IPC. I also felt confused about how, as an interprofessional PC, I could be helpful to teams if I was moving away from IPC. Much of what I said seemed self-evident to the participants and was, therefore, uninteresting. I did introduce a discussion about power relations, which veered from the dominant discourse, but it too seemed uninteresting to some and for others provoked a defensive response that I failed to take up as an opportunity for deeper reflection. As a defense against my own anxiety, I simply acknowledged their perspective without pursuing it further.

To my continued surprise, by the end of Project 2, I had virtually abandoned IPC as a focus of interest. This shift occurred primarily in relation to the realisation that while interprofessionalism and collaboration were typically the focus of IPC literature, IPC is about how practitioners from different disciplines work together in practice, but 'practice' was taken for granted. This seemed an important oversight in my own thinking and also in the healthcare literature. Thus, my interest shifted to understanding practice and, to paraphrase poet Robert Frost (1993), this road less taken proved to be the sustaining question of my research. This movement away from IPC to an interest in practice is the first major theme of my work. It is important to summarise and critique the discourse that I am moving away from in all three themes, and it is to this task that I now turn.

Interprofessional Collaborative Practice – The Dominant Discourse

Virtually all current policy, health services, and health human resource literature identifies IPC as essential to high quality, patient-centred care, and a sustainable health system from the perspectives of cost and continued access to a productive and satisfied healthcare workforce (e.g., Canadian Health Services Research Foundation, 2006a, 2006b; D'Amour and Oandasan, 2004; Health Council

of Canada, 2006; Romanow, 2002; World Health Organization, 2010). The first recommendation of the Health Council of Canada stated, *"Sufficient numbers of health care providers* ***trained in teams*** *… must be in place;* ***otherwise all other efforts [will] flounder****"* (2006: 1, emphasis added). IPC has been shown to improve patient safety, reduce undesirable symptoms such as pain and anxiety, and reduce hospital length of stay and readmission rates. There is also some evidence that IPC improves recruitment and retention of staff (Suter and Deutschlander, 2010).

IPC is defined as a patient-centred process of communication and decision making that enables the separate and shared knowledge and skills of providers and patients to synergistically influence care (Way et al., 2001). Specific characteristics of IPC are identified such as partnership and shared decision making (Orchard et al., 2005), constructive exploration of differences and the ability to seek solutions that go beyond narrow discipline-specific perspectives of what is possible (Gray, 1998), blurring of practice boundaries and the ability to offer the highest level of unique scope of practice (Gilbert, 2005), being responsive, evolving and emergent (Lahey and Currie, 2005), no single right way (Health Canada, 2006), continuous interaction and interdependence (Curran, 2004; D'Amour and Oandasan, 2004; Hartman et al., 1999), and collective responsibility for outcomes (Hartman et al., 1999). These 'ideal' characteristics of IPC are often thought of as competencies that can be taught, tested, and reliably applied (CIHC, 2010). I often highlight them in presentations about IPC (Project 2) as evocative phrases from which I believe participants could construct a feel for IPC and, therefore, know if they are practicing correctly.

Identified barriers to IPC include professional culture and the socialisation of healthcare students to their discipline specific practices (Hall, 2005), poor understanding of teamwork (Pearson and Spencer, 1995), limited opportunities for meaningful interprofessional communication (Lewin and Reeves, 2011; Reeves, Rice, et al., 2009), the influence of hegemonic power relations (Whitehead, 2007), failure to master the requisite competencies (CIHC, 2010), and technological and architectural barriers (Lamb et al., 2010). Leadership is thought to play a key role in achieving sustainable practice changes, so when leaders do not have the competencies required to support IPC, practitioners are less likely to practice collaboratively (Barker et al., 2005; Casida and Parker, 2011; Evans, 1994). Finally, barriers are identified related to the challenge of change, since initiatives often fail to meet or sustain predetermined improvement goals (Casida and Parker, 2011; Crabtree et al., 2010).

A Critique of the Dominant View of IPC

I want to critique four aspects of the dominant view IPC and articulate the possible consequences. First, much of the dominant discourse is grounded in systems thinking. This means that IPC tends to be (re)presented as a model or object—a system—that can be codified and enacted through competency-based education and carefully planned change strategies. Stacey argued that in this kind of systemic process thinking, practice is understood as a system that exists separate from experience, as a kind of hidden reality consisting of codified routines formulated by leaders and followed by individual practitioners as best practice (2007: 263-264). This can be a helpful simplification that supports interlocutors in a discussion about IPC. However, if it were the total story that some rational people (experts) could formulate best practices and design simple, or even complex, processes that other rational people (practitioners) could follow such that interprofessional practice would happen and achieve the intended results, then it would be even more puzzling that the widespread adoption and more or less perfect enactment of IPC seems to be elusive. Moreover, while codified competencies and teaching can be helpful to understanding the skills, knowledge, and attitudes that might be helpful to practice, competencies can also cover over the complex interplay between intentions and relations of power as interdependent actors negotiate their day-to-day actions (Glover et al., 2011).

Second, interprofessionalism involves interdependent relationships between people with different backgrounds who find themselves working together to achieve shared teleoaffective intentions (Sandberg and Tsoukas, 2011). This means that team members develop a shared understanding of the ends toward which the collective effort is directed and of how participants want to feel as they work together (e.g., experiencing job satisfaction and feeling included and valued) and agree to work together to achieve both. This is not a simple, linear process achieved through the voluntary cooperation of competent individuals (Stacey, 2007). Professional development is generally understood as a process whereby individual professionals learn, become competent, and continue to develop through the acquisition of knowledge that is taught by an expert, often in a classroom away from the sites of practices. The expert transfers his or her knowledge to an individual practitioner then the practitioner transfers that knowledge to the practice site. This way of thinking about learning and practice is congruent with the explanatory model in healthcare,

which is highly focused on autonomous individuals who acquire, transfer, and apply knowledge more or less skilfully and little influenced by the context in which the practice occurs (Boud and Hager, 2011). It is less congruent with the experience of practitioners, for whom things are not as neat and tidy. Such pre-specification and standardisation of what is to be learned oversimplifies practice as the application or transfer of acquired theory and cannot account for the inevitable uniqueness of each situation in which it is applied. More importantly, this way of thinking emphasises only the normative aspects of a practitioner's role. It ignores the equally important dispositional dimensions of practice—historically patterned perceptions, appreciation, and action or *habitus* (Bourdieu, 1980/1990) and the interactive-situational dimensions of the social construction of knowledge and knowing in practice (Goffman, 1983; Tsoukas, 2005).

At every turn the unavoidably social nature of practice and knowledge/knowing is lost. Learning, theory, and practice are viewed as distinct concepts in need of expert mediation to successfully translate knowledge to practice. In this divorce of theory and practice, theory (abstract, propositional, rational, expert, normative) is privileged to the virtual exclusion of other important ways of knowing (e.g., intuitive, imaginative, or practical wisdom). Importantly, the focus of the process of learning is almost exclusively on the dyadic interaction between an individual and an expert, whether live, print, or electronic (Benner et al., 2010; Boud and Hager, 2011: 2-5). Typical approaches to team building often acknowledge individual differences, but do so in order to eradicate them as efforts are directed toward gaining agreement about team vision, mission, values, goals and objectives, scope of practice, roles and work processes, and rules of conduct (often referred to as ground rules or rules of engagement), including rules for managing conflict. Lewin and Reeves (2011) observed that these formal team processes do more to perpetuate hegemonic structures than they do to break them down. This approach suggests that enlightened leaders and the 'aligned' members of the team can act as a single, unified entity and, therefore, meet their own and organisational expectations. These representations of and processes for building team-based practice have almost more status than people do, and discount the social nature of the practices of a community in which interactions are embodied, contextual, temporal, emergent, cooperative and competitive, and unpredictably predictable, all at the same time (Stacey, 2007).

Third, presenting IPC as *a* model of practice implies there is a way of practicing that does not involve two or more disciplines working together in more or less helpful ways. I can think of no circumstance in which one person or one discipline practices alone—there is always the patient in sight, and generally at least two and often many more disciplines work together and are required to communicate, cooperate, coordinate, and collaborate to more or less successfully achieve the teleoaffective intentions toward which their collective efforts are directed. Thinking that IPC is one among other types of practice underscores the reification of IPC, invites its depiction in normative language, and masks the temporal and emergent social construction of practices in particular contexts.

Fourth, in the IPC literature, much attention is focused on the involvement and recognition of multiple disciplines (the 'interprofessional' aspect of IPC). This leads to the articulation of rules of conduct intended to achieve the desired collaboration among team members and descriptions that focus on the roles, tasks, competencies and scope of practice of each discipline (CIHC, 2010). Moreover, the practices of all members of a given discipline tend to be considered homogeneously, as if the practice of 'physiotherapy' or 'medicine' is universal and invariant—enacted the same way by any member of the discipline independent of the interplay between the intent, values, and experience of individual practitioners collaboratively engaged with other practitioners.

Such thinking covers over the complex, contested, and unpredictable day-to-day interactions among interdependent agents. The world of practice in the dominant discourse is a 'represented' world of objects with pre-given characteristics that practitioners can know cognitively and apply correctly (Sandberg and Tsoukas, 2011: 340; Varela et al., 1991: 134-135). Attention is given to what one expert or another adduces should be done on measuring compliance with best practice and developing improved change and sustainment strategies. All of this is helpful but limited. Little attention is given to understanding how people actually work together, make sense of what is happening in the moment, and decide what to do next.

Thinking about IPC from these scientific, technical, and systems perspectives alone splits theory (cognitive/abstract) and practice (action/particular) and privileges theory. It considers people and relationships as instrumental, knowledge and power as individual possessions, and learning as a process of acquisition and transfer. Furthermore, expert developers of models of practice such as IPC codify structures,

processes, and relationships that local leaders can tweak (but not substantially change) to implement the practice model. Management experts then develop implementation plans intended to realise the enfolded reality and, through various metrics, compare the correspondence between the plan and what actually emerges to improve the match.

In the end, people are directed and managed by experts and are considered to be the means to achieving the harmonious working of a designed system through which the goals of the organisation become shared and are achieved. Schon (2001) described this general approach as a dilemma of rigour versus relevance, and further stated,

> *When planners or managers convert an uncertain situation into a solvable problem, they construct – as John Dewey pointed out long ago – not only the means to be deployed but the ends-in-view to be achieved. In such problem-setting, ends and means are reciprocally determined … [but] in the unstable world of practice, where methods and theories developed in one context are unsuited to another, practitioners function as researchers, inventing the techniques and models appropriate to the situation at hand.* (2001: 6)

Schon (and Dewey) pointed to the impossibility of solving complex social situations by theorising and then implementing solutions. Schon pointed instead to the importance of practice-as-research, in which ends and means influence each other recursively in the emerging context. Following Mead (1923: 247), I also argue that theoretical idealisations function as cult values and serve a useful purpose in terms of giving people a sense of what the game is and what the rules are. However, people determine the next move by making sense of and constantly adjusting to the actual situations they face. Uncertain (indeterminate) situations cannot be converted into problems that can be solved in advance.

How then do practice theorists conceive of practice(s)? It is to this question that I turn. First, I will set out the logics of science and practice. Then I will articulate a social view of practice.

From IPC to Practice as a Social Phenomenon

The Logics of Science and Practice

In their own ways, authors I have referred to in interpreting the project narratives, such as Sandberg and Tsoukas (2011), Bourdieu (1977; 1980/1990), Flyvbjerg (2001), and Schatzki (2002; 2005; 2010), have all critiqued the adequacy of

relying solely on the logic of science as an explanatory framework for practice. Particularly following the arguments of Sandberg and Tsoukas (2011), I want to revisit the problem of the logic of science, but emphasise that I do not do so in order to dismiss it. I do so because the hegemony of the logic of science in healthcare results, in my view, in a tendency to disconnect knowledge from its social construction in practice, in which knowledge encounters *"the wall that only practice can pierce"* (Deleuze, as discussed with Foucault, 1977/1980: 205). The logic of science reduces what is valued to rational cognition and loses the multiple ways in which meaning arises when practice pierces and further informs theory. I seek to show the generative tension between these two iteratively co-expressed perspectives; generalised knowledge can contribute to our understanding of particular situations, but it cannot take into account the particular circumstances of each situation. Nor can objective knowledge or practice guidelines that are developed from generalised knowledge account for or completely overcome the pre-reflexive practices of a community that powerfully enable and constrain action on grounds beyond rational logic. Furthermore, the logic of science abstracts the dimension of time, in which practices are embodied experiences that unfold moment by moment in the on-going interactions—in time, not out of time (Sandberg and Tsoukas, 2011: 341). As Bourdieu pointed out, the flow and *"directionality of practice is* ***constitutive of its meaning****"* (1980/1990: 81, emphasis added).

I agree with Sandberg and Tsoukas (2011: 342) that Heidegger's social ontology offers a helpful view of the logic of practice. Two aspects of Heidegger's work are particularly important. First, he argues 'being-in-the-world' as our most basic way of relating, not subject/object relations. By this Heidegger meant we are inseparable from the particular context we find ourselves in. Second, Heidegger insisted that experience is temporal and embodied—we dwell in time and in our experience (Heidegger 1927/1966: 48-51). Sandberg and Tsoukas referred to this as 'entwinement' and stressed, *"We are never separate but always already entwined with others and with things in specific … sociomaterial practices*[3] *such as teaching, nursing, managing"* (2011: 349). In other words, 'being', for Heidegger, is not an autonomous state, but a socially and culturally bound (entwined) state. In the context

[3] The term "sociomaterial practices" implies that practices involve interdependent interactions between agents and that artifacts such as documents and guidelines, as well as use of space and equipment are all part of the complex interplay of the practices of a discipline and of a particular community.

of the practices of a community, this creates conditions of intelligibility—that which makes it possible for practitioners to make sense of and decide how to proceed in the indeterminate and non-contingent yet coherent practices of a particular community (Lubinow, 2002; Traynor, 2009). I will turn now to develop a social understanding of practices, again emphasising the generative tension between the logics of science/theory and practice/action.

A Social Understanding of Practices – from IPC to Practice(s)

A range of social theories are helpful for understanding practices. Many emphasise practices as temporal, embodied interactions between actors in a particular context and in which particular actions make sense to those who are involved in relations of power and identity formation (Sandberg and Tsoukas, 2011; Stacey, 2007). Stacey (2010) emphasised that practices are complex, yet paradoxically stable and potentially novel at the same time and that human interaction is interdependent, unpredictably predictable, coherent, and complex. People cooperate and compete to develop and enact specific teleoaffective intentions and seek to produce goods that are internal to the practices of a particular context, such as a community of interprofessional practice or a profession (MacIntyre, 1984: 187; Sandberg and Tsoukas, 2011; Shaw, 2002). Standards of practice excellence are established and modified by the practice experience itself, the historical practices of a particular community, and by the regulatory requirements of professional bodies and artifacts such as policies and guidelines (MacIntyre, 1984).

Foucault argued that practice(s) are local discursive patterns *"where what is said and what is done, rules imposed and reasons given, the planned and the taken-for-granted meet and interconnect"* (Foucault, 1994: 225). Nicolis and Prigogine suggested that practices involve not only the interplay between the behaviour of its actors, but also the *"impinging constraints"* (1989: 232)—and enablement—of the practices of the community. Nicolis and Prigogine pointed out that human beings negotiate individual projects and desires; the radical implication of which is that there is no grand guiding vision or plan that can unproblematically unfold a designed future.

> *Recording a particular history among the multitude of the possible histories does not necessarily reflect the action of a global planner attempting to optimize some overall function, but simply that this*

> *particular pattern is a … viable mode of behaviour [for now].* (1989: 240-241)

Projects 2, 3, and 4 show how powerfully the established discourse of a particular community influences retrospective views about what happened and prospective views about what should or could happen. In Project 3, for example, there were patterns of practices unknown to me as a newcomer that powerfully influenced how my Director understood what my work would be. Her view contrasted to my perspectives that were just as unknown to her. Historical discursive practices influence the on-going constitution of social relations (how we organise ourselves), and these practices are always political (Shaw, 2002). They can, according to Shaw, literally render certain people and/or opinions silent, and I certainly experienced this, as described in Project 3. In Project 4, the team was open to reflexive discussion about the practices of their community and, as a result, there was a greater chance that historical practices could be understood and potentially modified. Their intent was to modify the practices in a way that would improve their ability to work together as a team, but whether a change would be an improvement or not, could only be adduced as they continued to work and reflect together.

As people practice together in specific contexts, they draw on history, background knowledge, experience, and habituated interactional patterns, including relations of power, that implicitly and explicitly guide how they make sense of and negotiate actions (Schatzki, 2005; Stacey and Griffin, 2005; Stacey, 2010). Thus, I argue it is in the embodied, interdependent and temporal flow of actions *in a particular setting* that persons are able to determine what action(s) makes sense. Schatzki argued, *"Action and its motivation … span past, present and future dimensions of time"* (2010: 115). The CRG faculty draw on Mead (1932) and arrive at similar conclusions, which they refer to as transformative causality (Project 2). Mead wrote:

> *Reality exists in a present … [that] implies a past and a future, and to both these we deny existence … for that which has passed would not have ceased to exist, and that which is to exist would already be in that inclusive present …* ***for that which marks a present is its becoming and its disappearing***. (1932: 1; emphasis added)

This is the profoundly important idea that ordinary experience is informed by and informs the past and future as well as the present. Time, in this view, is not understood as linear: what *"marks a present is its becoming and disappearing"*

(Mead, 1932: 1) that convinces the CRG scholars and me of the importance of paying attention to the actions we take together, since it is through those actions that organisation and change occurs. Strategic plans and normative guidelines are informative, but do not alone determine the actions we take. I contend there is paradoxical tension between the intentions expressed in evidence-based guidelines and those lived in the contingent situated action of humans. This tension was expressed in Project 4 when a nurse who became frustrated with the highly theoretical discussion we were having about boundaries wondered why we were discussing this and what it had to do with the team. That query opened a new and critical discussion that was extremely helpful. This reflects the tension I am arguing for between theory and practice, since it was this need to connect what we were talking about with practice-based experience that also moved the theoretical discussion in a different—and more pragmatic—direction.

Theme 2 is now beginning to emerge, so I will turn to it now.

Theme 2: From Practices to the Practices of a Particular Community

Introduction

By moving from practices to the practices of a particular community, I mean to imply that the influences of practices are strongest among people who regularly interact with one another; as such, in a hospital the practices of each local community or site of practice are unique. This is hidden by the near exclusive focus in healthcare on theory (represented as best practice), which is thought to be universally applicable and, therefore, discounts differences in the practice experience of each site. Other forms of knowledge and knowing, for example intuitive or phronetic knowing, can more easily render visible the uniqueness of each local context and patient and thus make important contribution to sense making and decision making. I also point to the significant influence of interdependent interactions among persons as they negotiate intentions, relations of power, and ideologies. A convincing account of practices must account for the uniqueness practices in local sites and the iterative co-expression of theory and practices. I will also address relations of power as an important consideration in all relationships because it tends to be overlooked in the dominant literature.

In Projects 2, 3 and 4, I described my participation in three very different sites of practices[4], and in each I experienced myself and my participation with and others differently. The CRG scholars have taken Mead's (1934) thesis that mind, self, and society are formed in paradoxical iterative co-expression very seriously, and show that in organisations particular patterns of interdependent interaction (the 'local') are enabled, while others are constrained by population-wide patterns that paradoxically both arise from and are modified by continued local interaction. Novelty potentially arises when differences expose what is taken for granted (Sandberg and Tsoukas, 2011; Stacey, 2007; Heidegger, 1927/1996) and are recognised as *"differences that make a difference"* (Bateson, 1972: 99). Bateson distinguished the difference that would make a difference (e.g., knowing the value of a coin) from a difference that would not make a difference (e.g., knowing when the coin was minted).

Understanding how the practices of particular communities come to be unique when compared to other practice communities has become, for me, a 'difference that makes a difference'. Varela et al. (1991) noted that when people self-organise (a feature of complex adaptive systems, which the CRG theorists take as an analogy for their work on organisation) they do not act on a representation of a pre-given, independent world. Instead, *"they enact a world as a domain of distinctions inseparable from the structure embodied by cognition"* (1991: 140). In this theme, I emphasise the social construction of reality through iterative co-expression of local and population-wide patterns within a given site of practice. This inevitably creates differences between sites of practices in an organisation, which collectively are also expressed as organisation-wide patterns. I will also discuss power in this theme, which emerged as an important consideration in Project 2.

Sites of Practices – Practices of Communities

Returning to the Narratives

In Project 2, I reflected on an in-service education presentation held in a conference room. In this instance, the actual site or location was incidental except as a

[4] I have been using the term "sites of practices" to avoid confusing what I am exploring (the practices of a community) with Lave and Wenger's (1991) "communities of practice". "Community" is an important concept with respect to what I am exploring, since I am arguing that practices are best understood in the context of a particular community. I further argue that the practices within a given site of practice can be thought of following Mead (1938) as a social object in which participants tend to act in particular ways.

‘container’ for a temporary community to come together for a brief and highly focused interaction involving me as an ‘outside expert’ and a team of people who routinely work together. As a one-off presentation, the norms and values that influenced the actions of all of us were guided by what it meant to each of us to be civil in polite society with relative strangers and how we all reacted in the moment to what happening and how we interacted. The team and I wanted to give a favourable account of ourselves in the context of this very temporary community—a particular relation of power that invited polite behaviour and constrained more engaged behaviour, particularly when experience was perceived to be negative. Following Mead (1938), I argue that the in-service presentation is a ‘social object’, by which Mead meant the generalised tendency of participants in groups to act in particular ways. He argued that groups were formed and continuously shaped by a struggle to both maintain and transform the ‘life process of the group’. This struggle is very close to what I am calling the practices of a community. Participants in the in-service education (including me) were unwilling to overtly challenge the ‘usual’ life process of a gathering like this; however, for the participants, this desire remained in tension with the fact that what I was discussing did not meaningfully connect with their experience, and my unwillingness to draw attention to my sense that they seemed disconnected from each other and from what I was presenting.

In Project 3, the site of practices was the Practice Office. The practices of the community in which my Director and I were both entwined, constrained and enabled our experience in particular ways that neither of us independently created. As a new member of the Practice Office, and as the only non-nurse, I made several erroneous assumptions about the practices of this particular community that inadvertently exposed particular power relationships in the office. For example, I assumed incorrectly that it was unnecessary to advise my Director in advance of bringing ideas to the Practice Office as a whole for discussion. The discursive patterns a particular community act to sustain specific relations of power that are unpredictably predictable. This paradox creates the possibility for transformation is also unpredictably predictable (Stacey, 2010: 68-70).

The idea of social object (Mead, 1923) as the generalised tendencies of people who consistently work together in groups of any size to act in particular ways is a useful way to consider the practices of organisations as a whole and of parts of organisations that constitute smaller work groups, like those in which the Project

narratives occurred. Organisations also have what Mead (1923) called cult values, expressed as corporate mission, vision, and values statements. For Mead, cult values do not direct, nor are they directly expressed in the on-going interactions of employees. Instead, cult values are particularised in local interactions; that is to say, cult values may influence local interactions, but these are necessarily also influenced by (for example) the values, relations of power, and habitus that uniquely form and are expressed in the practices of a particular community. The implication is that two medicine units in the same hospital that serve similar patient populations with similar staff, even if they are proximately located, develop unique practices. This happens through local interactions that are embodied, temporal, and discursive sociomaterial[5] practices that emerge in and from those practices, which include that community's response to and particularisation of a grand plan. All of this happens uniquely in each practice site through complex responsive processes of relating that are locally negotiated for a pragmatic sense of viability. In other words, the grand plan or best practice guideline is not without influence, but inevitably remains in generative tension with the strong influence of local discursive practices.

In Project 4, the site of the practices in which I participated was a small but very complex clinical unit in which the staff had experienced significant challenges over a prolonged period. Key changes in program philosophy and personnel had exposed and interrupted longstanding patterns of interaction, and the team was unsure how to proceed. Established patterns were viewed on balance as negative—there was a sense that things needed to change, and I was asked to help the staff work more closely together as an interprofessional team. We met together biweekly for loosely structured conversations aimed at making sense of their practices and determining how the team wanted to work together. We committed to continue meeting for at least a year; in this longer-term commitment I became a temporary participant/member in a particular practice (team meetings) of their community. This way of working together generated sustained change in how the team perceived its practices, and I will take this up more in Theme 3.

[5] My initial search to understand practice was more about finding the 'right' language, definitions, and representation, and less about the multiple factors that enable and constrain what people do in the context of specific complex interdependent interactions or the fact that practices also involve interaction with things (e.g., equipment and policies) and processes (e.g., wound care and documentation), hence 'sociomaterial' practices.

Stacey and Griffin argued organisation is the interdependent, cooperative and competitive, embodied, temporal experiences understood as *"acts of communication, relations of power, and the interplay between people's choices arising in acts of evaluation"* (2005: 3). These authors argued that local interactions form and are formed by population-wide patterns of acting, which I am framing as local and global patterns being iteratively co-expressed. Stacey and Griffin did not emphasise, as I am, how this local/global iterative patterning emerges in subgroups of an organisation that are also influenced by organisation-wide patterns. This nuance is important in healthcare since the dominance of positivism suggests that 'best practice' *is* independent of the practice context in which it occurs and *should be* independent of practitioners' evaluative choice or interactional patterns. It is this characterisation that I am specifically arguing against in thinking about the practices of particular communities. The inevitable interdependence between local actors and the iterative nature of local and global patterns *in particular communities* has profound implications for actors form and carry out intentions (ethics), who we are and how we recognise each other (identity), and how we learn, make sense of our world, and negotiate together in light of our inevitable differences (knowledge/power). This is crucial to understanding healthcare practices as complex responsive processes of human relating and to understanding the role of a PC (Theme 3).

The unique character of the practices in each of the project narratives importantly influenced what I attended to, how I participated, and how my participation influenced the life processes of the group. As a consultant, I may have a transformative intent and remit, but I can only act interdependently with members of the group and its particular life processes. Recall my inadvertent attempt to break the established discursive pattern in the practice office related to how ideas were developed and shared and being forcefully pulled back into line. Recently, another person joined the practice office who, like me, is not a nurse and has no previous experience working in this particular office. Our Director's advice to this individual was that she should 'observe meetings for a year before starting to contribute', so she could 'understand how things worked' and thus be accepted as a member of team. It was a very powerful silencing of a voice that, like mine, may have exposed particular power relations and other patterned behaviour that go unnoticed precisely because they are largely pre-reflexive patterned behaviours. This is a very strong constraint imposed in the interests of not disturbing the life process of the group, and it brings

me to the question of power as an important consideration in the practices of a community.

Relations of Power and Interdependence in the Practices of Communities

Relations of power emerged as an important theme in Project 3 and are rarely discussed in the healthcare literature or in the day-to-day working world of practising clinicians, despite being keenly felt. When power is discussed, it is often presented as an undesirable quality that can and should be 'levelled' so that everyone has an equal opportunity to influence decisions and actions. It is thought, for example, that team members will or ought to become willing to share power more equally through clarifying their own and each other's roles, learning to value everyone's input, and developing trusting relationships (Abdel-Halim, 1983; Heller, 1998; Krackhardt, 1990; Orchard et al., 2005). The implication is that power is a possession or character that individuals have. The argument is that those with more power cannot choose to have less, but they can choose exercise it in ways that allow others to have influence as well. This voluntary restriction on the use of one's power can be also be withdrawn, thus making it necessary to periodically re-learn the value of everyone's roles and re-establish trusting relationships (Orchard et al., 2005).

Elias (1970/1978) and Foucault (1982) are among those who contend that power is social phenomenon enacted in constantly shifting webs of interdependent relationships in which we experience being enabled and constrained. Elias (1970/1978) referred to these interdependent relationships as 'figurations' and argued that participants constrain one another to a greater or lesser degree in response to the unequal ability of each party to exert influence over the other. This influence is more or less stable, but can shift if the context unexpectedly fluctuates. I agree and further argue (following Heidegger, 1927/1966 and Sandberg and Tsoukas, 2011) that when participants are entwined in their context, they are less aware of how relations of power influence their actions. When the unexpected causes a first order breakdown (that is, a breakdown in habituated behaviour that happens naturally) or a second order breakdown (one deliberately induced by a leader or consultant to raise issues for discussion) occurs, the influence of relations of power and many other aspects of the practices of a community that are otherwise taken for granted may come into sharper focus and be questioned (Sandberg and Tsoukas, 2011).

Elias (1970/1978) stressed that whether specific actions in a figuration are enabling or constraining, the relationship is functional, by which he meant that each person (whether friend or enemy) performs a function for the other—they are interdependent. Foucault (1982: 790) argued interdependence as a necessary condition for relations of power to exist, citing that the need for interlocutors to have at least some measure of freedom to resist the action upon further action. This is an important distinction since, for example, interdependent practitioners may act 'as if' they are not ("I was only following the Doctor's orders") and thus fail in their ethical obligation to act in the best interest of the patient, even if that means not 'following orders'.

It follows that failure to recognise our interdependence may ultimately give way to resignation or violence. In Project 3, both my Director and I implicitly understood that there was a limit to the ways in which we could disagree without an unacceptable risk to our continued relationship and our identity as reasonable people, skilled at talking through differences. We were both well respected in the organisation and had different but relatively even power chances in terms our ability to influence one another. Margaret had more authoritative power and a longer history of service with hospital. She had a good reputation overall, but it included a reputation that she is aware of as being quite conservative in her thinking. I had a reputation as a good leader and innovative thinker in an environment in which both are valued. The new position I held was created with me in mind, so Margaret stood to lose credibility if I were to leave or be excused from the position. However, that did not give me free license to interfere with Margaret's reputation or standing. All of these nuances in our particular relation of power and our mostly implicit recognition of them made it necessary to act within and not break the generative tension between our very different views by taking extreme action with respect to our disparate views.

To further explore the idea interdependence, I want to point again to the CRG scholars who, drawing on Mead (1934), critique the notion of an autonomous self in favour of the concept of a social self, in which identity arises in continuing dialectical processes with others. Following Bourdieu (1980/1990) and Elias (1970/1978), they acknowledge the importance of the particular context in which these dialectical processes occur. The practices of a community are imbued with historically influenced patterns of sense making and behaviour, which Bourdieu referred to as the field (from which habitus arises) and Elias simply called *habitus*. Both are referring to

pre-reflexive patterns of interaction that inform, but are not solely determinative of, the actions people choose. New patterns of action and behaviour can and do arise, but what the idea of habitus emphasises is that not just anything can happen. These scholars argued there is paradoxical tension between the actions that follow past patterns and provide limited stability and predictability so that we know how to act into each new moment. At the same time, actions may destabilise aspects of patterned behaviour (through first- or second-order breakdown or recognition of difference) and potentially lead to transformation of the practices.

To summarise, in the practices of communities, personal and professional identity arise through dynamic, complex, contested, responsive processes of relating in which the interlocutors' relations of power are key influences. There are many influential sociomaterial practices in local sites of practice such as commitment to shared teleoaffective intentions; defined distinctions about what matters, such as what constitutes success or failure or what is worthy/unworthy of consideration; the expectation of achievement of certain standards of excellence defined by job descriptions, professional licensing boards, or best practice guidelines; the performance of tasks and actions such as providing and documenting care, attending meetings, and ordering supplies; and using particular tools, such as charts and clinical equipment. I do not mean to imply either the union of positivist thinking (theory) with complex, dynamical processes (practices) into some kind of mystical whole, or a dualistic Kantian both/and formulation. Instead, I am continuing to point to the paradoxical generative tension as theory and practice are iteratively co-expressed through the emergent moment-by-moment (in time, not out of time) lived experience of interdependent interlocutors engaged in and also continuing to form the particular and multifaceted practices of a community.

What I have presented in Theme 2 is a more complex, richer view of the practices of communities and processes of relating, including relations of power that express our interdependence, than is typical in the dominant ways of thinking about 'practice' in healthcare. I have not abandoned positivism but continue to hold that the logic of science and the logic of practice are equally insufficient to explain or explore the complexity of practices in modern healthcare settings. It is nonsensical to think, for example, that because it cannot account for the unique situations in which it will be applied science or evidence-based best practice guidelines should be abandoned. It would be equally nonsensical to insist that scientific evidence can fully account for or

determine the practices in a particular community. Drawing on Weick (2007), Sandberg and Tsoukas stressed,

> *Contrary to the possible impression that scientific rationality is merely concerned with theory … and practical rationality merely with practice … they are equally concerned with* ***both*** *theory and practice… [they] differ … in their assumptions about how theory and practice are related … practical rationality makes theory derivative of practice and thus more reflective of the "richness" of practice … scientific rationality … makes practice derivative of theory and, thus … more abstract.* (2011: 339, original emphasis)

What Weick (2007) was getting at is that practices, experienced as temporal and embodied phenomena, are contingent, complex, unpredictable, and emergent (thus 'rich'). When theory is understood as derived from practical experience, a more reality congruent range of influences are taken into account. It can be argued that practice (experience) is primary, since theory can only arise from and be revised through practice. Theory and practice are nevertheless iterative and co-expressed aspects of the practice/theory paradox.

It is noteworthy that, except for Shaw (2002), the CRG scholars have largely been silent about 'practice' and 'practices'. They have done this to avoid doubling their theory of action as a theory of practice and to emphasise their contention that theory/practice are paradoxically co-expressed. Taking a cue from Charles Taylor who argued that *"social theory arises when we try to formulate explicitly what we are doing, describe the activity which is central to practice"* (1985: 93), I contend that by ignoring the concept of practice, the CRG scholars contribute to the precise confusion between theory, practice, and action that they are trying to avoid.

Questions now emerge from Theme 1 and 2 about how this understanding of practices as social phenomena involving local communities informs my thinking/acting as a PC, and in particular when the specific remit of the consultancy is to support collaboration between members of different disciplines in practice, education, and research. This is the subject of Theme 3 and the 'so what' of understanding practices and the practices of communities. It is to this third theme that I now want to turn my attention.

Theme 3

From Practice Consultant as "*Expert*" to Practice Consultant as (Temporary) Engaged Participant in the Practices of a Particular Community

Introduction

I want to introduce Theme 3 by briefly recasting Themes 1 and 2 and setting out some of the strands on the practice 'web of significance' because I contend that the practices of the PC must reflect an understanding the practices of a community. I have argued thus far that the practices of a community are discursive and constituted in embodied, temporal interdependent action and include or are influenced by theory, policy, expected standards of excellence, what matters to people as they work together (values, ethics), relations of power, what is normatively binding (e.g., expected standards of excellence, policies, guidelines), implicit understanding of what constitutes success and failure, embodied and interdependent sociomaterial practices (including the use of tools), and relationships with other sites of practices internal to and beyond the organisation. Moreover, even though many of the practices of a community are implicit, they create the conditions of intelligibility for the participation and action in a particular community.

More simply, multiple elements (representational and relational) constitute the practices of a community; these practices help people to make sense of what they are doing and negotiate/decide what to do next. At the same time, what people do together maintains and transforms the practices of a community, which continues to influence interdependent interaction. Thus, transformation of the practices of a community happens through on-going embodied, temporal, interdependent actions. These actions constitute the iterative co-expression of the theory/practice paradox. I contend that by participating as a temporary member of the practice community—a stance that Elias (1987) called involved detachment—a PC can point to many of the implicit and taken-for-granted practices of the community, support more fluid conversation, and enlarge and deepen the sense of community among its members. This way of thinking reflects a shift from thinking of a PC as an expert and places the emphasis on the importance of the PC becoming a temporary participant in the on-going practices of a particular community. In this Theme, I will show how this thinking emerged from the projects, draw attention to important experiential aspects

of the research method, and discuss relational ethics as a framework for thinking about ethics in consultancy practices.

Loosening my Attachment to Consultant as Expert

Experiencing Experience as Method
Projects 1 through 3

Project 1 was an autobiographical exploration of my thinking and formatively influential literature—surely a topic in which only I could be the expert. A key aspect of research method is the reflexive engagement with project drafts by members of the learning set (primary supervisor and a small number of students). Through this reflexive engagement with others, the student is better able to understand what she is taking for granted and to notice how relations of power and her identity shift in the conduct of the research. In the Methods section of this synopsis, I will make the point that the method is in a sense beyond method—it is more a way of experiencing the complex responsive processes of our human relating through which we make sense of experience, and in the process, continuously construct ourselves and the social reality in which we participate. This idea of 'experiencing' (taking note of) experience is crucial to how I am formulating the role of a PC since it can be destabilising and thus open the possibility of change.

Making sense of being a PC began in the first draft of Project 1, in which I produced an almost unassailable first draft—my colleagues reported having difficulty 'finding a way in'. Although I was describing my own life journey—and surely I was the unassailable expert about that—it was only through reflexive engagement with others that my taken-for-granted presuppositions were surfaced and questioned. Colleagues asked what was 'different' about IPC, why I thought it was the best way for people to practice, why a single day early in my 40-year career remained for me the ideal enactment of IPC, and what 'ideal' would even mean in the highly complex and heterogeneous world of healthcare. My colleagues were, in effect, acting as consultants to the social construction of my becoming, and this way of working together continued to contribute significantly to how my views about myself and what a consultant is doing in her practice were forming.

By the end of Project 3, I was arguing that defining practice roles or how interdependent practitioners from different disciplines 'should' work together was not helpful, and that it was necessary to 'think within living participation' (Shaw, 2002).

Shaw was referring to the theory/practice paradox, but I had taken it up as a move away from theory to practice. I moved away from the acquisition and transfer metaphor of knowledge that is so dominant in healthcare, in which knowledge is acquired by and exists in the head of an expert and is subsequently transferred to someone else who enacts it in the practice setting (Boud and Hager, 2011). Practice-based theories of knowledge emphasise knowledge as provisional and learning as a participatory social phenomenon (Nicolini et al., 2003), and this I took up in opposition to rational knowledge. I increasingly believed that offering tools and techniques, representations, and algorithms would be ineffective and counterproductive, and instead vaguely advocated for participation within the practices of those with whom I was working. The baby was at risk of being thrown out with the bathwater, as I came closer to abandoning one pole of a dualism that included IPC, epistemic knowledge, plans, and tools and techniques, to take up participation as the other. I all but lost the paradoxical generative tension of theory/practice and positivist/interpretivist thinking that I am now arguing is so important.

The Social Construction of Knowledge

Practices Transforming Knowledge Transforming Practices

I now argue—following Shotter and Tsoukas (2011)—that organisational knowledge is developed through paradoxical, iterative processes of representation (artifacts such as policies and guidelines), signification (meaning making), and improvisation in practice (the interpretation and enactment of representations in the immediate circumstances and the enmeshed practices of the community). Situated experience can never be fully described, and this makes knowledge impossible to represent *in toto*, but this does not mean all things abstract, including representations, are worthless. The CRG scholars have tended to dismiss tools and techniques since they have the potential to restrain what can be talked about, but of course they also have the potential to enable conversation. In an unpublished work, Stacey (2012) modified this and suggested that tools and techniques can be helpful, but that because they are predictive devices (e.g., an agenda predicts how a meeting will go and a Myers-Briggs Personality Type Inventory predicts how people will act and interact),

and organisation is inherently unpredictable, he cautioned it is wise to reflect on what we think we are doing when we use them.

In an ethnographic analysis of how knowledge was produced and used by two health care CoPs, Gabbay et al. concluded that personal knowledge was ascendant over 'expert' knowledge, knowledge is transformed through experiential internalisation, knowledge processing in groups involves unpredictable contingencies, and that sense making in group involves complex interplay between roles, intentions, and power among participants (2003: 308). Gabbay et al. also found that CoPs did not adopt 'evidence-based' models of practice, even with considerable effort on the part of 'expert' PCs to help them do so. Instead, these communities exhibited more socially determined and dynamic patterns of collective sense making and decision making. These groups did not discount the evidence, but instead weighed it according to the degree of correspondence between the evidence and their own experience and also, but less so, relative to the power and influence of those who presented and defended the evidence. These findings also pointed to the generative tension between theory/practice and the primacy of the practice experience (Gabbay and le May, 2011; Sandberg and Tsoukas, 2011).

Becoming a (Temporary) Engaged Participant in the Practices of a Particular Community

Enlarging and Deepening a Sense of Community
Project 4

Stacey suggested that the role of the consultant

> *becomes one of participating in the local interactions of organizational life with the purpose of aiding the development of more fluid conversation in which the potential for both continuity and change emerge.* (2010: 299)

This made more and more sense to me. If practices are transformed in on-going interdependent interaction among the members of a community, it makes sense that a vital purpose being served by the consultant becoming a participant in it is the enlargement and deepening of a sense of community in which *"human desire and choice count for something [and people have the freedom to reorganize] experience based on intelligent inquiry"* (Dewey, 1922: 21).

In Project 4, I described working with a team that I met with twice monthly over a long period of time. Initially, I used some tools to identify issues of concern

and provided some information about IPC that helped to orient discussions in a particular direction. As we got to know one another and to understand what we could count on each other for, tools and diagrams were less useful and less welcome. Team members offered topics for discussion that came from their immediate experiences in practice, began to talk more freely about how they were impacted by very challenging patient situations, were satisfied with discovering just the next step, and began to resist solutions offered by 'experts'. People began to link discussions—"Remember when we talked about … I finally understand that. Today …"—and a story would unfold that reflected significant changes in how this community was making sense of its practices. By becoming a temporary participant in the practices of that particular community and maintaining a stance of detached involvement, I was able to articulate some of the practices of their community. This in turn helped the team to *"reorganize their experience based on intelligent inquiry"* (Dewey, 1922: 21), so they could make better sense of what they were doing together and decide what to do next.

I argue (following Sandberg and Tsoukas, 2011) that the focus of a PC also needs to shift from the intense focus on normative expectations, predictive devices, and measurement and control to include the relational context of the practices of communities and the temporary breakdowns that make it possible for practitioners to detach from their involvement and reflexively understand their sociomaterial practices. First-order breakdowns (naturally occurring) and second-order breakdowns (deliberately induced) allow community members to step out of absorbed coping so they are able to reflect on and *"reorganize experience based on intelligent inquiry"* (Dewey, 1922: 21). Working within the practices of particular community is important because work does not always involve contingently linked variables that can be predicted, planned, captured, and codified—work also involves the unpredictable flow of organisational life in which contingencies can become unlinked and new, unexpected patterns can temporarily or permanently emerge.

Mowles (2011) argued that consultancy is a form of temporary leadership, which, for Griffin and Stacey (2005), is a particular figuration of power identified through processes of recognition that are co-created and emerge in on-going social interaction. Griffin and Stacey suggested that what is being recognised as leadership is an ability to articulate the emerging themes in ordinary interaction so that people understand how to take the next step, an enhanced ability to take the attitude of others and to act in a wide range of ways (including the ability and willingness to take risks

and to act spontaneously), and the ability to tolerate anxiety and uncertainty (2005: 10-13). This is true of the leadership provided by a PC. Since a consultant is often called on to support a team through ethically charged challenges, I want to turn briefly to consider the ethical stance that came out of the discussions in Project 4 and that I argue is highly relevant in the complex responsive processes of relating together.

The Practices of Communities as a Context for Relational Ethics

I argued in Project 4 that ethical discernment was at the heart of that team's discussion about boundaries and ethics remains a preeminent focus as we make sense of working through challenging situations. If as I have argued a PC acts spontaneously, speaks directly into first- and second-order breakdowns, and takes risks, she will not just encounter but also generate tensions around values and ethics, thus the topic of ethics warrants consideration.

At the heart of ethical discernment lie processes of decision making about what one 'ought' to do. In that sense, ethical discernment tends to look to future actions. Traditional frameworks of principle-based ethics support ethical discernment by suggesting general principles that it can be helpful to consider such as avoiding harm, doing good, respecting autonomy, and ensuring just use distribution of resources justice (Bergum and Dosseter, 2005; Beauchamp and Childress, 1989). Simply applying these normative ethical principles often does not clarify solution, or even the next steps, and it is difficult in my experience to appropriately consider the complex, relational, and contextual circumstances in which challenging ethical decisions must be made using normative frameworks. This is precisely the dilemma the team in Project 4 encountered when they drew a simple diagram of how boundaries are formed. The simplicity and clarity of the diagram were immediately appealing, but questions were quickly raised that could only be considered in terms of the precise circumstances and relationships of a particular situation.

Relational ethics does not exclude normative considerations, but takes the wider relational context of the circumstances to be a legitimate focus (Bergum and Dossetor, 2005). Niebuhr (1963) argued the insufficiency of normative ethics, which are typically discussed in terms of duty (deontology), what is considered 'right' according to a rule or law, or teleology, what is the 'good' or the desired end to be achieved. Niebuhr argued for what he called an ethics of responsibility (relational

ethics), in which action may be judged 'fitting' if it makes sense in the context of on-going interactions of interdependent humans in particular contexts. Niebuhr's ideas were based on his interpretation of Mead's (1934) social construction of mind, self, and society. Following Mead, Niebuhr argued that the social self exists as *"members of a group"* (the use of the plural 'members' denotes that the social self is not an isolated individual) and that fitting action is not something to be decided through the approval and disapproval of other individuals, but through understanding *"the ethos of society"* and the on-going interpersonal interactions (1963: 78-79).

Like Mead's social object, the 'ethos of society', as Niebuhr termed it, is also very close to what I am calling the practices of a community, and I agree that these practices importantly influence how members of the community formulate, make sense of, and act into the ethical challenges they face, as was evident in Project 4. The processes of relating are complex and responsive, as I have been throughout this work, and again point to the generative tension between universal principles and experience as a deeply textured, historic, and emergent social phenomenon. I also intend to frame the role of a consultant as form of ethical practice, and that frame is underrepresented in the dominant literature about consulting or the practices of communities. Insofar as the dominant literature on consulting does take ethics into account, it tends to be inferred through teambuilding strategies that identify the values team members are invited to commit to and agreements about decision making and conflict resolution. Given that, it is important to say something about teambuilding.

Like the tension between principle-based and relational ethics, the tension between traditional teambuilding strategies and lived experience is instructive. Lewin and Reeves' (2011) ethnographic study of collaboration among disciplines in an acute care hospital showed that the formal structures and processes of teamwork such as shared team identity, goals, values, and formal agreements around rules of engagement do more to create the appearance of teamwork than to actually support its enactment. This is similar to principle-based ethics creating the appearance of ethically sound decisions, but failing when enacted in living experience. Lewin and Reeves found that when normative practices and communication mechanisms are identified and enforced, hegemonic power relations and strong professional identities tended to be maintained rather than weakened, and weakening these structures is valued since it is thought they inhibit collaboration. I suggest that traditional team-building activities can usefully orient the community to or develop shared intentions,

but these intentions rarely correspond directly in the practices of the community. Lewis and Reeves found greater collaboration and more equal relations of power in what Goffman (1959) called the backstage conversations that happen when the team is not 'performing' in its public role, but instead is acting more spontaneously. Returning the context of ethics, I argue that principle-based ethics can help teams to articulate intentions, but intentions must then be enacted through in the on-going, somewhat messy, and predictably unpredictable interactions between people. PCs, I contend, can use artifacts that demonstrate knowledge and evidence, but must also work iteratively with the generative tension between normative and emergent processes to enlarge and deepen the sense of community.

Earlier in this section, I discussed some experiential aspects of the research method used in this body of work. I will turn now to discuss the method in more detail.

The Research Method

Introduction

In this section I will describe and situate the research method of the DMan program with research traditions that focus on reflexive interpretation of experience. I will first set out the research method from the perspectives of the CRG scholars, and then discuss the distinctions typically made between positivist and interpretive methods. Following Rorty (1982) and his analysis of Dewey and Foucault, I will then present a view of the research method that holds positivist and interpretative methods in generative tension, rather than seeing them as oppositional methods, which I find to be a compelling perspective for the healthcare environment where positivism is so dominant. At the end of that section, I will discuss validity and generalisability. Finally, I will address issues related to research ethics.

Research in the DMan – The Perspective of Complex Responsive Processes of Relating

Focused on organisational development and change, the research methodology of the DMan is qualitative and takes an interpretivist stance grounded in pragmatist philosophy—described by Weiss as *"a method, not a creed; an attitude, not a conclusion"* (1942: 185)—and the specific discourse of complex responsive processes of relating. This discourse understands organisation as processes of human relating

that are simultaneously cooperative-conflictual and competitive-conflictual *"acts of communication, relations of power, and the interplay between people's choices arising in actions of evaluation"* (Stacey and Griffin, 2005: 3). In this way of thinking, local interactions are understood to both emerge from and at the same time form population-wide patterns of action. Moreover, actions lead to further actions that are always predictably unpredictable whether or not there is a blueprint or plan. It follows that to understand or influence an organisation, one must at least look to or actually be involved with the local interaction(s) in which global tendencies to act are taken up (Stacey and Griffin, 2005: 9). For Stacey and Griffin, this means the insights of research must arise in the researcher's reflections on her own experience and is thus reflexive in an individual sense. Importantly, the method is also reflexive in a social sense since the researcher locates her emerging insights in the wider traditions of thought, shares project drafts with colleagues in a learning set and the full program cohort who also engage reflexively with the narrative, and shares emerging insights with family and colleagues. All of this further deepens the potential to expose presuppositions and understand different perspectives on experience (Stacey and Griffin, 2005: 23).

Bourdieu (1997/2000) argued that action is never purely rational or individual in the sense of being entirely uninfluenced. Bourdieu argued, *"The agent is never completely the subject of [their] own practices"* (2000: 138-139); rather we act according to dispositional forces (*habitus*) of our historicity (*field*). *Reflection*, the recounting of experience in a detailed and nuanced way, can surface features of our thinking in the narrative that might not otherwise be considered, and bring alternative views into focus about what we are doing together. *Reflexive engagement* with the narratives goes beyond a description of experience and the immediate sense-making process, to articulate the assumptions and preconceptions that underlie thoughts and actions and explore the complex interplay of power, intentions, and the extant practices of interdependent experience. For Bourdieu, reflexive sociology is the *"systematic exploration of the unthought categories of thought which delimit the thinkable and predetermine the thought"* (1982, cited by Bourdieu and Wacquant, 1992: 10). In effect, we step back from our involvement through what Elias (1987) called a 'detour via detachment' to make sense of experience.

Broadly situated in a range of reflexive interpretative research methods, such as hermeneutics (Gadamer, 1975), phenomenology (Van Manen, 1990; 2007),

organisational ethnography (Alvesson, 2009; Alvesson and Skoldberg, 2009), autoethnography (Ellingson and Ellis, 2008), and phronetic research (Flyvbjerg, 2004), when used in organisational research, these methods all seek to interpret practice-based experience (phenomena) that both use and generate practical wisdom. These methods tend to not have an emancipatory agenda nor—in contrast to action research, which I will also discuss (Reason and Tolbert, 2001)—do they set out to solve a problem, though either may happen. The goal (and this point is crucial to the method) is to understand and build reflexive theory about the researcher's lived experience with others, *not* representational theory that seeks ultimate truth or universal law. This does not mean representational theory is wrong or unhelpful. It simply means that this method is likely to increase opportunities for engagement within a community of practitioners that open up and inform debate and transcend linear, deterministic metaphors (Greenlagh et al., 2011). Neither does the method seek to discover 'truth' as a given but hidden reality; this is more characteristic of what positivist approaches seek. Positivist and interpretivist approaches are often situated in opposition to one another, but I will argue they can be understood as integral aspects of the theory/practice paradox and, following Rorty (e.g. 1982; 1991), Dewey (e.g. 1934; 1958; 1984) and Foucault (e.g. 1975/1995; 1977/1980) suggest they are in generative tension with, not in opposition to, one another. First, I will situate the DMan method with other similar research methods, pointing also to some key distinctions.

A Brief Overview of Methods Similar to those used on the DMan Program

Research methods that focus on the science of management or organisational development privilege positivist empirical methods in which researchers study objects or subjects from a distance with the aim to discover inherent qualities or generate new knowledge, both thought of as truth (Alvesson and Skoldberg, 2009). This thinking stems from Galileo, who believed that thinking of things as objective, value-free, amoral masses of particles bumping into one another improved mathematical prediction and, therefore, the 'knowability' of things. Thus scientists used the language that nature herself uses, so science did not just happen to work, it worked because this is the way things really are (Rorty, 1982: 191).

The perspectives of complex responsive processes do not claim to be value-free or to seek absolute truth. Unlike sceptical post-modern traditions (e.g., Gergen,

2009a), this perspective does not abandon all claims to any kind of truth, nor does it reject the possibility of useful generalisations about human interaction (Stacey and Griffin, 2005). Many interpretative methods in the social sciences share the CRG scholars' intent to understand human experience without necessarily seeking a further specific emancipatory outcome, even though changes in the interdependent exercise of human freedom might result from understanding experience. If changes do occur, what the changes would be and whether they would be an improvement or not would be impossible to accurately predict or fully plan for.

A number of methods in qualitative methodology share some common features with the approach taken in the DMan program. For example, Alvesson (2009) advocated a method he described as at-home ethnography, in which researchers make sense of the lived experiences of their own organisations through observation within their own organisation, but do not emphasise their own experience. The term at-home ethnography *"draws attention to …what goes on around oneself rather than putting oneself and ones experiences at the centre"* (2009: 160). Alvesson likened the stance of the researcher to being a *"fly on the wall"* (2009: 162) and advised that while traditional ethnography requires the researcher to 'break-in' to a culture s/he is not part of, at-home ethnographers must 'break-away' from their own taken-for-granted views since those views may inhibit the development of alternative interpretations of experience. It is difficult to see how being 'at home' yet not part of the phenomena being studied is substantially different than more traditional participant observer ethnographic approaches that attempt to take an 'objective' or 'outsider' stance. The discourse of complex responsive processes of relating denies that such a stance is even possible. For the CRG scholars, one is inevitably involved even if one is observing as an outsider. The notion that there is a system that one can observe from a distance is common in the dominant systems thinking discourse (e.g., Senge, 1990/2006).

In Project 3, one interpretation of the narrative might be that I, as the researcher, was observing and interpreting Margaret's behaviour more like a fly on the wall than as a participant with her in the dynamic between us. If that were the case, the method might then be closer to at-home ethnography, in which the researcher is part of the organisation, but not a participant in the interaction s/he was actively observing. However, Project 3 was about *my experience* of the situation that I described (not Margaret's experience), and thus it is certainly possible that Margaret

would find the narrative untrue or objectionable—it is likely, in fact, that this would be the case. Someone interested in "truth", as it is traditionally understood (correspondence with reality—a thing as it actually is), might well take issue with what could seem like a biased presentation of the narrative. However, "truth" is not the purpose to be served by this method—first, because the method is grounded in a pragmatist philosophy that questions essentialism (a premise I struggled with but ultimately came to support), and second because the purpose of the method is to describe and interpret my experience through multiple processes of reflexive engagement with others and from those practices to move from one theoretical position to another and to continue to engage in further experience.

For Ellingson and Ellis, autoethnography *"operates as a bridge, connecting autobiography and ethnography … to study the intersection of self and other, self and culture"* (2008: 446). Except for the implied dualism between self and other and between self and culture, this is close to what the complex responsive processes research method seeks through the process of sense-making. Ellingson and Ellis further claimed social constructionism as the underlying epistemology (in which meaning is constructed through communicative interaction) and autoethnography as a process of critical reflection on *"taken for granted aspects of society, groups, relationships and the self"* (2008: 446) that is centrally concerned to *"understand what people know and how they create, apply, contest and act upon what they know and autoethnography"* (2008: 447-448). Ellingson and Ellis argued that autoethnography is a *"space in which an individual's passion can bridge individual and collective experience to enable richness of representation, complexity of understanding, and inspiration for activism"* (2008: 447).

The research data for autoethnography can take a narrative format (much like the DMan narrative), or it can consist of photographs, journal entries, two-chair 'conversations' in which the researcher interviews or counsels herself, poetry, or multimedia collages. This potential emphasis on creative imagery as research data is one feature that distinguishes autoethnography from social reflexive engagement with researchers' actual experience in work settings as in the DMan program. It also prompted a critique (or perhaps a warning) from Alvesson who equated autoethnography with memory work and suggested that both are more *"autobiographical than observational … the outcome of the research (writing) appears so personal that its contribution to scientific study is, for many readers, not*

clear or convincing" (2009: 160). By contrast, Alvesson argued that at-home ethnography *"emphasizes the careful documentation and interpretation of … social events …* [witnessed by the researcher] *… the analysis does not necessarily emphasize the personal meaning or strongly subjective aspects of the research/event/experience"* (2009:160). He did not argue that at-home ethnography is purely objective, only that the degree to which the researcher allows her own experience to influence or be expressed through the research process is low or moderate and is thus not introspection.

In Alvesson's writing about at-home ethnography and his critique of autoethnography, I experienced a tension between the embrace of the personal and (inter)subjective and the desire for acceptance in a world where positivist thinking remains hegemonic. In autoethnography, there is a striking lack of emphasis on the reflexive engagement *with others* that characterises the DMan method. Had I employed autoethnography as a method in my projects, I would potentially have included artefacts as data (minutes of meetings, care guidelines and protocols, for example), and may have written more creatively (narrating discussions or using entries from a personal or research journal); while these are all legitimate sources for reflection in the tradition of autoethnography, my purpose was to recount my own experience, seek the themes that emerge from the narrative and through reflexive engagement about those themes with others in the program of study and in the literature to make sense of my experience as I experienced it, not by way of the more personal and creative multimedia reflections of autoethnography. Engaging with my own experience in this way influenced the way in which I engage with others in my role as a PC, which would be more difficult using the methods common in autoethnography, although the methods might be equally helpful in interpreting the experience that a researcher writes about. Complex responsive processes of relating argues the inevitability of the paradox that global patterns arise from and influence local interactions, and this leads to an understanding that experience simply leads to further experience, the character of which is both personal and interpersonal, subjective and intersubjective, predictable (stable) and unpredictable (potentially novel) all at the same time (Stacey, 2007). As a discipline, autoethnography is less interested in global patterns and in a way denies the impact of local interactions on global patterning while being willing to embrace the impact of global patterning on individuals. This, to me, is both a key difference between autoethnography and

complex responsive processes of relating and a potential shortcoming of autoethnography.

Finlay (2008) explored what she called the phenomenological attitude that suspends presuppositions to go beyond the taken for granted. Following Husserl (1936/1970; 1928/1983) and Gadamer (1975/1989/2004), Finlay stressed that the researcher, in this approach, restrains pre-understanding and remains open to being moved by the experience of the other in a relational context. A key issue for Finlay is that the researcher is inevitably involved even in describing the experience of others, since describing and interpreting can only be done in the midst of the researcher's own experiencing. For Finlay (2003), the researcher engages with experience through an iterative and dialectic process of hermeneutic (interpretive) reflexivity that moves beyond the partiality of her initial understanding and her investment in particular research outcomes. This is very similar to the ideology of the CRG scholars, but unlike Finlay, the CRG scholars also engage a wider community in the reflexive process. Finlay does not discount, but also does not emphasise as the CRG scholars do, the value of reflexive engagement with the researcher's own experience.

Van Manen (1990) also followed Husserl (1936/1970; 1928/1983) and described phenomenology as

> *the study of the lifeworld – by which [Husserl] means the world as we pre-reflexively experience it—rather than as we conceptualize, categorize, or reflect on it ... [with the aim of] gaining a deeper understanding of the nature or meaning of our everyday experience.* (1990: 9)

Phenomenology aims to generate insightful descriptions of the way we experience the world rather than abstracting experience in taxonomic descriptions or classifications. Phenomenologists, therefore, avoid theorising about how to explain or control the world in favour of seeking plausible insights that *"bring us in more direct contact with the world"* (1990: 9). This too shares some common ground with the CRG method. While the study of experience (phenomenology) shares a commitment to study-lived experience, van Manen tended toward a phenomenological approach that sought to find the essence of a phenomenon—*"the nature of a thing ... (without which it could not be what it is)"* (1990: 177). Thus in the quote above, van Manen conflated "nature" with "meaning", in which nature is understood as truth and meaning as interpretation of truth. By using "or" between nature and meaning, he lost this important distinction. In contrast, the CRG group, following Mead (1934),

understands that the exploration of experience simply leads to further experience (not to truth) and argued there is no point at which the true and immutable essence of phenomenon could be found that would render any further interpretation pointless. This point is crucial to understanding concepts of validity and reliability in this method, which I explore in a later section.

Finally, action research is a research method that is increasingly common in healthcare contexts. I present it here not because of the similarities to the DMan method (though there are similarities[6]), but because of the differences. Like the CRG scholars, proponents of action research resist the positivist paradigms of truth as inherent and discoverable by an observing subject who is distant from the object of her observation (and is thus protected from subjectivity). This formulation of knowledge and truth is misleading in the context of practice (Reason and Torbert, 2001: 3). Empirical positivism ignored the infinite terrain of first-person research, and in the 1960s, the linguistic turn in organisational research embraced and sought to bring attention to first-person research through interpreting situated experience and grasping the crucial role of language in the construction of meaning (Reason and Bradbury, 2000; Reason and Torbert, 2001). Van Maanen argued that language carried constitutional force—no longer was something like organisation, or for that matter an atom, a priori to understanding and representation (1995: 34). The subsequent turn to 'action' re-envisioned not only the method of social science (from strict empiricism to greater reliance on interpretivism) but also the *nature* and *purpose* of social science (from discovered truth to "[forging] *a direct link between intellectual knowledge and moment-to-moment personal and social action, so that inquiry contributes* ***directly*** *to the flourishing of human persons, their communities, and the eco-systems of which they are a part*" (Reason and Torbert, 2001: 5).

Action research thus aims at changing three things: "*practitioners' practices, their* ***understanding*** *of their practices, and the* ***conditions*** *in which they practice*" (Kemmis, 2009: 463; original emphasis). This represented four important changes from empirical research: a turn from an abstract body of knowledge to practical knowing; a shift from an expert (distant) researcher to collaborative relations with those directly involved in the practices being examined; a shift of attention from

[6] Action research and complex responsive processes of relating share roots in pragmatism, phenomenology, and critical theory.

representational knowledge to knowing based in sensing, feeling, thinking, attending to the experiential presence of persons in their world; and from generating abstract theory to understanding what act is timely now (Reason and Torbert, 2001: 7). The direct and democratic involvement as co-researchers of those participating routinely in the practices that are being changed is crucial to action research. Action research then, is an emergent process of engagement with practice problems, through many ways of knowing, in participative relationships, the central purpose of which is the reflexive generation of solutions to practical problems that lead to a normative theory about what act is timely for the present moment (Reason, 2006; Reason and Torbert, 2001). Action research starts from what concerns us in practice with the intent to find a solution, which is then expressed as normative theory until the next concern initiates another research cycle. Complex responsive processes of relating method starts from experience with the intent to reflexively make sense of experience, and this simply leads to further experience. A change in practice, understanding of practice, and the context of practice may happen (and if it does happen may be an improvement or not), but this is not the explicit purpose of the research method. The principles of emergence and paradox are taken very seriously in the body of knowledge that constitutes complex responsive processes of relating. While both are acknowledged in action research methods, they tend to be downplayed in favour of finding and implementing solutions (albeit temporary).

If I had employed action research in my work with the EDP for example, our work together would first have involved the identification of a problem—something that was keeping the team from practicing in the way they wanted to. We might then have applied a common action research strategy such as empirically tested and successive small tests of change, until an appropriate solution was discovered and rolled out. Without denying that this may have been helpful, the complex interplay involved in the sociomaterial practices of that community would have been completely covered over. Small tests of change as part of broader on-going processes of shared sense-making process may have more to offer than PDSA cycles in the absence of the broader discussion, but the purpose of the body of work for this thesis was not to solve a particular problem (nor was the specific purpose of my work with the EDP team), and action research from that perspective would not have been an appropriate method.

Notwithstanding the noted differences between various non-empiricist research strategies and complex responsive processes of relating and between empiricism and interpretivism in general terms, I will continue to argue (following Rorty, Dewey, and Foucault) that rather than being in opposition, positivism and interpretivism are better characterised as being in generative tension that is iteratively co-expressed.

Seeking the Generative Tension between Positivist and Interpretivist Scholarship

Rorty, Dewey, and Foucault on Method

Rorty (1982) contended that binding the search for generalisations to rationality and method brought credibility to the scientific method in modern times. However, Rorty argued that the original sense of 'method', was *"simply to have a comprehensive list of topics or headings"* (1982: 192-193)—essentially, to have an efficient filing system, the purpose of which was to integrate and relate strategies for understanding the world more than to distinguish or separate them. However, in a post-Cartesian sense, there was methodological split that, instead of organising thought, filtered thought *"to eliminate subjective, non-cognitive or confused elements, leaving only the thoughts which are Nature's Own"* (1982: 193). Rorty suggested the usual casting of scientific method (in social sciences typified by behaviourism) in opposition to interpretive methods such as hermeneutic phenomenology is misguided. He argued that while the distinction is usually made on the basis of segregating evaluative or descriptive terms in language and using their absence as a criterion for being scientific (objective), there is nothing to prevent anybody from using any term 'evaluatively'.

> *The issue between those who hanker after "objective", "value-free", "truly scientific" social science and those who think this should be replaced with something more hermeneutical is misdirected as quarrel about method. A quarrel about method requires a common goal, and disagreement about the means for reaching it. But the two sides to this quarrel are not disagreeing about how to get more accurate predictions of what will happen [or what the true nature of a thing is].* (1982: 194)

Rorty argued against the view that the quarrel between qualitative and quantitative approaches is a dualistic quarrel about the best method to get the common goal of accurate predictions or the true nature of something. While it is more accurate, he also believed that casting the argument as a dispute between 'explanation' and

'understanding' is misdirected. Rorty acknowledged the contrast between them, but articulated it as a difference to be lived with, not resolved. I agree with Rorty. He did not see representational and reflexive approaches as oppositional—not two different ways of getting to the same end or even necessarily looking at the same 'object', but ways to articulate something distinct and contextually valuable that increases our ability to function and grow in social solidarity. If, in our embrace of an interpretivist agenda, we dismiss the logic of science altogether, I also agree with Rorty's claim that it would simply be another version of *"Nature's Own Vocabulary"* (1982: 195). However, there is a disclaimer:

> *As long as we think of knowledge as representing reality rather than [helping us to cope] with it mind or language will continue to seem numinous … We shall not worry about how [narrative] is related to … "quantified behavioral science" … When the notion of knowledge as representation goes, then the notion of inquiry as split into discrete sectors with discrete subject matters goes … the lines between subject matters are drawn by reference to current practical concerns, rather than putative ontological status.* (Rorty, 1982: 197-198)

Rorty's argument rests on the idea of how we understand knowledge. Behaviourism identified the constitution of humanity in individual, realist terms, and thus uses value-neutral methods intended to reveal truth; hermeneutics understands the constitution of humanity in social/relational terms and seeks to interpret experience. So as long as we understand knowledge as representational, only behaviourism makes sense and remains oppositional to interpretivism. However, if knowledge is understood as a means of understanding how to cope and continue on with life, Rorty argued that whether the knowledge is physical or social, meaning and constitution arise in a web of relationships formed through the generative tension between different methods.

> *Fossils are* ***constituted*** *as fossils by a web of relationships to other fossils and to the speech of the paleontologists who described such relationships. If you can't grasp some of these relationships, the fossil will remain, to you, a mere rock.* ***Anything is, for purposes of being inquired into****, "****constituted****" by a web of meaning****.*** (1982: 195, emphasis added)

Thus, by recasting our understanding of knowledge, Rorty found it possible to stand with Dewey in advancing the purpose of social sciences—representational and hermeneutic—as enlarging and deepening our sense of community and thus enhancing our ability to cope with life together – in other words, inquiry serves to

enhance social solidarity and as such, social inquiry is also moral discourse. Foucault (1977/1980) emphasised the way in which the social sciences have served as instruments of the disciplinary society through the relationships between knowledge and power as opposed to the Deweyan formulation of the relationship between knowledge and human solidarity. Rorty concluded that we should not view Dewey and Foucault as having a theoretical difference, but rather, a difference over what it is reasonable to hope for (1982: 198).

Dewey's position is, in a sense, beyond method, since it allows humankind to be free to make itself—in other words, experimentation is about understanding knowledge claims as proposals about what actions to try out next. For Dewey,

> *Experience [is] … the only method for getting at nature, penetrating its secrets, and wherein nature is empirically disclosed … deepens, enriches, and directs the further development of experience.* (1958: 2a)

Dewey classified his thinking in this regard as *"naturalistic humanism"* (1958: 1a). I contend this description is particularly relevant to the ways in which empiricism and interpretivism dance together in healthcare sites of practices in cooperative/competitive patterns in the intersecting iteratively co-expressed processes of representation, signification, and improvisation (Theme 3). There is hard push in health care to 'translate evidence into practice', even though it is generally understood that it is impossible to do, and that if it could be done would be harmful, since every patient, provider, and patient–provider relationship is unique. Greenhalgh and Wieringa (2011) pointed to the need to move beyond 'knowledge translation' metaphors to include phronesis (practical wisdom), and tacit knowledge built and shared through relationship between health providers in what we take to be legitimate knowledge. Like Foucault, Greenhalgh and Wieringa also called for an understanding of the links between power and knowledge, again, an important consideration in healthcare environments.

This idea is crucial to the CRG scholars and to the method of the DMan program. Reflexive engagement is not just *about* the narratives, *reflexive engagement generates knowledge claims about what to do next,* and this is what makes it so important that students reflexively engage with their own experiences. Keeping the generative tension between representation, signification, and interpretation alive was what made the work described in Project 4 valuable to the team. That way of working 'generated proposals about what to do next' that emerged in the context of our

discussions together and it generated knowledge claims that became proposals about how a PC can work with a team (Theme 3). In my interaction with the team, at times I focused on abstract theoretical constructs (e.g., the initial discussion about boundaries) but was called back to practical experience when the group needed to make sense of the immediate circumstances of experience. This tension is also evident in the process of writing and theorising about practice and practicing theory through the reflexive method in which ideas about what to do next are developed through reflexive engagement with rich descriptions of experiences in which conflict and uncertainty are played out in the complex interplay of intentions and relations of power.

Dewey understood habit as a mode of organisation that commands action and has a hold on us because we are the habit. He argued that the transformation of habits is the reorganisation of experience based on intelligent inquiry (Dewey, 1922: 21) and suggested there were two schools of social reform. One understood morality as a mysterious, hidden aspect of personality so that the purification of the hearts of the people would change institutions. The other denied the existence of inner power and attributed all change to the forces of the outside, objective world (i.e., the theory/practice debate). Arguing for both/and at the same time (also the paradox in which the generative tension exists that I am arguing for), Dewey argued instead that:

> *All conduct is interaction between elements of human nature and the environment, natural and social … freedom is found in [the] … interaction which maintains an environment in which human desire and choice count for something.… There are … forces in man [sic] as well as without him [sic] … the problem [is] one of adjustment to be intelligently attained.* (1922: 9-10)

Foucault understood knowledge claims as moves in a power game: *"We are subject to the production of truth through power, and we cannot exercise power except through the production of truth"* (1972: 229). Rorty contrasted Foucault's notion of power with Dewey's: *"In Dewey's hands, the will to truth is not the urge to dominate [as it is for Foucault] but the urge to create, to achieve harmony among diverse desires"* (Rorty, 1982: 180). I think Rorty is mistaken to interpret Foucault as associating power exclusively with dominance; in my reading of Foucault, I think he argued that power is a feature of all relationships and how it plays out is extremely complex and not all about dominance, but also about creativity and knowledge. I also read Dewey differently; I do not think he saw the purpose of knowledge as producing

harmony, but of understanding through inquiry what to do next. I do, however, agree with Rorty's assertion that *"Foucault's vision of discourse as a network of power relations isn't that different from Dewey's vision of discourse as instrumental, as one element in the arsenal of tools people use to"* (1982: 180) enlarge and deepen their sense of community and through which they make sense of their experience and determine how to go on together.

The CRG scholars describe the DMan research method as taking a reflexive stance to narratives from one's own experience. The emphasis on this reflexive stance means that the researcher learns to *"let things come to [her]; … to defer judgment, to investigate and comprehend the … case in all its aspects"* (Nietzsche, cited by Flyvbjerg, 2001: 66). Dewey made a similar point in his advice to postpone the acceptance and assertion of suggested meaning (1922: 31). Dewey noted that means and ends are two descriptions of the same reality, in which *"the 'end' is a series of acts viewed at a remote stage and "means" the same series of acts viewed at an earlier one"* (1922: 34-36). This, to me, is another way to think about the paradoxical essence of the research method—that following Rorty, Dewey, and Foucault—I am claiming is method that is beyond method, and is, essentially, method as *practice/theory discourse*. In other words, the method of the DMan program is not something this is applied to a problem to determine a solution; it is a discursive practice through which the researcher makes sense of the practices of the particular community in which s/he is embedded by taking a stance of involved detachment through which s/he engages in a series of articulations, disarticulations, and rearticulations of pre-reflexive understanding. This potentially enlarges and deepens a sense of community, both in the context of the research community (i.e., the DMan cohort) and the work community from which the narrative is drawn.

This research method does not produce or use data, or generate findings in the sense that these terms are meant in empirical methods of study, in qualitative or quantitative methodology. It does not aspire to describe essential truth, nor does it set out to make a specific change, although change may well happen through the researcher's engagement. I have indicated (following Dewey) that it is a method that goes beyond method, by which I mean that by making sense of experience in conversation with others, including the relevant literature, it is possible that different ways of thinking will emerge. The researcher is a *"knowing and active participant in the drama of an on-moving world"* (Dewey, 1984: 232), in which habit and novelty

emerge together in predictably unpredictable ways. Questions of validity arise not in terms of whether experience has been described 'correctly', but whether the experience as described and interpreted makes sense to others and offers ways for them to understand their own experience in a more nuanced way. Similarly, generalisability is of limited interest in this method, but that is not to say that generalisations are not possible. Indeed, I argue that as others consider their own experience in light of the deep description and interpretation of experience described by the researcher, insights about their own experience are likely to arise. Discussion between students on the program who are thinking about extremely divergent practice environments (from healthcare to railways, manufacturing, wilderness training, leadership development, and international development) often gain quite profound and unexpected insights from engaging with one another's work. Peirce and Burks noted, *"We must not begin by talking of pure ideas—vagabond ideas that tramp the public roads without any human habitation—but we must begin with men [sic] and their conversation"* (1958: 83). Peirce and Burks were arguing that while theory and practice are paradoxical aspects of a single phenomenon (i.e., experience), practice is prior. I agree. The generalisability of my contributions will be found in whether as others read my work they find new ways of exploring or understanding their own experience.

A Note about Research Ethics

It is impossible to say in advance what narrative(s) will be selected or how they will be presented and interpreted. As a result, traditional informed consent is impossible. Throughout the projects and this synopsis, I have been exploring my own experience, and although my experience necessarily involves others, I am nevertheless drawing first from my own embedded experience and then experiencing the experience further through the reflexive method discussed and drawing on relevant literature. I have sometimes been challenged to explain how I know that a particular statement I have attributed to someone in recounting the narrative is true or, if I have made a statement not backed by peer-reviewed references, if that is 'only' my opinion. These questions are understandable in the dominant research ethics discourse, but problematic with this method since they assume there is a truth that can be verified either with reference to the literature or by an interlocutor. A question

more appropriate to the method would be whether or not, given what I have described, my interpretation seems insightful, resonates with the readers' own life experiences, or is helpful in making sense of the described experience.

I advised colleagues with whom I work that I was in the program and that I would be reflecting on my experience at work as a key part of the research method. Furthermore, I extended an invitation to colleagues to read the projects and engage in the process of reflection. I was relieved that no one took up the offer, suggesting a concern that persons might be troubled by my characterisations of situations described in the narrative. It also reflected my own discomfort with the ethics of nondisclosure in terms of the specific situations I was writing about. I did sense, as Wittgenstein noted, that *"practice has to speak for itself"* (1969: 145). Tsoukas (2005) interpreted Wittgenstein to mean that the narratives had to speak for themselves directly in their enactment, in my reflective re-presentation of them, and in further discourse about them with others.

Traditional ethics approval would involve a process of anticipatory promises (e.g., what the result of the research is expected to be, the benefits and risks to research 'subjects', confidentiality, and the ability of subjects to withdraw from the study without explanation or consequence). Data and data verification in qualitative processes is often thought to be achieved by 'triangulation', in which similar information is discovered in more than one way. However, the process of this research is emergent, not planned, and I do not claim to represent an 'essential' or 'ultimate' truth that can be verified even if others choose to reinterpret my narratives. I can only show how I have made sense of experience that I have had with others, and how that has contributed to my own understanding about what to do next in the writing of this thesis and the further performance of my work. I have used pseudonyms throughout and without destroying the integrity of the narrative, have disguised some of the specific circumstances. Should these particular projects be used in published work, I would further disguise the narratives.

The CRG scholars do not hold explicit goals of making a change or solving a problem through this research, although they acknowledge that either or both may happen (Stacey and Griffin, 2005). However, as a PC, I both want and am expected to make a difference, and as Doctoral student I am expected to articulate what I have contributed to the bodies of knowledge I have been exploring. It is to this task that I now turn.

Original Contributions

This report is a work in progress, and it certainly does not stand as my work alone. I am, as Isaac Newton famously quipped, *"a dwarf standing on the shoulders of giants"* (Turnbull, 1959: 416). I have been challenged and humbled throughout the process of my studies by feeling alternately brilliant and dull, original and fraudulent. Nevertheless, it is necessary to identify what I consider to be my original contributions to organizational development and change, and to professional practice.

The first contribution of this work to knowledge and practice relates to having problematised the concepts of 'interprofessional collaborative practice' and 'practice'. Following authors such as Stacey (2007), Stacey and Griffin (2005), Schatzki (2005; 2010), Gherardi (2009a; 2009b), MacIntrye (1984), and Sandberg and Tsoukas (2011), I have articulated practices as embodied, temporal social phenomena that emerge in interdependent interactions among participating members of particular communities in ways that are both cooperative and competitive and predictably unpredictable. Thought of in this way, all practices are both interprofessional and collaborative. Casting IPC as a form of practice (as opposed to understanding interprofessionalism and collaboration as aspects of all practices) has problematically diverted researchers and practitioners away from what is actually happening as practitioners work together and kept attention on more abstract ideals, including the effort to link change strategies such as team building with outcomes such as improved patient outcomes. While the corpus of published work in interprofessional education and collaborative practice has grown in both scope and depth over the last 20 years, the major research focus in that literature has been on building international consensus on definitions and competencies, strategies for team building, and empirical demonstration of improvements that can be related to health care teams practicing collaboratively. More recently, this literature has included research about pedagogical approaches that support interprofessional education and collaborative practice and the type or style of leadership needed to support its enactment. In both the general healthcare literature and the IPC literature, there is very little emphasis on practices as interdependent and emergent social phenomena that are influenced by many factors that include, but go well beyond, the intentions of organisational leaders (expressed in plans and policies) and the current evidence of 'best practice' (which it is hoped can drive practice).

The second contribution of this work to the healthcare literature challenges current thinking about what influences the practices of particular communities and how practices change. In healthcare efforts to 'close the gap' between evidence-based theory and practice continue to dominate both the philosophy of practice (as the identification and application of necessary tasks and processes so that the best available evidence is directly translated into care) and practice change strategies (which assume linear if-then causality where changes and change processes are planned and unproblematically unfolded as new practice). I argue (following authors such as Boud and Hager, 2011; Glover et al., 2011; Sandberg and Tsoukas, 2011; Stacey, 2007; and Varela et al., 1991) against the dominant view of organisations as systems, practice change as a linear process involving the cooperation of competent individuals who willingly follow experts and understand what to do next based on abstract and idealised representations. I do not deny that there is value to the current way of thinking, but find it insufficient to understand or explain how practitioners make sense of their work and decide what to do next as they continue to negotiate the moment-by-moment circumstances they face. My work proposes an understanding of the practices of a community in which theory/practice is viewed as a complex iterative co-expressed phenomenon in which theory and practice always remain in generative tension.

This calls for a significantly more complex understanding of nuances in the practices of communities in much smaller, local sites of practice, than is typical in the dominant literature. I have argued that the implementation of a strategic plan or evidence-based guideline happens uniquely in each site of practice because the plan can only be enacted through the on-going actions of interdependent practitioners in a specific practice environment in which practitioners are influenced by a very broad range of sociohistorical practices that are local to that community. How plans are enacted in the multiple sites of an organisation iteratively influence one another. How this iterative process goes—how practice/theory actually emerges—cannot be completely known in advance.

This has implications for the work that a PC would do, and the third contribution of my work picks up this theme. There is a surprising paucity of literature about the role of a PC in hospitals. In general, the consultant is viewed as being an expert with knowledge that is intended to help individual or groups of practitioners to understand and perform their duties. Typically, this is done through

brief instructional or ‘coaching’ contact. A PC may also be tasked to develop and/or implement changes in the practice environment, such as changes in staffing models, quality improvement strategies, new care processes or equipment, or supporting novice practitioners. In these roles, the consultant acts very much like a project manager, documenting the required changes and change processes and rolling out the change to the appropriate areas. I found no health-related literature that suggested a PC needed first to understand what practice is and none that discussed practices as I have characterised them. Without denying the valid role for rational positivism, the near total absence of health literature about the sociohistorical construction of the practices of communities, leaves PCs as experts in what people *should* do, and lacking in any focus on working as a temporary participant in the practices of a particular community to understand and explain what is *actually happening*. I have argued that it is only through doing so that a PC could understand and expose the implicit practices of the community that influence the moment-by-moment interactions between people (practitioners, patients, and visitors—all people). I have also argued, following the CRG scholars, that change happens through the living practices of a community and (following Shotter and Tsoukas, 2011) that these practices are influenced by simultaneous iterative processes of representation, signification, and improvisation.

In my work as a PC, I have radically changed how I think about what I am doing and what I am actually doing. For example, instead of starting with a plan or a facilitated process, I now generally start assignments, whether they are short or longer term, by talking with leaders and staff about the practices of their community, how they understand the issue at hand and how they think the issue arose. I take more time to work with people to understand and work with them to make sense of their day-to-day experience through having them tell and think about their own practice stories, understanding how people are impacted by their experience, and engaging in reflective practices. I draw attention to solutions if they emerge in the discussion and feel much more comfortable when I do not have solutions to offer. I also offer processes and information (including representations) that help to orient thinking and frameworks for thinking about many sides of an issue (e.g., the traditional ethical principles and the relational and contextual issues that colour and shape ethical discernment in practice). I point out the tensions between different ways of thinking/experiencing and to invite multiple perspectives. I am more comfortable

when things, for the moment, do not seem to make sense, and I do not grasp too tightly to moments when things do make sense.

I have proposed through this work (largely following Foucault and Elias) that power is an inherent aspect of human relating enacted through our relating. I also argue that relational ethics (following Bergum and Dossetor, 2005; and Niebuhr, 1963) is a practice-based ethics framework that holds traditional ethical principles and frameworks in generative tension with complex responsive processes of relating in practice. How I have formulated power and relational ethics are not original contributions, but coupling them with the understanding of practices of communities, the practices of consultants, and the body of work comprising complex responsive processes of relating offers a nuanced approach and context that taken all together is original.

Finally, the body of work of complex responsive processes of relating has to date, been largely silent about 'practice'. Given the ubiquitous use of 'practice' in most organisational literature, including health, and the tendency for practice and theory to be understood as dichotomous, barely related concepts, it is puzzling that this important literature about organisational development and change has ignored the concept of practice. Therefore, my extended treatment of 'practices' and the 'practices of communities', which importantly provides a way of talking about healthcare practices as a sociological phenomenon, contributes to that body of work. A final narrative will illustrate how these contributions would inform the potential approach to a critical issue in a health care setting.

A Final Narrative

To underscore the significance of my original contributions to my professional practice, I offer the following brief narrative. Mr Smith, an 86-year-old man, had minimally invasive abdominal surgery to remove a cancerous tumour on his kidney. After surgery, he developed delirium, an acute state of confusion often accompanied by paranoid delusions, visual or auditory hallucinations, and behaviours that include loud and continuous vocalisations, extreme physical agitation, and striking out at persons nearby. Delirium is considered a medical emergency and can persist over several days. The elderly are particularly vulnerable and can suffer permanent loss of function that places them at risk of placement in a nursing home. Mr Smith was extremely agitated; he yelled out in a loud voice almost constantly and frequently

tried to climb over his bedrails. When his assigned nurse went on her 1-hour break, she transferred Mr Smith's care to Nurse Glenda. Mr Smith had a "care aide" (an unregulated health assistant) whose job was to try to keep Mr Smith safe and prevent him from falling out of bed. Soon after his assigned nurse left for her break, Mr Smith was still yelling loudly and thrashing about. He got one leg over the bed rails. The care aide rang the emergency call bell and tried to prevent him from falling. When Glenda entered the room, she saw Mr Smith punch the care aide and climb the rest of the way over the bed rails; the care aide tried to prevent Mr Smith from injuring himself by breaking his fall to the floor. Mr Smith continued to thrash and yell and was bleeding from a minor cut on his head. The care aide was flustered, but appeared unhurt. Glenda shouted at Mr Smith, "You stupid old man – this serves you right. You can just stay on the floor until you stop yelling." She left the room, closing the door behind her. When she arrived back at the nurse's station, Glenda chuckled to herself and told two colleagues what she had done. She advised them to not say anything to the supervisor because "she would just get her tail in knot". Her two colleagues said nothing on that shift, but two days later one of them told two other colleagues, one of whom reported the incident.

Having been apprised of the situation, the leader considered the actions of each person directly involved. She determined that the assigned nurse acted responsibly in ensuring that when she went on her break, a specific person was designated to look after Mr Smith. She found Nurse Glenda did not act in a responsible, ethical, or professional manner and furthermore, that she acted with reckless disregard for the duty owed to both the patient and the care aide, who at that time was under her direct supervision. The extremely serious nature of her acts (blaming and severely punishing the patient for his involuntary behaviour; failing to determine if Mr Smith or the care aide were injured; taking pleasure in what she had done, literally boasting about it and advising colleagues not to tell the supervisor; failing to document this serious fall) were deemed sufficient to warrant her immediate dismissal from the workplace. She was also reported to her professional licensing body for failing to comply with the terms and conditions of her nursing licence, and to the police for investigation of what the leader felt was patient abuse (assault) on both physical and psychological grounds. The three nurses who knew of the incident and failed to report it immediately were each suspended for three months without pay and their actions were also reported to the licensing board. The care aide was suspended

for a week for failing to immediately report the incident—the shorter suspension recognised his place in the power dynamics in this situation and the fact that he continued throughout the incident to attend to the patient's needs. In addition, the hospital immediately and fully disclosed the details of the incident and the action taken to Mr Smith's family. Based on the actions taken by hospital against the staff responsible for this horrific incident, and that fact that Mr Smith was not injured by his fall, the family did not pursue legal action.

In this narrative, the leaders acted quickly and decisively and subscribed to a conception of practice in which individuals voluntarily choose to act in particular ways. Those choices are thought to reflect the combination of knowledge, skills, attitudes, values, and behaviours the individual holds. Further, it assumes that individual choice is free—not influenced or encumbered by what I have called the 'practices of the community'. Thinking in this way the redress for this incident was limited to action against individuals whose knowledge, attitudes, values, and/or behaviours failed to meet established standards of practice. This is appropriate, but it was all that was done and I argue it was therefore a grossly insufficient response to circumstances that were far more complex than is suggested by this individualistic approach. Efforts to prevent future incidents of a similar nature would be limited to ensuring policies and standards of practice are clear and clearly understood by each practitioner, and increasing both supervision and auditing to ensure individual compliance with those policies and standards. This individualistic response to serious incidents is all too common in healthcare.

I argue that conversations are urgently needed (in addition to the appropriate action taken against individuals whose practices were in fact negligent) to explore the practices of this particular community. This narrative illustrates that questions were asked about Glenda's conduct and that of some of the other nurses involved, but none were asked about the practices of this particular community – what were the global patterns emerging in the context of the on-going relations among the members of this particular community? In the days following the reporting of this incident, it came out that Nurse Glenda was known as a "bully"; she reportedly took equal aim at patients and staff. What could account for the tolerance of this behaviour? How was it that it took something this extreme to happen before someone felt obligated to advise the leader? How are we to account for the reluctance of three professional nurses and a care aide to report this extreme case of abuse? Did they fear Nurse Glenda? Had the

issue been raised previously and ignored? How do members of this particular community understand the causes of and treatment for delirium? How do they understand delirium? These questions need to be raised among the whole community – medical, nursing, and other clinical staff as well as administrative staff. Could Mr Smith's delirium have been better controlled through medical and other treatments? How does this community define success and failure, in general and with respect to this particular incident? How will this incident continue to play out in this particular community—will people be more likely or less likely to report incidents of poor patient care or frank abuse? Have there been other incidents like this that have gone unreported? Which practices within this community constrain practitioners from doing their best, and what enables stellar practices?

I have shown in this thesis that practice(s) are social in nature in both cooperative and competitive ways, and that they emerge in both predictable and unpredictable ways at the same time. Moreover, the practices of communities are influential pre-reflexive tendencies to act in ways that favour some practices and hinder others. I have also shown that these tendencies can only become visible or conscious when first- or second-order breakdowns expose those tendencies to conscious scrutiny. Since the tendencies arise from the on-going interdependent interaction between members of the community, seeking to explicitly understand the practices of the community can also potentially change them. The narrative described above is a first-order breakdown and certainly induced an incredible amount of discussion—both front-of-stage and backstage—but a second-order breakdown, in which leaders or consultants deliberately create opportunities for practitioners to understand and discuss the practices of their community, was also needed. Doing so could have exposed and led to discussion about the complex totality of influences that made it possible for this incident to happen in the way that it did, or at all. While such a discussion would not aim to find a single abstract truth that could be deliberately altered so that such incidents could not occur again, it is reasonable to think that no one would want this, or any similar situation to happen again. In light of that, the discussion would aim to help the community to understand the situation in a much more nuanced way that could broaden and deepen the sense of community among practitioners who will continue to work together.

It is unlikely that discussion of this type would unseat entrenched behaviours considered undesirable, but it is possible that small differences in thinking and acting

would be generated that would amplify over time and change the tendencies to act that characterise the practices of this community. Efforts to prevent future occurrences of a similar kind by developing and rolling out better policies or best practice guidelines, and auditing the practices of individual members are more likely to call out dualistic dynamic of (clinical) relevance resisting (scientific) rigour, and lose the paradox that relevance and rigour are not opposed, but instead are iterative ideologies that are co-expressed. Such actions are also less likely than reflective conversation to enable the community to articulate and understand its shared teleoaffective goals. Similarly, implementing action research, in the form of PDSA cycles, to improve nursing management of delirium or compliance with essential nursing practice standards are unlikely to be helpful to this community as it tries to understand the complex interactions that led to this tragic situation and that will continue to influence the practices of this community.

I support the actions that were taken with respect to individual nurses and the care aide in this brief narrative. However, it is far from the whole story, and I would go so far as to suggest it was negligently inadequate on the part of the leaders. On-going reflexive engagement with the continuing story in this community (for it did not start or finish on that fateful shift) is critical precisely because practice is a social phenomenon that is influenced by the global tendencies to act that arise from continuing interdependent interactions. I have also shown that leaders or PCs participate through involved detachment as members (not experts) in the on-going practices of communities with the intent to help practitioners understand and discuss aspects of the practices of their community that they take for granted in their everyday work life. In so doing, reflexive practices that are grounded in the concrete everyday experience of the members of a particular community may transform the practices of the community in ways that allow its members to better understand how to go on together and flourish in human community.

Conclusion

These contributions are significant and, if taken up, could change the way the work of healthcare and of PCs is understood and managed. Organisational development and change perspectives in healthcare continue to rely heavily on individualistic conceptions of practice, manufacturing models of quality improvement, and

acquisition and transfer metaphors of knowledge and knowing. Emerging challenges to health services related to the ever-increasing opportunities to prevent and treat illness and injury coupled with the aging of the population (including the workforce) have pundits predicting that health services in many countries are at risk of imminent failure. We keep trying to improve on methods for development and change that have not worked to date. Something new is needed, and the contribution of this work and those from whom this work has taken its lead is an important part of that 'something new'. We need not be concerned that the intent of the method that is beyond method is not to make a change, for change is inevitable. We would be wise indeed to be willing to be more conscious and reflective of both our experience and our becoming.

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APPENDIX: PROGRAM DESCRIPTION OF MASTER OF ARTS IN LEADERSHIP (HEALTH)

Royal Roads University, Victoria, British Columbia, CANADA.

Specialization in Health

Through a combination of online courses and a series of short residencies, the MA in Leadership with a specialization in Health program allows you to gain the leadership skills necessary to develop strategies and processes that can be applied immediately to meet the business and service needs of the health care system. The program is designed to better equip graduates to create high performing workplaces that deliver improved health services.

Online and on-campus courses include Fundamentals in Personal Learning, Leadership in Organizational Systems, Concepts and Theories of Leadership in Organizations, Leading Systematic Inquiry into Organizations, Action Research and Learning, Strategic Leadership, Sustaining Power of Vision and Values, Financial Management for Leaders, and Performance Measurement and Financial Management for Leaders.

Who it's for
Middle and senior managers who lead clinical service departments, health policy development, and community agencies, including those involved in health services, strategic planning, human resources, finance, information technology, communication and other program services.

Outcomes
Graduates of the program will have the ability to:

- Develop personal, organizational and societal learning practices
- Use systems theory, thinking and planning in problem discovery, identification and solution skills
- Apply concepts and models of strategic leadership within the organization
- Apply action research and evaluation processes to improve decision-making abilities and implement innovation, and create results
- Use business planning processes and organizational performance measures to implement change from concept to evaluation
- Use evidence-based indicators to analyse and develop strategies to engage employers, interest groups and stakeholders in implementing change.

Outcomes

Specialization in Health

The MA in Leadership with a specialization in Health program will provide new competencies and insights that clearly demonstrate how inspirational leadership can deliver exceptional employee and organizational performance. Through 'real world' problem-solving, professionals in both the public and private sectors learn to identify, analyse and build cost-effective solutions to organizational challenges, while helping to lead and manage change under dynamic conditions.

Organizations will benefit from skilled leaders who can seize and capitalize on new opportunities by creating working environments that foster organizational learning, initiative and high performance.

Graduates of the MA in Leadership with a specialization in Health program return to their careers with a heightened ability to:

- Identify, analyze, and build solutions to organizational problems;
- Manage positive organizational change;
- Leverage technology to empower yourself and your organization;
- Develop effective problem solving teams;
- Manage your organization's internal and external political environment; and
- Effectively communicate with colleagues and clients.