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Pepperdine University
Graduate School of Education and Psychology

DIALOGUE: A CASE STUDY

A dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Education in Organizational Change

by

Debra Milburn Kelley

May, 2016

Kay Davis, Ed.D. – Dissertation Chairperson

This dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

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ABSTRACT

Dialogue is a useful organizational strategy that supports a shared understanding that is useful in the solving complex problems. A community hospital challenged with publicly transparent quality metrics and the associated financial and reputation penalties developed a culture supportive of dialogue and participation and was the setting for this research.

The purpose of the research was to explore the decisions and messages an executive leadership team implemented that support the practice of dialogue and facilitated a culture of participation. This retrospective, qualitative study reviewed documents and artifacts over a seven-year time span from 2007-2014. Two sources were reviewed: (a) the Operation Committee meetings and (b) the all-employee forums provided by the senior leadership were reviewed. These source were coded utilizing a predetermined coding scheme based upon information from 3 theories: (a) Isaac's dimensions of dialogue, (b) Isaac's action theory of dialogue, and (c) Fischer's levels of participation. These three theories when integrated provide a three dimensional perspective that supports the practice of dialogue.

The conclusions of this study are that: (a) a single theory of dialogue is not sufficient; (b) an effective model for communication must include, at a minimum, contain an aspect of action theory, a dimension of dialogue, and a level of participation; (c) delaying decision-making in order to obtain feedback allows for the prolongation of deliberation and for the emergence of dialogue and deliberation; and (d) expansion of the deliberation time is a mechanism that helps the group to suspend assumptions and is a methodology supportive of dialogue.

This research recommends a three step, *how to* approach to supporting dialogue and a culture of participation. The recommended pattern is to (a) ask for feedback, thus, (b) delaying the decision, and (c) listening to the feedback.

Chapter 1

Background of the Problem

What's the difference between a meeting and a presentation? If one posed this question to a group of hospital workers, the answer might be a shrug, or a response of, *Not much!* Communication can be unidirectional, can come from a position of knowledge, and may function primarily to implement change or fix a problem. Information about a particular issue, problem, or change along with the current recommended fix was presented much as mandates and did not explore alternative ideas or other unresolved issues. This nice, neat, simplistic type of communication style was a pattern in the hospital. One might think that the unspoken rule was that one brought up problems to which one already had a solution. In this type of culture, opportunities for dialogue were infrequent.

One specific example of this non-dialogical culture occurred in a 4-hour training in preparation for an accreditation survey at one community hospital almost a decade ago. A great deal of work and training went into a presentation on patient safety and policies required for accreditation. An administrative leader was paired with a clinical leader to provide the message of leadership and clinical expertise. Staff attendance was mandatory. Rows of seats were arranged in a classroom style; this is a classic example of a one-way communication, one not reflecting the practice of dialogue. This unidirectional training was well received according to evaluation results, so much so that one might conclude that the practice of presenting information in this manner should be repeated. Despite the apparent satisfaction with the status quo, communication and training methods at this community hospital have evolved to a more participative style that often includes the practice of dialogue. This evolution to a culture supportive of dialogue has occurred over the past 7 years.

What has changed at this community hospital? There are many answers to this question. Some of the more obvious answers might include a change in leadership, or the introduction of an operating system such as Lean a process improvement methodology initially developed at Toyota (Graben, 2012). Although leadership and operating systems are relevant and literature supports their ability to contribute to systemic change, they will not be the focus of this research. Rather, this research reviewed decisions and communication grounded in the practice of dialogue and the evolution of a culture of participation as factors in organizational change by using a case study approach. This research explored the journey to a participatory culture based on dialogue at this community hospital and describes the course of action that supported this journey.

One of the first actions at this hospital was an investment in several dozen round tables in order to convene employees for training sessions. Literature about dialogue often mentions the practice of sitting in a circle. Isaacs (1999) described the round table as a tool to support dialogue. In addition to purchasing round tables, leaders were trained in facilitation. Facilitation training focused on participant engagement and participants were taught various techniques such as making inclusive eye contact, asking questions, personal disclosure, and elements of presentation and storytelling.

These small but impactful decisions initiated what became a transition into the practice of dialogue and a culture of participation in a community hospital. The process was similar to action research in that it was a process seeking practical knowledge and supported by theory (Coghlan & Brannick, 2005). It differed from action research in that it was more evolutionary rather than iterative. This research describes a hospital's evolution into dialogue and the development of a culture of participation. As an evolutionary process, change built upon change, making it challenging to identify specific interventions and the associated responses. This

research did not intend to link an intervention with a specific change; instead, it attempted to align a variety of interventions and create a logical sequence that supports the cultural evolution. The changes made at this hospital include the gradual transition from fragmentation of what may seem to be disconnected actions toward periods of coherence.

The impetus for these changes might not have been evident if evaluated from the perspective of training sessions, as the previous training sessions received praise from participants. The drive for change was more global and may have been reflective of the environment of the healthcare industry along with this hospital's situation. The rationale for making these changes was based upon an informal cultural assessment by the executive leadership team that described the culture as siloed, fragmented, and non-participatory.

The Issue

Currently, U.S. hospitals are facing many pressing issues (Porter & Teisberg, 2006). This particular community hospital faces challenges that come from sources both external and internal to the organization. Two of the large external issues are quality and increasing costs, both of which can threaten a hospital's very survival. The internal challenges are those of fragmentation and a culture of limited participation. External and internal issues do not remain segregated; external forces influence and may actually magnify internal issues, and external issues may exacerbate internal issues. The distinction between external and internal issues is made to emphasize the complexity and breadth of the issues and ensure that complexity of external issues does not completely overshadow the internal issues. Combined, these issues create a need for issue resolution on a large scale, perhaps increasing the cost of the changes beyond the capacity of a hospital. Rather than taking each issue independently, would a more global approach to issue resolution be more impactful?

Internal issues. Initially, issues of fragmentation and a culture of limited participation created various significant gaps in the hospital's ability to function efficiently and provide a high quality of care consistently. The drive to meet external demands of efficiency (cost containment) and quality in itself was strong motivator of change. Unfortunately, the cultural support for the sheer variety and number of quality and efficiency initiatives created inability to successfully focus and address this diversity of and complexity. The hospital culture supported departments functioning independently and, by doing so, allowed for conflicting priorities adding to the challenges.

Culture. Culture is the collective programming of the mind and thinking; culture is important in the resolution of large, complex issues (Hofstede, Hofstede, & Minkov, 2010). One's thinking is influenced by culture (Bushe, 2013). Escalating internal and external demands may require different ways of thinking in order to resolve them, thus perhaps necessitating a culture change. Different ways of thinking include different perspectives and assumptions and may include the concept of thinking collectively rather than individually.

In his model of dialogical change, Bushe (2013) described how the way people think impacts culture, noting that the way people think drives actions and behaviors, which drives shared attitudes and assumption that develops culture, which in turn impacts the way people think. In this cyclical model, culture change is achieved by influencing thinking and behaviors, which in turn impact shared assumptions and culture. Changing thinking and behaviors occurs when a generative image—a new way of seeing and thinking about an issue—is introduced, and thus acts a mechanism for cultural change.

The role of thinking in changing culture is essential in the Dialogical Organizational Development (OD) model, as described by Bushe (2013). Therefore, it seems logical that an

approach that alters thinking has the potential to alter culture and help solve the problems facing hospitals. One methodology that has contributed to the ability to support thinking on a collective level is that of dialogue (Isaacs, 1999). It follows that it might be a useful endeavor to study dialogue as a methodology to resolve significant issues facing hospitals through its ability to impact thinking and evoke cultural change.

Fragmentation. Hospitals have responded to multiple measures of quality from multiple agencies in ways that can fragment the processes of providing care and the overall approach to improving quality. One example of fragmentation of clinical information can be illustrated through a registry database associated with cardiac surgeries. This mature measure of quality in cardiac surgery now has thousands of metrics. The data analysis has been published and spans hundreds of pages. When the data are published, as it is in California and in other states, the question emerges as to its meaning and interpretation and how they relate to quality. Regardless of whether the definition of quality is agreed on or the metrics for measurement are surrogate markers for process; quality of care is a pertinent issue for hospital survival (Porter & Teisberg, 2006).

Fragmentation contributes to both the issues of redundant, isolated, and at times out of context collection and measurement of quality data. For example, measurement for quality of care provided for the treatment of heart failure is assessed by the American Heart Association (AHA), the Center for Medicare Services (CMS), Healthgrades, and others. The definitions and data measurement and analysis differ from agency to agency and the inconsistency of meaning contributes to incoherence for both the providers of and receivers of care. Goals and outcomes can and do become overshadowed by accrediting agencies' need to document data. The focus of care is directed to a specific task or activity rather than an understanding of the overarching goals

and a coherent approach to disease management. The issue of fragmentation may be increasing in response to escalating external issues.

External issues. Recently and globally, many hospitals in the United States are facing profound challenges. In particular, hospitals are expected to respond to two large external challenges: the ever-growing costs of health care and the demand for quality of care. These issues reflect a change that demands increased efficiency and quality in a publicly transparent manner.

Cost and revenue. If viewed in comparison to the economy of nations worldwide, healthcare in the United States would be the fourth largest economy in the world, according to the Institute for Healthcare Improvement (IHI). Hospital services represent the largest sector of healthcare dollars spent and account for a whopping 35% of all healthcare dollars. This growing expenditure is leading to disaster for hospitals, causing them to be the first target in tackling this growing healthcare sector of the economy. From an economic perspective, this consumption of resources drives attention, which brings a high level of scrutiny and even an effort to villainize these costly institutions. As a result, hospitals need to provide quality of care and minimize waste in order to remain economically viable (J. Orlikoff, personal communication, April 16, 2012).

Increasing costs may be associated with breakthrough in technology. One example is associated with a cardiac (aortic) valve replacement. Technology has developed a new process to deliver a valve via a catheter in a less invasive procedure; however this valve is four to five times costlier than a traditional valve. Under many payment structures, such as Medicare, there may be no additional reimbursement for providing this new more costly technology. Given the financial impacts and reputation, a hospital is motivated to improve quality and reduce costs in hospitals, and the leadership at this case study hospital shares these global concerns.

Quality. Quality can be described and measured in many ways in hospitals (Porter & Teisberg, 2006), with many regulators and consumer agencies defining quality differently. One such organization whose guidelines are used commonly is the Joint Commission. Each hospital that uses the Joint Commission to evaluate quality is reviewed for compliance with thousands of standards approximately every 3 years, or more often if a visit identifies significant deficiencies. This one agency with thousands of requirements creates a challenge regarding prioritization and coordination by virtue of its sheer number and inter-relatedness of standards. One issue identified by the Joint Commission can result in violation of multiple standards, aggregating to system-wide issues such as leadership. The complexity of the scoring of the standard contributes confusion to attempts to improve quality.

Obtaining quality care is important externally and specifically for this studied hospital. Regulatory bodies are investigating and evaluating multiple elements of quality, all of which contribute to conflicting priorities for an organization. In addition, each organization develops its own definition, identifying and emphasizing different aspects of quality. For the purpose of this paper, two definitions of quality were used; one was an external definition from the Institute of Medicine and the other came from the study hospital. The Institute of Medicine of the National Academies (2013) defined healthcare quality as:

The extent to which health services provided to individuals and patient populations improve desired health outcomes. The care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision-making. (para. 1)

In pursuit of quality, this hospital has developed an internal definition of quality as:

Those sets of behaviors and practices that improve patient outcomes, reduce patient k, enhance patent experience and reduce inefficiency. Quality is a prime goal and

responsibility of every member of medical staff, medical center leadership and all medical center employees.¹

The common thread in both of these definitions is the achievement of improved or desired patient outcomes. However, it is difficult to measure or achieve desired patient outcomes, and thus other metrics are often utilized. To achieve this vast goal and concept of quality, healthcare institutions and organizations have reduced outcomes to a series of process and outcome metrics. The data collected are not routinely authenticated or audited, which creates inconsistency and inaccuracy of reported information.

Additional publicly available sites for quality include those measured by the *U.S. News and World Report*, which ranks top performing hospitals by specialty. These rankings may not provide meaningful differences, and may overlook care provided at less well-known hospitals (Topol, 2012). Healthgrades is another consumer rating agency that rates hospitals in terms of number of stars. These sites exist in addition to the government-supported sites that use numeric ratings that provide percentile rankings. Because each of the many organizations that rate hospitals use different criteria, a hospital can appear to be at a very high quality level on one listing, whereas another rater may describe the same hospital as of inferior quality for the same time period. This creates confusion around the concept of quality for both the consumer and provider. In addition, prioritizing quality improvement efforts in a hospital may focus on addressing the most recent negatively reported public site publication and not prioritizing the improvements with the highest clinical benefit.

In response to these overwhelming metric-based criteria for measuring quality, the current trend in hospital leadership is to alter the focus from discrete data metrics to an overall aim to improve care. For example, in 2012, the hospital's board quality goal was broad: to

¹ Divulging the source of this information would break the confidentiality of the hospital under investigation. Therefore, the source has been omitted.

decrease harm to patients by 50%. Achieving this broad goal meant including the variety of metrics that are parts of the goal, but setting the global aim involved an attempt to decrease the fragmentation of the work process. The intent of using an aim instead of specific fragmented goals is to develop an understanding of overall quality throughout the organization, including at the highest level of the organization: the board of directors.

Broad goal. Broad quality goals may not be achievable utilizing only the processes that support traditional process improvement strategies that are used when improving these tightly defined, highly measureable processes and surrogate markers for quality. In addition to the well-known process improvement strategies, system level participatory activities supporting a shared understanding are needed. An example of this type of system level change is the development of a participatory culture. From 2007 through 2014, this hospital has supported the growth of participation in multiple venues at the level of the board, staff leadership, operations, and internal trainings. In particular, the organizational changes at these levels have been grounded in supporting communication that values dialogue as a way to create shared meaning and understanding. Dialogue supports understanding across silos and is participatory by its nature. Thus, the issue of fragmentation and its impact on quality and costs of healthcare and associated non-participation may indicate that substantial levels of dialogue are not occurring. Improving dialogue and associated participation has the potential to address multiple issues of quality, fragmentation, and ultimately the survival of a complex organization such as a hospital.

Purpose of this Research

The purpose of this research project is to explore how organizational interventions grounded in dialogue can support a developing culture of participation at an independent, community based hospital among board members, staff leaders, nurses, and physicians. As a part

of this research culture is studied a factor in resolving large issues in the hospital through shared understanding. This study sought to explain how these interventions connect logically to one another, supported by literature to create this evolutionary process of culture change. Over a 7-year span from 2007-2014, leadership at this hospital implemented a series of interventions that seems to have contributed to the development of a culture of participation among the nurses, physicians, and staff. One example of interventions was training sessions, many of which were grounded in the four dimensions of dialogue: listening, respecting, suspending, and voicing (Isaacs, 1999). Additionally, support for system wide implementation of shared decision-making councils was based on the principles of dialogue and participation. This case study explored in depth the dialogue-based trainings and interventions conducted at a hospital for the purpose of examining relationships of dialogue and participation.

This case study can be described as a retrospective chronology of events that were a result of leadership decisions and actions as recorded in documents, curricula, and artifacts that were produced during this time frame. The case study format allows for exploring “the depth a program...bounded by time and activity...collecting[ing] detailed information using a variety of collection procedures over a sustained period of time” (Creswell, 2013, p. 15) and thus was appropriate methodology for research on dialogical cultural change.

This case study chronicled the “emergent inquiry process in which applied behavioral science knowledge is integrated with existing organizational knowledge and applied to solve real organizational problems. It is simultaneously concerned with bringing about change in the organizational members and adding to scientific knowledge” (Sahir & Passmore, as cited in Coghlan & Brannick, 2005, p. 4).

Research Question

This research specifically explored two activities that are grounded in the theories of dialogue and social participation that have supported movement of the hospital's culture toward one of participation. These two actions were the implementation of participative training and the development of shared decision-making councils. These two organizational implementations provide an opportunity for dialogue and participation and may have influenced the emergence of a culture of legitimate participation and belonging.

The question that this research explored is, *What decisions and messages been implemented in a hospital that support dialogue and the culture of participation?* The purpose of the research is to explore how an executive leadership team in a community hospital made decisions these decisions, implemented the practice of dialogue, and facilitated a culture of participation.

This research explored examples of the four aspects of dialogue—listening, respecting, suspending, and voicing—and their association to the organization's initiatives of Magnet designation, implementation of shared decision-making, and implementation of a corporate development program. This study approached these questions by reviewing the decisions made by the senior leadership group, including the decisions about the messages that were used to explain, provide rationale, and communicate the decisions through planned communication session called Vision Sessions. Because this research was exploratory, it also sought to answer the sub-question as to whether other observations are associated with the use of dialogical interventions and development of a culture of participation could be made.

Conceptual Focus of this Study

Two concepts composed the focus of this study: dialogue as a part of dialogical interventions and participative culture. This case study focused on the practice of dialogue and explore whether there is evidence of its use in development of a cultural change in the setting of a community hospital. This study explored the methods used to support dialogue and the evolving culture of participation. The culture of participation is based in the levels of participation that was developed in a social media setting (Fischer, 2011).

Dialogue and dialogical intervention. Dialogue has often been described in terms of the concept of *talking with* (Isaacs, 1999). This is differentiated from *talking to* in that it includes a shared understanding. If asked to recall one of the best conversations a person has ever had, one would likely describe a situation in which many of the characteristics of dialogue were present.

Dialogue is often described as a particular type of conversation in which the purpose is:

To reach new understanding and in doing so, to form a totally new basis from which to think and act . . . We do not merely try to reach agreement; we try to create a context from which many new agreements might come. (Isaacs, 1999, p. 19)

Dialogue is an iterative process requiring time for a repetitive interchange and is not achieved in a simple back and forth exchange. Schein (1999a) further differentiated it from deliberation, discussion, dialectic, and debate. This differentiation occurs at the point of deliberation where a choice is made for suspension. Dialogue develops from the ability to suspend assumptions.

“Dialogue is a discipline of collective thinking and inquiry, a process for transforming the quality of conversation, and in particular, the thinking that lies beneath it” (Isaacs, 2000, p. 25).

As a communication methodology, dialogue overlaps with inquiry (Preskill & Torres, 1999).

Dialogue includes the curiosity associated with inquiry, but is not necessarily formatted in a questioning format. However, beyond a method of communication, dialogue has impact on

one's thinking, which is achieved from the open-mindedness associated with suspension of assumptions. Dialogue is not a new process; historical references to dialogue date back centuries and have been described by the ancient Greeks as well as Native American cultures as a natural, preferred state (Isaacs, 2000).

However, dialogue, as a process has not been widely adopted in organization change literature until more recently starting in the 1990s with the work of David Bohm. Three decades later a growing appreciation for the use of dialogue in supporting change and development has emerged (Bushe, 2013). Although dialogue as a topic of study has been mentioned little in traditional handbooks of organizational study, its importance to organizational functioning has been apparent since Greek civilization. The early research in OD attests to the importance of dialogue in organizational change.

Despite differences of opinion as to the definitions of dialogue and categorization of qualities of dialogue, experts agree that it can help people communicate about complex issues (Bohm, 1996; Isaacs, 2007; Scharmer, 2009; Schein, 1993). In addition, dialogue is thought to support sustainability of cultural change (Arnold, 2010). Hospitals such as the one under investigation in this study need to be able to communicate about complex and challenging issues, and dialogue offers a viable an option for doing so.

Fragmentation. In the health care environment, differentiation and specificity contribute to fragmentation. Hospitals have a multitude of disciplines and specialties, and a high level of differentiation of technology. In the short span of a day, multiple physicians in different specialties managing different systems may influence the care of a single patient. Nursing staff may range from a nurse aide to a nurse practitioner independently providing care. Ancillary specialists such as respiratory, laboratory, and pharmacy technicians are also likely to influence

care. All come from different disciplines and perspectives and have different goals associated with the care and different language associated with the discipline community of practice (CoP), which can contribute to misunderstanding and confusion.

Not as evident at the bedside are the business support staff members in administration, finance, and coding. These personnel also impact policy, supplies, and other aspects of care. These processes are also often times fragmented. For example, auditing of billing and payment requires review by admitting, case managers, information technology staff, coders, billers, and administration. Each staff member holds a piece of the knowledge and process, giving a different meaning to the information provided. In addition, not all participants may have knowledge of the impact that a change in one process has on the system-wide process.

These specialties all come with the perspective of their practice and the inherent limitations thereof. Because of the limited scope of each, they can lack a shared understanding. Some of the disciplines may not have a perspective on the full process view; they may not have knowledge of the outcome and only whether a process was completed. As care is broken into discrete process steps, it is easy to lose an understanding of the rationale for the task being conducted.

Culture of participation. Participation is a principle of dialogue (Isaacs, 1999). The culture of an organization is important and is evident through the beliefs, values, rituals, and artifacts found there (Schein, 1999a). Cultures manifest themselves at a variety of levels; the deepest level is values, followed by rituals, heroes, and symbols. The last and most surface of the levels of culture and thus most visible level is its practice (Hofstede et al., 2010). The practice of dialogue in an organization is an indication of a participative culture.

Hofstede et al. (2010) described six dimensions of organizational culture. Four of these are deeply grounded in values, whereas two of these dimensions are more dependent on practice; one addresses the degree of emphasis on the person versus the job, the second addresses the degree by which the organization's communication is open or closed. These two dimensions will be discussed further in Chapter 2.

The concept of participation is different from that of engagement. Participation implies that "the worker is a member of a distinct epistemological community" (Ibert, 2007, p. 105). Ibert (2007) further defined participation as part of the practice of a professional identity (Wenger, McDermott, & Snyder, 2002). Lave and Wenger (1991) have dubbed these *communities of practice* (CoPs). Participation occurs for multiple reasons: some want to further the practice, others identify with the community and want to establish a sense of belonging, whereas still others want to make a contribution.

Participation is more than *events of engagement*, but refers to being active in the practices and the identity of the community (Wenger, 1998). "Participation suggests both action and connection" (p. 55). One significant challenge with creating a participative culture is that it requires authenticity. Quinn (2000) warned that when a change has been deemed necessary and the strategy for achieving the change is participation, the result could be a sense of manipulation, which then results in cynicism. Thoughtful consideration of the invitation and how the invitees might perceive it are thus critical to successful use of participation as a strategy for cultural change so that the outcome is positive. The invitees would not view positive engagement as manipulative, but instead as an opportunity to make a contribution of knowledge, practice, ideas, and skills.

Levels and types of participation are varied, and include legitimate peripheral participation and central participation. In legitimate peripheral participation, it may not be obvious that the participant is engaged. For instance, he or she may not talk during a meeting, or may not demonstrate a behavior or action that visually denotes participation, but instead may be thoughtfully incorporating learning by watching others. Central participation is more easily identified by a behavior such as voicing and sharing knowledge. Legitimate peripheral participation is different from non-participation, which is referred to as *illegitimate peripheral participation*. This legitimacy of participation is grounded in belonging (Lave & Wenger, 1991), which is not readily observable.

The Organization and Role of Researcher

The hospital under investigation is a community based, not for profit hospital located in California. As such, it is somewhat unique in that the Board of Directors and the administrative team run it locally. In this light, initiatives are local to the institution and not based upon the needs of a system or stakeholder targets. From a research perspective, exploring this hospital lends itself to understanding an independent organization.

During these 7 years of study, this hospital has implemented three major initiatives that provide a rich laboratory. These three initiatives are: (a) development of a corporate training program, (b) implementation of shared decision-making councils, and (c) pursuit of Magnet designation for nursing excellence. Planning, implementation, and monitoring of these initiatives spanned the duration of this research and provided a setting to study dialogue and participation during organization change. The processes of implementation of these intensive initiatives afforded opportunity for practice and have influenced this research, and my practice. I have had the opportunity to experiment and observe change as it was occurring. I am

“simultaneously holding an organizational functional role which is linked to a career path and ongoing membership in the organization, and a more temporary researcher role for the duration of the research project” (Coghlan & Brannick, 2005, p. xiii). For the purposes of this research, my role is that of an internal consultant, which provided a basis of understanding for minutes and other documents within the organization.

One direct responsibilities of my role was to create and support the development of the corporate education program. Over the past 7 years this program has focused training on the development and strengthening of personal relationships in the hospital. Some of these programs have been directed toward building relationships with patients, peers, and other community members. The corporate training program supports the development of the Vision Sessions: interactive meetings led by executives that provide information and seek feedback on goals, initiatives, and events for the next year, explaining the current environment. All employees are invited to attend 1 of 20 or so sessions.

As a scholar in the Doctorate of Education in Organization Change (EDOC) program, my self-assigned role was to create the corporate education program in alignment with the theory in which I was being trained. These processes were grounded in whole system change and included group cohesion plans, personal alignment programs, coaching and action plans, and alignment of behaviors and talent development programs with values awareness and vision (Barrett, 2006). I aligned my practice with Edgar Schein’s (1999b) concept of process consultation as an internal consultant utilizing concepts of dialogue. The corporate training program added the round tables to the organization and integrated interpersonal participation into the sessions, allocating a portion of the setting for dialogue, which is referred to as a *container* (Isaacs, 1999).

With decades of experience in management roles in hospitals, I am a practitioner, which means that I analyze the activities that occur in a hospital from the lens of applying theory to the events rather than for the more academic perspective of using a theory or model to drive practice. This lens was predominant in the research for this case study.

Significance of this Case Study

This case study explored in depth the supporting processes of dialogue and a participatory culture over a 7-year period at one independent community hospital. This research was empirical and field-oriented, reflecting observations and experiences. The researcher retrospectively reviewed the documents, archival records, and artifacts that were produced in the organization over these years. The researcher strove to be non-interventional and used natural language in her descriptions (Stake, 1995).

Some of the research on dialogue over the last several decades has discussed organizations including the steel industry, the university setting (Isaacs, 1999), car companies (Scharmer, 2009), and manufacturing (Van Eijnatten & Putnick, 2010). In addition, a case study for large system change in a citywide initiative in health care utilizing the construct of dialogue has also been conducted (Isaacs, 1999). However, there seems to be a paucity of research regarding the use of dialogue in a hospital, particularly related to the decisions made and messages utilized.

This research might provide hospitals with an approach to the complicated and diverse number of initiatives that are required to meet numerous quality measures and complex challenges facing hospitals utilizing methods used by this leadership team. Doing so might assist others undergoing accreditation, meeting quality metrics, seeking a Magnet Nursing Designation, or seeking to improve patient experience. In addition, this study might be helpful to an

organization seeking to create a culture of participation. It might serve as a holistic, process-based example of methodologies designed to decrease the problems of fragmentation, and in that breadth might have relevance for other organizations that face similar levels of complexity. It sought to provide the contextuality of events occurring within the hospital, identifying practice and culture along with the interventions that were implemented. This case study attempted to avoid reductionism to specific goals, metrics, and departments, and instead strove to focus on the overall culture of the organization in the description of the case (Stake, 1995). As an example, description of specific metrics of employee satisfaction was not part of the analysis, but how employee satisfaction supported a culture of participation was a part of the study.

The trend to provide more information on the practice of dialogue may be helpful to organization change practitioners. Further expansion of the study of the practice of dialogue grounded in a case study research might provide additional valuable information to the practitioner of organization change, regardless of the type of organization. This study may influence others to conduct case studies in dialogical interventions that may add to the field of knowledge and specifically to the practices of OD.

This study was conducted from the perspective of the practice of the organization's members. Organizational practice as visualized through operational processes was analyzed from the perspective of practice grounded in theory. Practice is not static, thus the state of having learned is not acquiring knowledge, but that of knowing. Practice occurs through the iterative type of learning described by Wenger (2002) as situated learning. The understanding of practice is limited, "there still is a lack of empirical accounts, which explicitly address the geographical dimension of knowledge practices" (Ibert, 2007, p. 111). This research was fully situated in a practicing hospital and the events that created learning in practice. Practice can be broken down

into parts or the iterative cycle of learning, but can also be viewed holistically. This case study strove to provide a holistic approach to the study of both the theory and practice of dialogue and participation.

Chapter 2

Review of Literature

As described in Chapter 1, the major concepts that will be reviewed in support of this research case study include dialogue and a culture of participation. This chapter explores current literature related to these concepts and this case study. This study was a longitudinal qualitative review of the practices supportive of dialogue and participation.

Construct of Dialogue

Dialogue is a form of meaningful conversation that has a foundation in the identification, awareness, and suspension of assumptions for the purpose of reaching shared meaning and understanding (Schein, 1999b). According to Preskill and Torres (1999),

Dialogue is what facilitates the evaluative inquiry learning processes of reflection, asking questions, and identifying and clarifying values, beliefs, assumptions and knowledge. Through dialogue, individuals make connections with each other and communicate personal and social understandings that guide subsequent behaviors. (p. 53)

Dialogue has also been described as “talking with” or a “shared inquiry, a way of thinking and reflecting together” (Isaacs, 1999, p. 9); however, dialogue may be more than that as well (Leahy, 2001). Beyond talking and thinking with, dialogue is a way of also being with and working with others. Often in defining dialogue, there is an emphasis on the root structure of the word. The roots *dia* and *logos* yield a definition of “the meaning flows through it” (Bohm, 1996, p. 6). Going into further detail, Bohm (1996) described dialogue as “aimed at going into the entire thought process and changing the way the thought process occurs collectively” (p. 10). The focus of dialogue is often on the conversation, but it is also fundamentally based in the participants’ thinking, which is revealed during conversation.

Dialogue has been used for centuries to help achieve shared meaning and has played a key role in the development of modern civilization. Early philosophers such as Aristotle and

Plato as well as more modern philosophers used dialogue to clarify and communicate an understanding of complex philosophies. In the 1990s, dialogue became more popular in some of the organization development and change literature. In 2013 dialogue has been expanded as a practice of organization development (OD), known as dialogical OD. These discussions have sparked controversy regarding a potential split in OD; namely, the debate over whether or not dialogical OD is different from a diagnostic approach to OD (Holman, 2013; Marshak & Bushe, 2013). Regardless of whether dialogical OD is distinctively different from or a continuation of the evolutionary process of the discipline, dialogue has been used as an important practice in organization change (Isaacs, 1999; Schein, 1999b).

Differentiation of dialogue from conversation. The term dialogue is used in the vernacular to describe any two-way conversation between people. Similarly, the term has been used in other disciplines such as scriptwriting to indicate the spoken conversation between two or more people in a scene. In common understanding and usage, the term dialogue is not clearly differentiated from other types of conversation. However, this common usage is not the definition of dialogue used in this research, which makes important differentiations between dialogue and other types of conversation. Schein (1999b) mapped out the placement of dialogue in relation to other types of conversation (see Figure 1).

Figure 1 illustrates the transition from conversation into deliberation, which refers to the critical point when a conversation moves to suspension or discussion. The decision to suspend or discuss is described as a *crisis* (Chiva, Grandio, & Alegre, 2010). Deliberation is sometimes described as careful consideration, which may be initiated by a disturbance. A disturbance can be stimulated by a number of factors; sometimes it is a sense of disagreement with or a lack of understanding of what another is saying. A disturbance may be subtle or unsettling, and it elicits

a response whereby either a judgment or assumption is made or is suspended. Deliberation or consideration may occur with or without the individual having an awareness of the activity. During deliberation, the thinking may move toward suspension, acceptance, and perhaps even trust, or the thinking might move the conversation toward discussion, which has characteristics of advocacy and competition (Schein, 1999b). Deliberation is important because it is the point where a conversation can move into a dialogue.

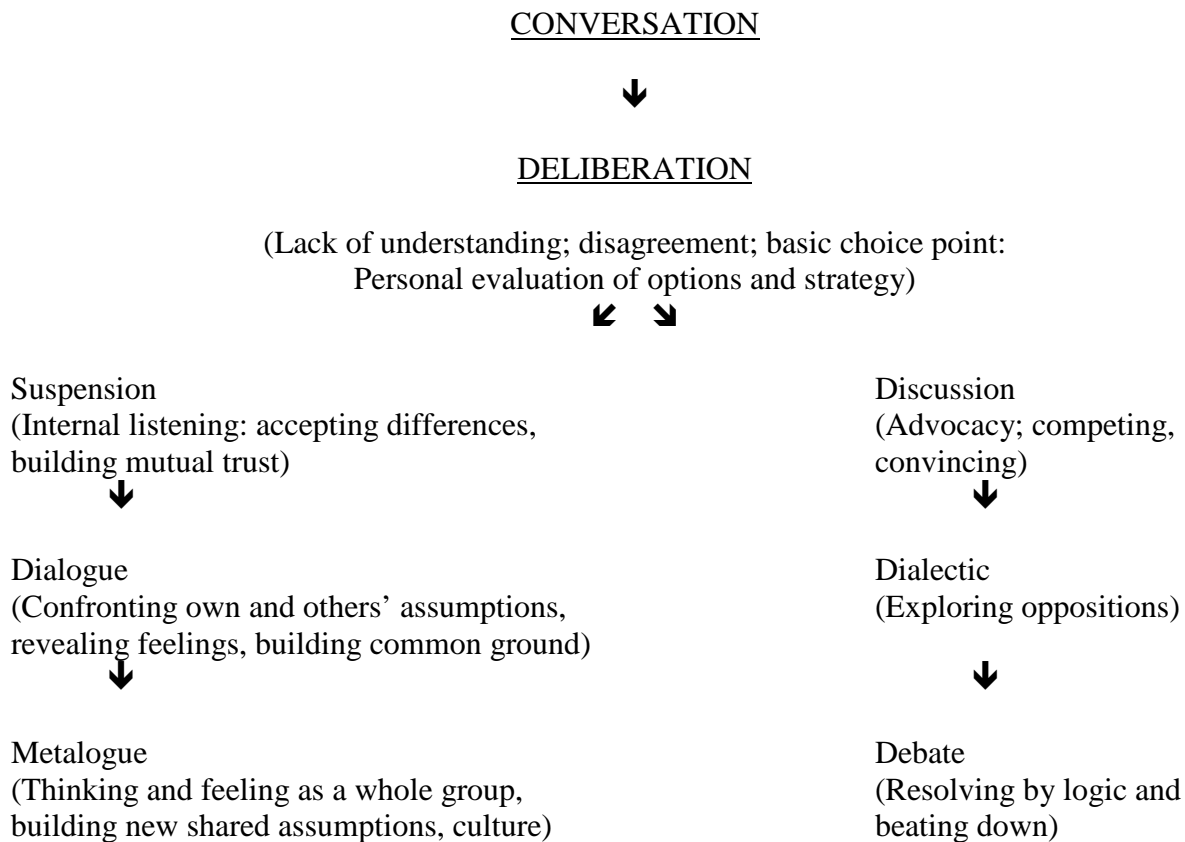


Figure 1. Placement of dialogue in relation to other types of conversation. Adapted from *Process Consultation Revisited: Building the Helping Relationship*, by E. M. Schein, 1999, p. 209. Englewood Cliffs, NJ: Prentice Hall. Copyright 1999 by Prentice Hall.

Complexity theory describes disturbances, such as those that stimulate deliberation, as tensions that are based upon issues of identity, outcome, meaning, voice, and field (Hammond & Sanders, 2002). Issues of identity are deeply rooted value-based constructs; strong emotion is associated with identity. Because of the emotional connection when exploring issues of identity,

it may be difficult to suspend assumptions and biases and thus move toward a conversation of dialogue. In failing to suspend and move to dialogue, the conversation defaults into debate. Traditionally, debate is characterized by creating winners and losers. Winning a conversational point and persuading others to one's viewpoint are the activities that occur in a debate, but they do not necessarily support or stimulate better understanding. In debate, the possibility remains that the opponents may have achieved understanding but have different perspectives on advocacy. As Hammond and Sanders (2002) noted, "It is only when we don't understand one another that we find the need to communicate" (p. 13). One might argue that communication with an assumption of some level of understanding might be achieved efficiently through dialogue. Dialogue is a method of conversation that supports shared meaning and understanding, and thus is supportive of effective communication.

Understanding the role of deliberation in moving toward dialogue, it is logical that increasing awareness of deliberation might impact the decision to move to dialogue. In order to support conversations where dialogue is achieved, it is critical to have a greater awareness of when a disturbance occurs that leads to deliberation. Reflection and an awareness of self may be useful skills to develop in order to better engage in dialogue, in addition to an understanding of the dimensions of dialogue.

The practice of dialogue. Dialogic OD has been described as a theory of practice. The theory that supports dialogue describes the impact of thinking on decisions and actions that evoke shared attitudes and assumptions that form culture, which cyclically shapes thinking. Thinking and behaviors can be altered significantly by a generative image (Bushe, 2013). A generative image is simply one that conveys a new meaning or understanding and is thus useful

in supporting organization change. Generative qualities of dialogue will be described later in this chapter.

The current gap between theory and practice in OD and organizational change may be more pronounced with the new OD or dialogic OD (Hutton & Liefoghe, 2011). Isaacs (2000) described the power of dialogue is in its use, and further acknowledged the inherent difficulties in creating a practice of dialogue. Practice is developed over time; it is usually based on theory, is developed as a result of repetition, and continues to develop. Practice informs theory and theory informs practice; practice is not acquired, but rather is developed over time. These qualities of practice are significant in that studying the practice of dialogue, especially in a case study, might inform further development of theory. In addition, the review of practice over an extended period such as in this case study of time can shed some insight into this evolutionary process of practice development related to dialogue.

According to Isaacs (1999), “Practices are institutionalized ways of acting” (p. 81). Practice is a repeated activity performed for the purpose of achieving experience. A practice “arises in context of a community: groups of people establishing a tradition for accessing this knowledge. The community reinforces the necessity of the practice, supporting continuous reflection and improvement” (p. 80). Dialogue is a practice that promotes learning from multiple dimensions of time; it is grounded in conversation and awareness. The assessment of the practice of dialogue may contribute to its effectiveness (Wolff, 2004). A focus on the practice aspects of dialogue may contribute to providing concrete examples that might add to understanding.

The practice of dialogue leads to normative features surrounding the process of dialogue, as Odell (2005) identified. In a community setting, 10 distinctive normative features of dialogue typically emerge in group dynamics from participation in the practice of dialogue. Interestingly,

these features are not practiced by individuals but as dialogical groups. These normative behaviors and attitudes include an appreciation of (a) complexity, (b) the interests of others, (c) common ownership, (d) difficult trade-offs, (e) openness to persuasion, (f) talk that leads to action, (g) freedom to enter and exit dialogue, (h) open access to dialogue, (i) differences and disagreement, and (j) consensus. This research supports a focus on the practice of the groups instead of the practice of the individual as an important factor in understanding dialogue and how groups evolve when practicing dialogue.

Components of dialogue. In developing a practice of dialogue, it is helpful to identify observable skills for development. The theories that support dialogue are described as observable components that, when observed in combination, might also help to define the existence of a dialogical interaction, as differentiated from other types of conversations.

Dimensions. William Isaacs (1999) proposed that dialogue could be broken into four dimensions: listening, respecting, suspending, and voicing. These dimensions describe skills that might be enhanced in developing a practice of dialogue.

Listening. Hearing is something that one does without thinking; one does not have the ability to turn it off. Listening is different from hearing, as it goes beyond hearing to embracing and accepting (Schein, 1999b). Typically, listening implies that one is seeking understanding. In dialogue, listening goes beyond understanding and includes a component via which one listens to one's self. During this process, one becomes familiar with one's own feelings, biases, and remembered experiences, which requires the cultivation of an inner silence (Isaacs, 1999). Listening to one's inner narrative instead of simply listening to the other is an important, seemingly contradictory prerequisite for developing listening skills: quieting the mind, the consciousness, in order to listen. As Gryn (2003) noted, "The important thing about group

dialogue is listening—not just to what the other participants have to say but to yourself as you are listening and holding back your own judgment of what is being said” (p. 97). Listening to one’s self increases self-awareness and knowledge of one’s own biases and assumptions, enhancing one’s ability to listen to others nonjudgmentally.

Listening also includes searching for inference regarding the conclusions that are drawn. The communication of assumptions and biases is generally hidden from others but may be revealed in conversation (Argyris, 1993). Assumptions are not blurted out in conversation but may reveal themselves throughout the conversation. The non-sharing of assumptions is “not just a mechanical problem. It is a problem that if I really, really told you what I think, I might be disrupting the social order” (Lambrechts, Bouwen, Grieten, Huybrechts, & Schein, 2011, p. 136). In some cases, direct communication of assumptions might be considered taboo.

Listening competes with other brain activities. Listening to the nuances of what is said—and not said—may be compromised when the brain is simultaneously composing a response. Indeed, the nuances of both what is said and what is not said can reveal assumptions and biases and enhance understanding (Isaacs, 1999). Other activities also interfere with listening, such as texting, typing, and reading. Listening at the level of self-awareness and identification of biases does not support multitasking activities.

Listening without resistance requires openness. It is based in self-awareness and reflection and requires embracing uncertainty and a focus on inquiry, including self-reflective inquiry, such as, *What if I am wrong about this?* Listening of this type that is associated with dialogue is not often taught in courses.

In summary, listening is reflective in nature and is often based upon an individual’s attitude rather than instruction. Listening for one’s own feelings helps individuals become more

aware of personal biases. Indeed, the work of listening is internal (Isaacs, 1999). Listening to others as well as one's self at this level is a precursor to suspension, since listening allows for the identification of assumptions that might be suspended.

Respecting. Respect is a core aspect of dialogue. Part of respecting someone is seeing him/her as a legitimate individual human being. This recognition honors the boundary line between individuals but also recognizes the connection between them. Respecting is a way of thinking about others in a holistic way: one focused on identifying qualities in others that also exist in the individual. Isaacs (1999) described this perspective as viewing others as “part of the whole, and, in a particular sense, a part of us” (p. 117). This inability to fully segregate the individual from the group is an important component of respect.

Part of the challenge of respecting someone occurs when an identified attribute or characteristic is not viewed in a positive light. The point of disagreement or disrespect may be based on core values and beliefs (Isaacs, 1999). Such conflict may leave little room for understanding or maintaining respect. The challenge then becomes how to acknowledge some of the undesirable behaviors or values that are also part of one's own values. The challenges of respecting exist at the level of individual self-awareness but manifest themselves in group conversations.

A key to demonstrating respect can be to practice inquiry rather than advocacy. A basic aspect of respect is a self acknowledgment that one may not be right, as beliefs based in a lack of certainty help one to demonstrate respect, depolarize conversations, and support pluralism. Indeed, uncertainty provides for possibility. Demonstration of respect does not include a focus on niceness, politeness, or the avoidance of conflict; rather, it includes elements of challenge and an expectation of abilities and growth (Graben, 2012).

Suspending. Suspension requires a high level of awareness. This dimension speaks to suspending action and judgment, not awareness (Bohm, 1996). Suspension shares similarities with reflective thinking, the difference being that reflective thinking occurs retrospectively, whereas suspension occurs in the moment, simultaneously with dialogue (Gunnlaugson, 2006).

The first step of suspension is awareness; one must have knowledge of one's own biases and opinions. This can be achieved by self-reflection at the time a disturbance is felt. In reflection one seeks first to understand what beliefs one holds that are being challenged, thus creating this disturbance. The challenge is to gain this insight at the time of the conversation, in the moment. The timeliness of reflection is one factor that differentiates suspension from other reflective practices (Schein, 1999b).

Once self-awareness and an understanding of the self are achieved, the second part of suspension involves suspending one's biases, assumptions, and beliefs. Suspension does not imply giving up a value or belief, but simply setting it aside to understand better another's point of view. Suspension might also be described as being open to another's perspective (Schein, 1999b).

Suspension and openness occur when a person maintains a perspective of inquiry. Inquiry allows for better understanding through a sense of curiosity that *asks* rather than *tells*. Inquiry uncovers assumptions, beliefs, values, and opinions. Suspension interrupts the cycle of a natural tendency to simply fix problems by confronting one's ignorance. This reactive tendency to fix problems can prevent the discovery of the root problem; thus, the solution may be only superficial. The inquiry that is associated with suspension allows for a better understanding of the problem and ultimately better solutions. An important tool in suspension is the use of questioning, which helps people let go of certainty. With certainty the tendency emerges to look

for answers, not questions, and uncertainty is a helpful perspective in suspending (Bohm, 1996; Isaacs, 1999).

Voicing. Isaacs (1999) used the term voicing rather than talking or advocating as a way to differentiate this aspect of dialogue from other ways of speaking. Voicing is an aspect of saying what needs to be said in a group, as distinct from talking or speaking, in that those methods are also used to demonstrate knowledge, share expertise, or advocate for a position. Voice serves to answer the questions, *What purpose would this statement have? What contribution to the whole will this make?*

Voicing has an aspect of honesty in revealing what is true at the moment, and can also be described as authenticity. Voicing has been described as talking to the center of the conversation; this is different than talking to an individual. In talking to the center, a part of the conversation is directed to the self as well as to others. Talking to the center of a conversation removes some of the dynamics of interpersonal relationships from the conversation by drawing focus away from what an individual thinks. The voice of a group is different than that of the individual and may help drive more honest communication (Isaacs, 1999).

In addition, voicing has an aspect of avoiding self-censorship. In self-censorship, one may remain quiet in order to avoid upsetting others or being disagreeable. This tendency is not responsible behavior in dialogue. In dialogue, disturbance is viewed as containing the potential to trigger a better understanding of the group (Isaacs, 1999). Absent advocacy in dialogue, different ideas may simply exist as different perspectives instead of creating a level of contention.

Container. The concept of a container for dialogue is universal, referring to both concrete and abstract aspects of the space for dialogue. In the concrete form, the container is often

described as a round table and an understanding of rules that invite participation. The container seeks to maintain a sense of equality with participants. In the more abstract form it provides a place to handle issues that might be too challenging to handle outside of the relationships developed by the group. It is through dialogue that the participants in dialogue develop a shared understanding. Normative behaviors of conversation are included in these shared understandings and become part of the container in which the dialogue occurs (Isaacs, 1999; Schein, 1999b).

The concept of a container might conjure a concrete visual image with an emphasis on the physical arrangement of a table, chairs, and symbols that imply equality. This is only one aspect of the container, with the behavioral components perhaps having more importance than the physical ones. The container for dialogue has some of the same characteristics as the dimensions of dialogue. The construct of dialogue and the use of the container supports trust by providing for respectful interactions in which listening, respecting, suspending, and voicing are the expected behaviors. A container for dialogue allows work to be done in groups that are large and address complex issues. A container is “a time and space where normal, business as usual ways of interacting are suspended so that different generative conversations can take place” (Bushe, 2013, p. 15).

Coherence. Coherence in dialogue refers to understanding, alignment, and synchronization. David Bohm’s (1996) book *On Dialogue* has stimulated a great deal of thinking on this topic. In it, he described the rhythms of dialogue as similar to the light coherence of a laser. This visual description seems to resonate with current authors, as his seminal writing is often quoted in modern literature on dialogue. The application to conversation is that in coherent conversations, the ideas are aligned in a manner that supports a shared meaning. Dialogue

involves an ongoing tension between coherence and incoherence; ideas and concepts align and then fall out of alignment. Meaning is shared, then not shared.

Coherence in conversation is increased by three factors: presence, patterns, and replication. Presence is characterized by paying full attention in a manner that Isaacs (1999) described as listening. Patterns can be described as an understanding of shared meaning, such as the recognition of a pattern in a photo or drawing that was not initially visible. Replication contributes to dialogue by repeating episodes of shared meaning. Incoherence is increased by absence (physical or mental) and randomness. Dialogue supports coherence and order by creating shared meaning (Hammond & Sanders, 2002). Furthering the concept of coherence, Gunnlaugson (2006) described dialogue as:

Facilitating coherence between our perspectives, conversations, our actions, and our capacity to co-create (i.e., aligning what we think, what we say, what we do and what we see), in turn developing young adult and adult learners' capabilities to sense, presence, and enact emerging ways of knowing, being and learning that are needed to flourish in our complex age. (p. 16)

Coherence is fleeting and not shared by all simultaneously. It provides the “motivation to communicate in dialogue, and it is a hard-won moment more often than an enduring state of clarity” (Hammond & Sanders, 2002, p. 18). Although temporary in duration, coherence is critical in that it allows a group to take collective action, not depending upon individual agency or consensus. This collective action is based in a shared understanding of diverse individuals.

Emergence. Emergence occurs when “increasingly complex order arises from disorder” (Holman, 2013, p. 19). Holman (2013) drew the connection between the term *emergence* and the similar word *emergency*. The sequence of emergence includes three steps. First, the disruption of an emergency changes the status quo—the normal operations. An emergency requires a response that is different than normal. A different response is described as *differentiation*. Differentiation

is a catalyst to the development of a more complex understanding, and with this new understanding coherence emerges.

C. Otto Scharmer (2009) described the importance of dialogue related to emergence, using the term *reflective inquiry* to describe the activity of dialogue and describing dialogue as entering the space of “seeing together” (p. 142). His model of emergence, Theory U, is constructed using “3 methods: phenomenology, dialogue, and collaborative action research” (p. 19). Dialogue plays an important role in the interconnection of these three constructs that, when combined, support emergence.

Emergence is an important aspect of transformation, which is a complex process that does not lend itself readily to the project type of management. Typically, project management has a specific desired outcome. In contrast, transformative process change may have a more generalized direction, and the specific desired outcome may be difficult to articulate. Emergent practices include a probe or stimulant, a sensing or reflection, and a response (Bushe, 2013). A probe could be an inquiry or a question; it is anything that stimulates thought. Reflection is a process supportive of attaching meaning or understanding to the thought. A response can be described as the change that occurs as a result of the probe and reflection and can be manifested in thinking, conversations, values and beliefs, and actions and behaviors.

Generative. Dialogue is generative; it creates new ideas and ways of thinking (Bushe & Marshak, 2009). Generative dialogue (GD) creates “not yet embodied tacit knowledge” (Gunnlaugson, 2007, p. 44). The characteristics of GD include elements of presencing and flow, a sense that time slows down, and the perceptions that boundaries have collapsed. According to Scharmer (2009), “The term presencing can be either used as a noun or a verb and designates the connection to a deeper source of self and knowing” (p. 192). It is a way in which the present is

experienced utilizing all of the senses. GD helps to create rules and is described as listening from the future self. Gunnlaugson (2007) described GD as having four characteristics:

1. GD is a discipline of life long learning and practice.
2. GD is informed by three sources of learning (past, present and future)
3. GD theory takes into account conversations as a developmental process
4. GD relies on the primacy of meta-awareness versus thought or feeling. (p. 9)

GD has the ability to create distinctively different ways of thinking. This level of dialogue is supportive of change beyond the incremental and lays the groundwork for transformation.

Dialogue in OD and Change

Much of the literature on dialogue comes from a theoretical perspective. Less research has been published on dialogue from the perspective of practice, as is described in case studies. Even though it is now over a decade old, the work of William Isaacs (1999) has provided a basis of practice for the use of dialogue in several settings such as the steel industry and community healthcare. These studies provide examples of the practice of dialogue in case studies. The following sections focus on dialogue literature in case studies.

Dialogue is becoming more common in OD and organizational change literature. A variety of change tools facilitate dialogue and multiple organizational outcomes have resulted from utilizing dialogue. The tools used and the outcomes of dialogue can be found in a variety of case studies involving dialogue. Relevant case study literature is organized in Table 1, which presents the industry in which the case study was conducted along with a brief summary of the findings.

Empirical evidence. The literature in Table 1 that is categorized as empirical data provides information regarding cases in which dialogue has been used and offers insight into the

practice of dialogue. Odell's (2005) research into the community practice of dialogue provides observations describing how people freely enter and continue dialogue, and notes that consensus can be reached through dialogue.

Table 1

Summary of Organizational Dialogue Case Studies

Evidence Type	Subject/Industry Focus	Author	Related Outcome/Benefit
Empirical Case Study	Dialogue in UK private schools	Cantore & Hick (2013)	Plan and schedule for convening dialogue
	Neighborhood association	Odell (2005)	Social action supportive of participatory practices
	Intergenerational rural community	Waugh (2006)	Changed attitude toward working together and other's perspectives
	8 person dialogue group over extended time frame	Southall (2007)	Dynamic sharing, rewarding relationships, expanded world view, openness, but not cure all
	NGOs and organizational learning	Burchell & Cook (2008)	Trust, understanding, organizational learning, reflection, difficult to quantify
	Manufacturing	Van Eijnatten & Putnick (2010)	Useful for teambuilding, has generative qualities
	Dialogue in global organizations	Waddell (2005)	Transformational relationships help in creating deep change
	Dialogical action research in information systems industry in Europe	Martensson (2004)	Useful for combining theory and practice and combining scientific and practical knowledge
	Post-graduate civic engagement	Diaz (2009)	Sustaining dialogue training impacted ability to participate in variety of civic arenas after graduation.
	Meta-ethnographic review of dialogue methodology	Gallup (1998)	Dialogue analysis may help second-order learning
	Four countries and performance	D. Jones (2005)	Uses Appreciative inquiry and LEAN. Transformative dialogue supports cultural change.
	Mass scale dialogue	J. Jones (2003)	Dialogue can be used via internet vs. face to face
	Federal Emergency Management Association (FEMA) post 9/11	Windmueller (2005)	Shifts in narrative and relationships occur in dialogue. Individual contributors have large impact

(continued)

Evidence Type	Subject/Industry Focus	Author	Related Outcome/Benefit
Evidence Used to Teach	Dialogue used by a municipality on dialogue relative to absenteeism	Storch & Ziethen (2013)	
	Coaching the institutionally wronged	Oliver & Fitzgerald (2013)	Relationship between identity and culture
	Telecommunications industry's warring leaders	Inman & Thompson (2013)	Used World Café and 2 step process dialogue then deliberation
	Dialogue used in organizational structural change	Ray & Goppelt (2013)	Organization managers learning to collaborate, Use in complexity
	Dialogue used between sales and warehouse in accounting software firm	Zobizarreta (2013)	Co-creating with all stakeholders and can be used to find solutions
	Union negotiations, community healthcare, corporate entities associated with automobile, oil, telecommunications and others, and communities, schools healthcare system, prisons and factories	Isaacs (1999)	A model of dialogue, shared understanding
	Building new facility, education, and community	Holman (2013)	Open space, AI, World Café used
Opinion based examples	Learning at Presbyterian Hospital and Department of Education	Preskill & Torres (1999)	Supports organizational learning
	Technology & public schools Classroom experience	Senge (1990) Kaufmann (2005)	Supports organizational learning Observations that informed practice of teaching
	Student nurse clinical education	Haugan, Sorensen, & Hanssen (2012)	Practical knowledge vs. theory Understanding vs. explaining

Burchell and Cook (2008), Diaz (2009), Gallup (1998), D. Jones (2005), Southall (2007), and Waugh (2006) focused on the use of dialogue in community groups. These authors described the importance of relationship building and the development of trust and understanding in community based groups, but did not provide information as to how this might apply to a work environment such as a hospital.

Dialogue has been applied practically in school systems as shown in the study of its use in United Kingdom private schools (Cantore & Hick, 2013). This study reflected on the importance of structure for the implementation of dialogue. This case study provides a very concrete plan that might have application to implementation in a structured organization such as

a hospital. The review of these empirical case studies demonstrates a lack of research on dialogue occurring in a hospital setting.

Selected case studies of dialogue in organizations. Table 1 outlines various case studies or examples related to the use of dialogue in organizational settings. The organizational settings identified in empirical studies include manufacturing, information systems, and the Federal Emergency Management Agency (FEMA). These studies performed within an organization support the use of dialogue for teambuilding and creation of new shared understanding within an organization (Martensson, 2004; Van Eijnatten & Putnick, 2010; Windmueller, 2005). The industries studied and the findings in these case studies are relevant to a hospital organization, but application of specific components might differ when implemented in an organization such as a hospital.

In addition to the empirical literature, certain cases in the literature have been used to teach and explain dialogue. As a practicing consultant, Schein (1999b) described the use of dialogue in the oil industry, specifically related to creating understanding among subcultures. In this case study, consensus was reached on the basis of shared understanding on a topic that had historically resulted only in debate. Schein (1993) described dialogue as a necessary part of the problem solving process, so much so that he advocated that all problem-solving groups be organized to support dialogue. Some organizational problems can be resolved using dialogue. The following sections describe some of the tools that can be used in support of dialogical intervention.

Interventions and tools to facilitate dialogue. OD and organizational change use a number of tools and processes to manage change that can also be useful in stimulating dialogue. One criticism of these processes is that they may be used in isolation and can be demonstrated by

a consultant in an organization, but might not become part of the organization's practice. These, as well as other, conversational techniques can be embedded in practice in support of dialogue. In light of the enormous amount of research and descriptive literature on appreciative inquiry, open space, and World Café, these tools will be described in terms of the role they play in dialogue.

Appreciative inquiry. Appreciative inquiry (AI) is a process where instead of identifying the problem, the focus of dialogue is directed to the positive aspects of the topic at hand (Cooperrider & Whitney, 2005). The focus of AI on what is working well rather than on problem identification, diagnosis, and resolution. The inquiry that is the basis of AI facilitates transformational conversations; asking questions is essential to dialogue. In appreciative inquiry, four primary arenas for inquiry have been identified, also known as the four Ds: discovery, dreams, designs, and destiny. These four topics can encourage dialogue by virtue of having an element of the unknown or uncertainty. Talking to others in term of appreciation often includes a sense of respect, another dimension of dialogue (Cantore & Hick, 2013).

Some have suggested that AI is useful in helping to bridge cultural differences and boundaries, and has meaningful applications in divergent cultures. One case study described transformative dialogue using AI across the distinct cultural divides of the United States, England, Thailand, and Brazil (D. Jones, 2005). The use of AI helped facilitate dialogues in these diverse cultures.

Open space. Open space is a process that operates using a very simple rule; the right people are in the room for the right outcomes. In this process, there are no preset agendas or topics; the group determines the topic and course of conversation (Owen, 2008). This

unstructured approach creates an open container that allows dialogue to occur (Cantore & Hick, 2013).

World Café. World Café is another process by which to convene conversations. This model provides a structure for an ongoing conversation even after the original group that started a conversation has disbanded. In World Café, after a group has met to have a conversation, one member remains to host the next group and carry the conversation forward. This methodology allows subsequent groups to build on and contribute additional ideas and thoughts (Brown, 2005). This can result in achieving a shared meaning for the conversation even when members of the group are not all present concurrently.

The World Café format was used effectively in promoting dialogue in a telecommunications leadership team (consisting of 16 senior leaders) that was in conflict. The format involved three 20-minute sessions. In the first session, a group discussed the issues. Then a host from this first group attended the next two meetings to further the conversation. This scalable process allowed for cross-pollination of ideas and collaborative conversations, resulting in new language and narratives. In addition, this process helped participants to recognize the insignificance of some of the issues at hand. Doing so deescalated the conflicts in the group, which led to participants' continued engagement. In this case, World Café was a useful tool to support dialogue in a leadership group that was in conflict (Inman & Thompson, 2013).

Process consultation. In 1999, Edgar Schein (1999b) introduced the topic of dialogue as a facilitative process intervention for process consultation. Schein proposed that dialogue is a method by which diagnostic information can be obtained. He emphasized many of the same topics that Isaacs (1999) also identified as aspects of dialogue, particularly the principles of listening and suspending. Schein focused his work on the aspect of assumptions and particularly

on tacit assumptions that influence conversations. Schein described the need to learn to “listen to ourselves before we can really understand others, and such internal listening is especially difficult when one is in the midst of an active task oriented discussion” (p. 2,009)

Lean. Lean is sometimes referred to as the Toyota way, as it was developed at Toyota based upon the teachings of William Deming, a leader in process improvement and initiator of Lean methodology. Lean has been described as a set of tools, a management system, a philosophy, and even a culture. The philosophy of Lean is based on a goal of continuous improvement and respect for people (Liker, 2004).

One methodology of Lean is called a *kaizen*, which is a method of bringing people together for an extended period of time—hours, days and even months—to talk (Graben, 2012). A kaizen occurs when a group convenes for an extended period of time, usually 3-5 days. As a type of meeting, a kaizen serves as a container that might be used for dialogue. Conversations based in continuous improvement discourage some of the universal assumptions of the workplace, such as being in unilateral control and not revealing mistakes (Argyris, 1977). Respect as a dimension of dialogue supports the type of conversations that may not be described explicitly as dialogue, but that may often lead to dialogue. Although dialogue is not usually described as an integral part of a kaizen, these sessions where conversation is held in a respectful way that supports suspension of some natural assumptions can be supportive of dialogue. Lean has been used in conjunction with dialogue based in appreciative inquiry and has supported quality improvement (D. Jones, 2005).

Possible organizational outcomes from dialogue interventions. Dialogue is becoming an increasingly important part of the OD literature (Marshak & Bushe, 2013). Dialogue provides a broad approach to complex issues and can facilitate many possible organizational outcomes

such as organizational learning, shared understanding and meaning, diminished polarity, and decreased fragmentation and siloing that occur within organizations. The combination of these effects might contribute to a culture that is supportive of participation (Odell, 2005).

Organizational learning. All organizations have the capacity to learn, some much more slowly than others, and some may only learn to adapt rather than to generate knowledge and disperse it throughout the organization. Dialogue supports collective learning (Bohm, 1996; Isaacs, 1999; Senge, 1990).

Organizational learning can be inhibited by “unilateral behavior strategies” (Argyris, 1993, p. 10). Common managerial behavior involves advocating a position and pushing to win that position. In addition, it is a human tendency to hide one’s errors. These unilateral behaviors are based in assumptions. By allowing for the suspension of these assumptions—such as the belief that one needs to hide errors—double loop learning is achieved. Double loop learning occurs when underlying assumptions are open to confrontation (Argyris, 1977).

Dialogue and advocacy appear to stand in contrast to one another, as seen in Figure 1 (Schein, 1993). This visualization serves to clarify the difference between dialogue and advocacy, the latter of which can undermine organizational learning by increasing defensiveness (Senge, 1990). Dialogue, as Senge (1990) explained, allows for self-observation of one’s thinking and, in doing so, transitions advocacy from “being held by a position to simply holding a point of view” (p. 231). This distinction may diminish the pervasive and underlying behavior to *win* a point of view (Argyris, 1977). The use of dialogue to support learning in institutions has been demonstrated in a variety of industries from the steel industry (Isaacs, 1999) to non-governmental organizations (NGOs; Burchell & Cook, 2008).

The organizational learning that occurs as a result of dialogue can be generative. Generative learning is different from adaptive learning in that it is based in inquiry rather than logical extrapolation of current knowledge. Generative learning creates transformation and radical innovation (Chiva et al., 2010) rather than incremental change. Such transformation includes cultural transformation. The analysis of dialogue can produce additional learning, serving as a valuable learning tool that yields second-order learning (Argyris, 1977; Gallup, 1998). In second-order learning, where evaluation of learning occurs, meanings and patterns are reviewed for some of the non-stated meanings and values utilized in dialogue. The analysis of meaning and values provides a forum for the reflection of the validity of the meanings and associated values. The evaluation of values shapes culture. Dialogue facilitates second-order learning, evaluation of values, and cultural change (Argyris, 1993).

Shared meaning. The concept of creating shared meaning is an outcome or goal of dialogue. Hammond and Sanders (2002) proposed that shared meaning is critically important and relevant in that it may be *the* goal of dialogue. Shared meaning can be developed with reflective practice.

According to Holman (2013), “Reflecting helps meaning to coalesce” (p. 23). The act of making meaning through reflection is retrospective. Sharing meaning has components of shared pattern identification and reflection, and because of the variety of perspectives that are available in a large group, the pattern created can incorporate the complexity of diverse perspectives.

Language creates meaning, and new and different language can be created in dialogue, thus creating new meaning. Meaning is sometimes shared via metaphor, and it is the metaphoric aspects of language that drive transformation (Storch & Ziethen, 2013).

Diminished polarity. The emphasis on dichotomies or polar opposites, such as good or bad, may contribute to a way of thinking that inhibits the ability to make or sustain change (Cayer & Minkler, 1998). The thinking and conversations that support polarity are likely aligned with discussion, dialectic, and debate: conversations where assumptions are prevalent. Surfacing the assumptions that accompany polarity enables individuals to change their thinking process to identify underlying assumptions. The act of suspending assumptions allows for the exploration of a decreased certainty, and that decrease in certainty may decrease polarization. It is also possible that the recognition of polarization may become more apparent in dialogue, along with the increased awareness of different thoughts. The act of simply recognizing and labeling polarity can also be useful as a first step to diffuse the opposition.

Cayer and Minkler (1998) noted that the “‘either/or’ thinking associated with the polar dichotomies might develop more common ground in the process, and support organizational transformation” (p. 67). Dialogue “goes beyond the duality of content/process, of observer/observed” and “attempts to transcend the dualistic thinking” (p. 67). Decreased polarity results in the potential to find common ground and create a sense of community.

Decreased fragmentation. Fragmentation occurs when thoughts are divided into categories or groups that are connected at fundamental levels. Isaacs (1999) clarified that it is not the mere act of dividing that creates fragmentation, but rather it is forgetting or not acknowledging the connections that still exist. The existing relationship is thus diminished; instead, individuals focus on the parts as if they are not connected. Fragmentation occurs when there is a lack of awareness or acknowledgement of the larger system in which the fragment is embedded. Metaphorically, it can be understood as a focus on single tile of a mosaic without recognizing each tile’s relatedness to the entire mosaic. Continuing with this analogy, each tile

still maintains its individual characteristics while participating in the creation of the mosaic. The diversity of tiles contributes to a pattern or picture of a mosaic, enhancing its richness and beauty.

In using the analogy of a mosaic, dialogue is most effective when the group is highly diverse because diversity provides a variety of perspectives. When a variety of viewpoints and perspectives are spoken, support is given for the connectedness of ideas and disciplines, and patterns and connections may become more apparent. The end result is a decrease in fragmentation, as dialogue's main focus is to recognize the *whole* (Bohm, 1996; Isaacs, 1999).

Culture of Participation

Dialogue is a participatory experience, and participation has been shown to have an impact on sustaining cultural change (Arnold, 2010). Participation is generally viewed as positive and is considered to be the most visible variable in organizational democracy. The terms *democracy* and *participation* are sometimes used interchangeably in the organization. As Downs and Carlon (2007) noted, "Participation is a social contract" (p. 148), and there is some evidence for a positive "relationship between participation and corporate learning or cultural change performance" (Arnold, 2010, p. 70).

Corporate culture, which encompasses espoused values, norms, as well as artifact and symbols (Schein, 1995), should be changed to acquire and maintain sustainability. This in turn, requires gaining and reflecting sustainable knowledge. In this context, stakeholder dialogues and stakeholder communication within corporate culture (Osterholt, 2002) can contribute to sustainability. (Arnold, 2010, pp. 61-62)

Level of participation and culture are difficult to define. Measurable outcomes are problematic; thus, a culture of participation is challenging to measure (Burchell & Cook, 2008).

As a rule-making practice, dialogue has the ability to create rules that create cultural change (Gunnlaugson, 2007). It has the ability to "help participants better understand their social

and cultural identities as *constructs*” (Gunnlaugson, 2006, p. 14). The recognition of cultural constructs includes the possibility of reconstruction. Because language plays an important role in the construction of culture (Odell, 2005), language has the capacity to reconstruct culture. Therefore, dialogue has a powerful impact on the cultural construct.

Cultures of participation have unique opportunities to address problems. Cultures of participation can address: (a) large problems that large teams cannot solve, (b) systemic problems that require a variety of perspectives, (c) problems that are poorly understood or defined, and (d) problems that exist in a changing environment that are open to a number of changing factors (Fischer, 2011). All four of these issues that are addressed by dialogue are relevant in a hospital setting.

Dialogue has applications to the type of effort needed to resolve issues that emerge as part of hospital work, such as those explored in this case study. The work of an individual hospital is influenced by the global state of healthcare, and healthcare reform is a national issue. The issues in a hospital also require a multispecialty approach, especially from a clinical standpoint, in order to ensure patient safety. Another poorly understood, ill-defined problem relevant to hospitals that might benefit from a culture of participation is the open architecture of information systems used to share pertinent patient information (Fischer, 2011). The example of the electronic health record is an issue that is driven by regulation, technology, and a multitude of entities that lack a shared language or understanding. A culture of participation allows for the ability to gather knowledge to meet new challenges by pulling together multiple perspectives and sources of information.

Theoretical Framework of Participation

Fischer (2011) described three major components of the theoretical framework for a culture of participation: meta-design, social creativity, and a rich ecology of participation. Meta-design includes an assumption that not all uses and needs can be anticipated; thus, the ability to change must be embedded in the systems. The design to support a culture of participation needs to include a perceived benefit or reward by the participant in order for him/her to continue to participate. The environment must support the activities of the diverse participants in order to maintain participation.

The level of participation research conducted by Fischer (2011) was done in the social media setting. The advantage of social media is that it provides a measurable estimation of participation that may not be obtained as easily as social media posting. Level of participation in the hospital setting is often derived from employee surveys with the limitations of self-reported instruments. Participation in social media has a concrete measure of posts and views that might provide a perspective into participation that might not be seen in other methods of assessment.

Social creativity depends on diversity to contribute a variety of perspectives and knowledge. In addition, individuals who maintain a level of independent thinking contribute to social creativity. Foundational to social creativity are the principles that individuals must be able to participate, have a reason to contribute, and be allowed to contribute in the group. As Fischer (2011) noted,

Although creative individuals are often thought of as working in isolation, much human creativity arises from activities that take place in social context in which interaction with other people and the artifacts that embody collective knowledge are important contributors to the process. (p. 46)

A culture of participation does not demand that each participant contribute, but it does issue an invitation for each person's contribution. The culture of participation assumes that all

may contribute and each person has a responsibility to contribute unique knowledge.

Contribution needs to be supported by both leadership and also peers. Participation occurs on many levels, all of which need to be recognized and rewarded. Fischer (2011) further defined five levels of participation, which he labeled level 0 through level 4.

Level 0 is described as the unaware consumers. On this level, the public community may not be aware that consuming a service is still a level of participation. Level 0 participation is passive and may be a challenge to identify in an organization. When purchasing a product, the consumer may not be aware of his/her participation, but by doing so participates in the economy of the organization and thus may be a level 0 participant. In an employee relationship, level 0 may describe someone who is disengaged, not thinking that he/she has any impact on the organization (Fischer, 2011).

Level 1 participation occurs when the consumer/producer is aware of the possibilities to contribute, but may not behave overtly as a participant. A level 1 participant understands that he/she may participate and the participation may be through voicing or other behaviors. In level 1, the participant may not select behaviors that demonstrate participation to others, but is aware that he/she may choose an action of participation at some point (Fischer, 2011).

Level 2 participation is that of contributors and decision-makers. Level 2 participation is more visible and can be traditionally associated with roles such as managers in a hospital. Decision-making and contributions are not limited to managerial or even employee roles such as with physicians and volunteers. Patients might even fill this role when making decisions regarding the plan of care (Fischer, 2011).

Level 3 participants are in the role of collaborators, facilitators, and organizers. These participants bring others together so they can also participate and contribute. In doing so, they

may raise the level of an individual participant. The group helps to grow both volumes of participants and levels of participation. They may convene sessions of dialogue (Fischer, 2011).

Level 4 participants are meta-designers. The meta-designers create support for a culture of participation, recognizing that acts of participation will continue to provide information and create knowledge that continues to evolve the design. This group provides a vision that includes participation. This level may be associated with senior management in a hospital, but it may also be found in a volunteer group or a single department (Fischer, 2011).

As information comes from a variety of participants in a culture of participation, the defined space between a teacher and student becomes unclear and is not based in role, but rather in context. Participants are both providing knowledge and receiving knowledge simultaneously, often in peer-to-peer communication (Fischer, 2011).

Issues Associated with Communities of Participation

A culture of participation may have some drawbacks, one of which is its potential to increase fragmentation. This can occur when multiple competing issues are identified and participants divide along these issues. This conflict may be addressed by ensuring that dialogue supports the participation, as it has been shown to decrease fragmentation.

It may also be challenging to identify erroneous information and misinformation coming from participants. Participation invites a variety of perspectives, some of which may come from individuals who lack the skill level to validate information. Critical thinking skills that support verification and validation of information become a necessary skill in facilitating the emergence of new knowledge in cultures of participation.

The emergence that takes place in a culture of participation has been described as *chaord*. This word is a combination of *chaos* and *order*, and is used to describe the tension that is created

between chaos and order in a culture of participation. Finette (2012) suggested that this tension can be balanced by following four rules: (a) strive to make things significantly better; (b) push decision-making to the edges of the culture; (c) build on participation, encourage it, and reward it; and (d) treat others as and expect to be treated as a community of citizens. Participation also brings forward multiple issues such as the need for trust and reciprocity in support of participation.

Measurement of Participation

The level of participation in a culture can be measured in several ways:

(a) responsiveness of the community to its members' needs, (b) the intensity of engagement, (c) support given to one another, (d) the types and diversity of the participation, and (e) the reward system's impact on participation behavior (Fischer, 2011). A culture of participation may be better understood by exploring these attributes through a review of its communications, documents, and other artifacts. Challenging as it may be to measure aspects of a culture, these components provide opportunities for study.

Further insight into a culture of participation might also be revealed by assessing the levels of participants as described earlier by Finette (2012). Descriptions of interactions rated for level of participation might also provide useful information about conversations held between the different levels of participation, perhaps allowing for increasing levels of participation in some instances.

Chapter Conclusion

The principles of dialogue have elements of participation, and dialogue seems supportive of a culture of participation. Some shared principles are those of open and effective communication, contribution by participation, and emergence of knowledge and meaning. Since

they share many principles, these two concepts seem supportive of each other, and may be difficult to separate in practice. This research that sought to explore aspects of both dialogue and a culture of participation provides additional insight into the utility these principles might have when integrated in practice in a complex organization such as a hospital.

Chapter 3

Methods

This chapter describes the data collection methods, tools, and protection of human subjects in conducting this case study research. The timeframe for this case is over a 7-year period (2008-2014) at a hospital in California. Historical qualitative data were analyzed. This exploratory empirical research was conducted as a holistic inquiry in a natural setting and sought to better understand and recognize the uniqueness of an institution (Creswell, 2013; Yin, 2014) in the practice of dialogue and supporting a culture of participation. It involved the collection of detailed, content-rich data from multiple sources.

Case Study Research

Case study research design involves an in-depth inquiry placed in context in a real world setting. Case studies rely on multiple sources of data from six possible sources; this study utilized three of these sources: review of documents, archival records, and physical artifacts. Case study includes some elements of storytelling in that it creates a story that describes the case in a manner that creates understanding. Case study research necessitates a level of rigor that differentiates it from a narrative, and this research was conducted using a rigorous approach. The approach included complete data collection, data aggregation, and creating understanding through a logic model, providing valid, reliable, and reproducible information (Yin, 2014).

Case study research is an iterative process and, as such, data collection and analysis can result in the need for further data collection and even revision of the design of the study (Yin, 2014). In this study, the extensive literature review and identification of pertinent categories based upon current theory facilitated the gathering and analysis of data. Since the extent of the

existing data available for the case is vast, sources were targeted to those most likely to provide the necessary information to address the research question.

Isaacs (2007) identified the need for a relationship between the theory and action of dialogue and the need to connect practical experiences with theory. A case study such as this focuses on the experiences and outcomes of an organization's dialogue and thus represents an attempt to bring theory and experience together in a way that Isaacs described as creating meaning and knowledge.

Sources of Data

Multiple sources of evidence were aggregated and analyzed in researching this case study. Three sources of evidence were utilized: documents, archival records, and artifacts. Documents refer to meeting minutes and attached documents. Archival records are presentations that include slides, embedded video, and scripting for the presentations. Artifacts were used to describe room set-ups, large post-it notes used for meeting facilitation, and participant interactions, such as handheld voting questions used during interactive sessions. Appendix A includes the list of coded documents. Additional documents were used that are summarized in the coded documents as described subsequently. The sources used were made available through permission from the hospital. Appendix B includes the letter of permission.

Archival records, documents, and artifacts are existing data and assisted in defining the case. Operation Committee meeting minutes and Vision Session presentations were requested. The term *artifacts* relates to what is made or used in the institution (Creswell, 2013). In this case study, artifacts included vision statements and items produced during Operations meeting and Vision Sessions. One example is the abundance of large white 3M sticky charts that contain ideas and conversations from Vision Sessions. Information from the sticky papers, slides, and

video presentations were summarized or transcribed into documents for review and coding purposes.

Document review is useful in case study research in that it provides an opportunity to retrospectively review events occurring over a lengthy time span across an entire institution, as was the case in this study (Yin, 2014). The documents that were reviewed are associated with hospital wide initiatives and institutional scopes; departmentally focused documents were excluded from the study. The meeting minutes represent the conversations of the organization's leaders and decision makers and reflect a high level of oversight and cultural insight.

Document review has limitations; in this case, bias may have been introduced by the authors of these documents, and may have been identifiable in the act of coding. It is possible and perhaps even likely that dialogical information and levels of participation may not have been recorded adequately; additionally, the descriptions may be focused on tasks rather than the process. This possible limitation is further addressed in the analysis of data, with the construction of a logic model that describes any relationships between the activities and dialogical interventions and participation.

These records, documents, and artifacts were reviewed and abstracted data were codified based upon the pre-determined themes found in existing literature, with an un-coded category provided for emerging themes categorized as *other*. Care was taken to transcribe specific descriptions. Understanding a common language is a characteristic of a CoP (Wenger, 2002), and as a member of this CoP, this researcher possessed the common knowledge of terms used in the organization, which proved to be helpful in codifying these documents.

No names or means to identify an individual were taken from the documents and entered into the coding sheets or compiled after coding. These original records, reports, and documents

were kept at the confidentiality level that is currently maintained at the hospital, which varies according to the document. For example, Board Minutes have limited distribution, which includes the Board and executive guests; operations committee minutes are distributed to Operations Committee members; and other documents associated with Vision Sessions could be distributed to all employees. No data were shared that are confidential or relate to any level of Protected Health Information (PHI).

Minutes from executive level meetings served as a primary source of information for document review. The rationale for qualitative analysis of these meetings was based upon the following assumptions: (a) leadership establishes communication styles, patterns, and levels of participation; and (b) most significant institutional information is presented or reviewed in these forums. In addition, training classes were selected for review because they are inclusive of roles and departments in the hospital; the intent was for the data reviewed to be representative of the variety of interactions that occur at the hospital. Selected meetings had more than 10 participants. The meetings selected were organization wide in scope. The meetings identified for review were:

- Operations committee: This is the executive leadership of the hospital, chaired by the CEO. It meets approximately three times per month on Wednesdays from 2-5 pm.
- Course curriculum and associated videos developed or utilized in annual interactive training sessions were reviewed and coded. Curricula selected for review were associated with the internal corporate training program, Hospital University (HU).

The programs offered by HU include an Annual Vision Session provided to all of the managers and staff by executive leadership and other programs that have applied behavior perspectives. They are offered across the disciplines and divisions in the organization and have a breadth of participation representative of the organization.

The following documents were included in the review:

- Operations Committee Minutes
- Summary of feedback compiled from Vision Sessions

The following archival records were also reviewed:

- Annual Vision presentation slides, videos, and scripting
- Idea sticky sheets retained after annual Vision training programs

These sources of data provided adequate information to define and describe the case and to investigate how decisions may or may not have been supportive of the development of dialogical interventions and a culture of participation.

Triangulation of Data

Validation of data occurred on a holistic level after data collection was completed by triangulation (Stake, 1995; Yin, 2014). Triangulation of observation and coding of themes was performed by reviewing coded data with a reviewer. The purpose of triangulation was to limit research bias in the coding and analysis process performed.

The researcher validated and triangulated the data by asking a non-participant OD colleague to read and validate the interpretations based on the literature (Stake, 1995). Any discrepancies were resolved with a conversation where the researcher explained the rationale for a specific coded entry.

This individual challenged codes and provided insight from several perspectives on the meaning of the data collected with the intent of triangulating interpretation and providing a source of validation (Yin, 2014). This process of validation as expected to provide a second check against researcher bias. In addition, triangulation had the potential to present alternative and rival explanations for activities and perhaps the co-mingling of the theory related to

dialogical intervention and that of a culture of participation. This information had the potential to be supportive of either theory, both theories, or neither theory associated with dialogical intervention or culture of participation.

Human Subjects Protection

In conducting this case study research, human subjects were protected. Ethical considerations included maintaining confidentiality and protecting participants from harm. Confidentiality of individuals was maintained; names were not used in describing events or discussions of dialogue or participation in the case study. Original documents may contain participants' identities, but they were redacted at the time of data entry and no names or personal identifiers were used in narratives that reported participant observations.

This study did not include vulnerable populations. Participants were between the ages of 18 and 70 years old and were engaged in their normal work during the time that minutes were taken. All were aware that minutes were being taken and that those minutes would be published for internal use.

Original confidential documents were archived and maintained in one of two private locations: a private locked office in the administrative department and the researcher's personal residence. Any transport of documents between the two sites was done in a closed briefcase or portfolio, as is the current practice, in order to prevent any breach of confidentiality.

An Institutional Review Board (IRB) exemption approval and waiver of consent was requested from Pepperdine University, since no participant harm was identified in conducting this study (See Appendix C). Research was conducted on group characteristics of behavior including language, communication, and cultural practices of participation. All participants were capable of providing informed consent, and no vulnerable populations were identified as a part

of this research. This study involved no medications, medical devices, or procedures, and no PHI were captured in this study.

There were no clearly identified benefits to participants of this study. Results of this study were made available to the leaders of the hospital, which was given permission to publicize and utilize the findings. The findings may have an additional benefit of fostering a better understanding of dialogue or the culture of the organization, which might facilitate continued cultural change in the organization. Because of the appreciative perspective of this study in looking for a better understanding of dialogue and participation, it was not anticipated that the study would result in any negative repercussions to the institution's reputation.

Instrumentation

A data collection tool was developed for collection of data from documents, archival records, and artifacts. The spreadsheet included the source of the data; date of meeting, session, or creation; description of the data; coded evidence of dialogue or culture of participation; and themes. The initial format that was designed for data abstraction is shown in Appendix D.

The researcher used the data collection software HyperResearch and the items listed on the coding scheme were all entered. All data were referenced, indexed, and maintained. The data will be maintained for 3 years as required after the completion of this research and will include the narratives abstracted from the data (Pepperdine University, 2013). The codification from each meeting referencing the minutes by meeting and date were catalogued. (The original meeting minutes will be maintained by the hospital and may be accessed by date and meeting.) These data were maintained by date and theme.

Data Analysis

Analysis of the qualitative data was conducted on this single case study in a holistic manner via codifying themes and action theory, utilizing a linear-analytic structure (Creswell, 2013; Stake, 1995; Yin, 2014). This methodology involved reviewing the issues, current literature, methods, discovery of findings, and the development of conclusions. The predetermined themes to be reviewed were dialogue and participation. The intent was to explore the presence and practice of dialogue and participation and current application of literature as well as to allow for exploration of logical associations of these actions with theory. Evidence of dialogue was presented according to dimensions and aspects of dialogue, such as listening, respecting, suspending, voicing, descriptors of the container, coherence, and generation (Gunnlaugson, 2006; Isaacs, 2007). Perhaps because of the breadth and overlap of existing codes, other aspects and themes did not emerge as data collection progressed.

Isaacs (2007) also identified three aspects of action theory associated with dialogue that provide a perspective on a deliberate intervention that he undertook in instilling dialogue into the steel industry. Isaacs described the paradox of not being able to will or force dialogue into existence, noting that one must instead support the development of dialogical skills. Thus, these aspects of action theory might be useful in helping to describe the actions at this hospital. The action theory aspects coded included: (a) face to face efforts to change behavior; (b) the shared field or environment, which includes co-created meanings; and (c) understandings, assumptions, and artifacts in addition to the physical field. Activities and interventions had the potential to fall into any of these three codes of action theory, relate to multiple codes, or be indeterminate.

The level of participation in a culture can be measured in several ways:

(a) responsiveness of the community to its members' needs, (b) the intensity of engagement,

(c) support given to one another, (d) the types and diversity of the participation, and (e) the reward system's impact on participation behavior (Fischer, 2011). These were predetermined themes based upon the literature review; no additional measures of participation were identified. These levels of participation were reflected as categories in the data collection and codification sheet. Elements were documented that supported a description of the level of participation.

Level 1 participation occurs when the consumer/producer is aware of the possibilities of contribution, and level 2 participation is that of contributors and decision-makers. Level 3 participants assume the roles of collaborators, facilitators, and organizers. Level 4 participants are meta-designers (Fischer, 2011). These levels of participation were also utilized to evaluate participation. Evaluation of the levels of participation reflected the predominant participation level in the group and was assessed by event.

Data narratives were coded based upon the predetermined attributes of dialogue and participation, which were used to identify themes and patterns. Prevalence of codes and themes as randomly reviewed by another organization change practitioner to triangulate categorization and validate or provide credibility to the observations and data (Creswell, 2013).

After a validation process, the data were interpreted to determine patterns. The researcher categorized and identified what has been learned from the study. Because the data for this study extended over 7 years, chronology was used in the interpretive process (Creswell, 2013; Yin, 2014).

Logic was used to describe the events, tactics, trainings, and conversations that logically might be supportive of both dialogue and participation. The flow of the events in a real life organization was used to demonstrate the practice of developing dialogue and participation. This modeling also sought alternative explanations and theories related to these chronological and

large-scale organizational practices. Attention was paid to process transitions in addition to activities and outcomes to avoid the common case study analysis error of focusing solely on the activities (Yin, 2014). Additional real world and rival activities were included to provide a holistic analysis recognizing the influence of the environment and other activities on developing dialogue and participation. As an open system, acknowledgement of possible impact of forces outside of the organization was included, such as economic and regulatory factors.

In addition, the review of dialogue and participation case study was also designed to potentially support, challenge, expand upon, and provide new examples of the practice of the supporting theories. Analysis included all of the evidence, regardless of whether it supported or challenged existing theory. This case study included extensive data for analysis and focused on the most significant aspects of the case—the process of developing dialogue and participation—and avoided analysis of other factors that might also be part of this data collection and analysis.

During analysis, the researcher sought out rival explanations as plausible interpretations. The researcher sought to validate her interpretation with the expectation that the meaning she discerned and applied would be challenged. This combination of case knowledge and subject knowledge had the potential to contribute to the analysis with a depth of understanding and insight that might be helpful in understanding both the practice of dialogue and culture of participation, as well as supporting of the evolution of both.

Chapter 4

Results

This research is a retrospective qualitative case study of an independent, community hospital that explored the development of the practice of dialogue and a culture of participation. This study reviewed documents and artifacts for evidence of these practices, exploring the organizational decisions documented in the Operations Committee and organization-wide communications during the Vision Sessions. This chapter reports on themes and examples of the coded data in the exploration of how an executive leadership team in a community hospital made decisions and developed messages that support the practice of dialogue and a culture of participation.

Sources

The two primary sources of data, the Operations Committee minutes and annual Vision Session presentations, were selected because they addressed distinctly separate perspectives. The Operations Committee focused on the types of decisions made in this decision-making committee. In contrast, the annual Vision Sessions provided insight into the communication and messaging around the decisions made by the leaders in this hospital. The different primary functions of the messaging of the Vision Sessions and the decision-making of the Operations Committee offer contrast and clarity to practices associated with these two perspectives, providing depth and detail to decisions through the message communicated.

The Coding Schema and Coding Nuances

The coding schema was described in Chapter 3 and is included in Appendix E. Coding was performed sequentially, meaning each document was coded starting from the beginning of

the document and finishing at the end of the document. From both reviews of the minutes and the summaries of vision statements, a passage of narrative often had more than one code applied.

Overlapping code is understandable in that a dimension of dialogue, an action theory, a level of participation, and an additional aspect of dialogue can be seen in a single decision or message regarding a decision. These combinations provide a multidimensional view of the application of dialogue to decisions and messages in this institution by holistically reviewing actions, levels of participation, and dimensions of dialogue with an overlay of the three large institutional initiatives of achieving Magnet status, developing a corporate training program, and initiating Shared Decision Making.

At times, the coding pattern of going from the beginning to the end of a document resulted in a subject being coded in two separate locations in the documents, yielding some inflation in frequency of occurrence. For example, the code for action theory of shared field of environment (125 occurrences) and the action theory of face-to-face behavior changes (69 occurrences) may be inflated. The entire Vision Session reflected action theories when viewed holistically, and may have resulted in multiple codes of the action theory such as when the narrative is coded shared field of understanding, then coded as face-to-face behavior and then later in the same passage, the code returns to shared field. In addition, frequent narratives reflected the action theory concepts of understandings, assumptions, and narratives. The decision was made to code each block of narrative rather than each session with the reasoning being that when viewing a coded document the application to each passage provides a visual of the fluidity with which the transition from one action theory to another occurs.

In addition, there was significant overlap in coding. A specific narrative page globally represents the action theory of shared understanding and a specific phrase embedded in the

narrative represents in its entirety the action of creating a shared understanding. Embedded in the same narrative can also be a phrase specifically directed toward the action theory of uncovering assumptions. In summary, during the coding of documents, a total of 663 codes were applied to the 19 codes from 35 documents.

Code Frequency

The grid presented in Figure 2 depicts the coding for all source documents. The graphic shows the frequency associated with each code that is supported by a narrative of the examples of activities that may be associated with or supportive of each of the codes. The individual codes are aggregated into a summary of frequencies by each of the three theories used in developing the codes. The sum of Isaacs's (1999) four dimensions of dialogue is 148 codes and the 0 to 4 level of participation codes were found 121 times. The highest number of codes associated with a theory is attributed to Isaacs's (2007) three action theories, with 230 codes associated.

The frequency of the initiatives codes was as follows: professional development, 38 occurrences; shared decision-making, 48 occurrences; and Magnet designation, 14 occurrences. A possible explanation for the fewer number of times for coding Magnet could simply be reflective of this initiative as one that was delegated to the nursing division. Therefore, more detail would appear in those minutes, with a higher level of reporting occurring at the Operations meetings and Vision Session.

Findings include 90 codes associated with these three initiatives, representing a consistency of follow up and reporting over a lengthy time span. These programs were given valuable time and attention, which may be associated with their successful implementations.

Code	Total	Bar Graph
Coherence	29	
Container for dialogue	19	
Emergence	9	
Face to face behavior changes	69	
Generative	7	
Level 0 unaware consumers	2	
Level 1 consumer aware of possibilites	16	
Level 2 contributors and decisonmakers	33	
Level 3 collaborators facilitators organizers and	43	
Level 4 metadesigners	27	
listening	49	
Magnet Designation	14	
Professional Development/TMU	38	
respecting	57	
Shared Decision Making	48	
Shared field or environment	125	
suspending	5	
understandings assumptions and artifact	36	
voicing	37	
Total: 19	663	

Figure 2. Coding for all source documents.

Initiative Coding

Three prominent programmatic initiatives were occurring during the time period studied in this case: (a) the initiation of a corporate training program designed to provide training beyond task oriented skills, the *softer skills* associated with communication and teamwork; (b) achievement of a Magnet Award for excellence in nursing; and (c) implementation of a shared governance approach, including a council structure. These three complex programmatic process-oriented changes are based on the decisions and messages used during a dialogical approach to management.

Coding Example: Shared Decision-Making Initiative

One lengthy text from an Operation Committee minutes of May 5, 2012 describes the report out of the council's work for the shared decision-making councils. This passage was coded *shared-decision-making* in its entirety. It describes the report out of decisions made by the councils that are approved by the Operations Council, in this case the changes made to an employee recognition program. It also describes the role of the Operations Committee in requesting clarification of goals; from the decision-making level this is a non-approval of the current goal.

This text comes from a single Operations Committee but provides context to the past and ongoing decisions and messaging associated with the shared decision-making initiative, in addition to integrating information about the corporate training initiative. This narrative is representative of Operations Committee's documentation of dialogue. The initiatives and codes associated are not distinctly separate but instead overlay, overlap, and integrate, as seen in this excerpt:

A. Organizational Council Updates – We need to identify which goals each of the councils is working on. A list of council members was distributed along with an update summary.

* Pride & Communication Council – Roles have remained the same and new members have been added. The Reason is You recognition award process has been streamlined to get the information back to the employee much quicker. A copy of the recognition still goes to the manager for the employee file. We are looking to expand the number of candidates. We will also be adding a monthly raffle from the list of nominees for a pair of movie tickets. Talked with [deleted name] regarding the use of volunteers as wayfinders. Logoed items are popular and we are looking at ways to expand the offerings. This group is trying to align with the Service (Standards of Behavior) and Community (Employee Pride and Satisfaction) goals. Will come back with some smart goals.

Working with a new group of unit-based volunteers to be useful members of the HCAHPS team in collaboration with the Service Excellence Council. Collaborated with IPCC on Patient Safety Week. Looking at Patient Experience training for all employees in the fall. This group is trying to align with the Knowledge (Staff and Manager

Development) and Community (Employee Pride and Satisfaction) goals. This group will need specific data and goals of what we are trying to achieve.

* Service Excellence Council – The first meeting with the new members occurred last week. Some of the initiatives being addressed include: No overhead paging at night (exceptions of codes and physicians), Through the Eyes of the Patient (expand beyond volunteers), IHI/VHA Collaborative (families and patients partners in care; focus on nursing communication, physician communication, and response time). This group is trying to align with the Service (Patient Experience and Culture of Compassion) and Excellence (HCAHPS) goals.

Physician Relationships need to be covered by a council – chairs will discuss with sponsors. We will also add [deleted name] as a sponsor for the Leadership & Education Council.

* Interdisciplinary Patient Care Council – [deleted name] is taking over the chairmanship from [deleted name]. The new members have been brought on board. This group is focusing on the culture of safety and the patient safety issues focused on the reduction of harm. The hand hygiene campaign is still an ongoing initiative. This group is trying to align with the Excellence (Quality and Patient Safety) goal.

* Leadership & Education Council – Turnover was done at the last meeting. The goals need to be reviewed with the team at the next meeting. They all want to work on the health and wellness of our staff.

The level of detail in this example is descriptive of shared decision-making, professional development, and the Magnet program. (The reference to Magnet is not named Magnet in this passage, but is embedded into the culture of safety, reduction of harm events, and service excellence topics.) These excerpts yielded multiple and overlapping codes; five other codes were also associated with this narrative. Further demonstrating the interconnectedness of the coding, portions of this his narrative were also coded as respecting, professional development, a shared field, understanding assumptions, and face-to-face behavior change.

Action Theory

In action theory, three actions are associated with dialogue: face-to-face behavior changes; a shared field or environment; and understandings, assumptions, and artifacts (Isaacs,

2007). All three of these were identified as actions used over this 7-year period. The most commonly coded action theory found in the study is that of creating a shared field or environment. This code is also the most common code in the study, with 125 occurrences.

Shared field or environment. The shared field or environment was utilized extensively in the Vision Sessions and applied to multiple narratives in every session. The pervasive frequency and application of shared field and environment across these documents may indicate some preference for implementing this action in this institution.

In addition to messages and the planning associated with shared environment at the Vision Sessions, there were other examples of developing the shared environment associated with employee satisfaction survey. Another example of shared field or environment was coded for the following text from the November 5, 2008 Operations minutes:

D. Employee Survey Results – We need to get the results here and discuss them first and then figure out how to get this to the staff. We do not want to wait until the first of the year to share this information.

Even prior to knowing the results, the leadership group was concerned with sharing the results in a timely manner. This representative example, along with multiple others, demonstrates the high level of attention that the leadership placed on creating a shared environment.

Face to face behavior changes. Approval for face-to-face training and behavior changes occurred at Operations meetings. Several examples of narrative discuss mentoring, managerial training, and creating relationships with staff in order to provide information that might influence them regarding union activity. This first example comes from the October 3, 2007 operations committee minutes: “The managers want training in how to be a coach and mentor.” A line from the October 5, 2012 entry was also coded as face-to-face behavior change: “G. Formal Mentoring Program - Please get back to [deleted name] regarding prioritization so that she can

bring the list back to the May 16th meeting for discussion.” Mentoring is one of the tools this hospital used to provide face-to-face coaching and behavior changes.

The following narrative from the Operations committee describes the face-to-face meeting that occurred as requested by staff located in text from Operations Committee Updates:

[Deleted] Union Activity Update – We have had some activity in the [deleted] with staff meeting with union reps. Staff wanted to meet with [deleted name of administrator] without [their] managers, director or leads. [Deleted] met with them this morning. Their issues are with [deleted] who have now been [deleted]. The department has been short-staffed due to an increase in LOA’s, terminations, and an increase in volume for July. [Deleted names] have an increased presence in the department that is very helpful. The staff perception is that we are trying to keep the rooms open for the physicians, but to the detriment of the staff. The new [staffing] agency we are working with has been very helpful with getting them temporary staff. [Deleted] need to be spending time in their departments even on off shifts and we need to give them the slack to do that in the next 4-6 weeks.

This passage is an example of the use of listening, respecting, and voicing using face-to-face behavior during a staff meeting as it was reported to Operations Committee. This example illustrates and appears typical of the attentive and detailed approach to decision-making in this organization.

Understandings, assumptions, and artifacts. An example of the action theory, understandings, assumptions, and artifacts use story telling as a methodology for creating understanding. In this case, artifacts from a lecture were provided to leaders in this organization. The stated goal of this methodology is to develop appreciation of group work where the practice has been individual recognition.

[Name deleted] distributed the feedback from the [name deleted] session. We want to take some of the messages and clips from this session into the Vision Session. We have a live video and we purchased the DVD series. We would like to use stories of appreciation from one group to another; less about recognizing individuals and more about groups. We would also like to look at memorable stories.

This passage describes how a shift of focus from individual accomplishments and successes to that of team successes might be understood through the stories of historical events.

Dimension of Dialogue

The dimensions of dialogue were codified using Isaacs's (1999) four categories: listening, suspension, respecting, and voicing. The most commonly coded dimension were respecting and listening, and these two codes were given for the same passage in both Operations minutes and the Vision Sessions.

Listening. Listening is reflective in nature; listening for one's own feelings helps an individual become more aware of personal biases. Indeed, the work of listening is internal (Isaacs, 1999). Hearing is something that one does without thinking; one does not have the ability to turn it off. Listening is different from hearing, as it goes beyond hearing to embracing and accepting (Schein, 1999b). Listening implies that one is seeking understanding, although listening is an important tool for the critical thinking used in debate. In dialogue, listening goes beyond understanding and includes a component by which one listens to one's self. During this process, one becomes familiar with one's own feelings, biases, and remembered experiences, which requires the cultivation of an inner silence (Isaacs, 1999). Listening was both the most frequently coded dimension of dialogue in this study.

Listening was a common code both in Operations Committee minutes and in Vision Sessions. The Operations Committee minutes depict the decision-making impacting dialogue as well the communication provided during the Vision Sessions. A review of the examples of listening brought observations of two slightly different approaches to listening, both being based in inquiry. The first approach identified was a generic request for feedback and the other was a more defined, specific inquiry.

The generic request for feedback has aspects of consensus building and seeks to gain insights into unexpected or unanticipated reactions. This can be seen in some of the instances when, at Operations Committee meetings, a change in policy is under consideration. The operations minutes reflect a delay in the decision-making while waiting for feedback from each department. The minutes include a *follow-up* agenda item that requests each administrator go back to the directors to ask how this policy change will impact their departmental operations and report back to the committee on a future date. This request was coded as *listening* because it challenged the act of accepting assumptions and instead pushed toward inquiry.

Open-ended feedback was also solicited from employees during the Vision Sessions primarily during the breakout round-table workgroup sessions. Broad questions that ask for ideas on how to improve patient experience and quality of care elicit a variety of ideas and opinions. This open approach assumes that the group possesses a knowledge base that the administrative staff does not have. This open request for feedback also features aspects of respect that will be addressed subsequently under that heading. Another example of a request for feedback is related to explaining rationale. The open-ended question asked in 2008's Vision Sessions was *Why do we have Standards of Behavior?* This request for rationale or explanation requires listening in order to ask others for additional explanations or to summarize or reframe the explanation. Vision Sessions in 2012 for all of the managers included lengthy leader-facilitated conversations about strategies that might be effective in achieving goals.

Vision Sessions introduced to this organization a component of audience response to questions using *voting machine* devices. This methodology elicits listening for group responses from the executive team. An example of this is seen in the Vision Session in 2008, participants were asked about the rationale for a new building project. The real-time answers identified any

misunderstanding about reasoning behind decisions made in the moment and allowed correct information to be communicated.

Additional use of the voting machines occurred in 2010 when the first question was *How are you feeling today?* followed by four answer choices. This question also served to establish a container where listening to one's feeling became an acceptable topic of conversation during this training session.

Respecting. Respecting is a way of thinking about others in a holistic way: one focused on identifying qualities in others that also exist in the individual. Isaacs (1999) described this perspective as viewing others as “part of the whole, and, in a particular sense, a part of us” (p. 117). Respect can be seen in the both Operations Committee minutes and Vision Sessions. In the Operations minutes, the coding of respect in some incidences occurred during updates from the shared-decision-making councils. This association may be representative of the embedded aspect of respect when sharing decision-making, as the act of sharing decision-making implies an element of respect; it is a part of acknowledging that the individual is part of the whole.

Respect was communicated overtly through explicit statements scripted into the Vision Session presentations. The participants were told multiple times that they were valued and key contributors to the success of the hospital.

In the review of the coded data, respecting is seen 57 times. Twenty-six of these passages came from the Operations Committee and 31 of these were associated with the Vision Sessions. Respecting was paired with listening in the Operations Committee minutes over 80% of the time that respecting was coded. The construct of respect includes valuing a person's contribution, which logically includes verbalizations and communications, and thus it is logical that listening can also convey respect.

Suspending. This dimension speaks to suspending action and judgment, not awareness (Bohm, 1996). Suspension has similarities to reflective thinking, the difference being that reflective thinking occurs retrospectively, whereas suspension occurs in the moment, simultaneously with dialogue (Gunnlaugson, 2006). Suspending was coded less frequently, with only five passages coded. By definition, suspension of assumptions and beliefs may be not be transparent. Unless stated explicitly, assumptions, biases, and beliefs were not be revealed in the course of either Operations Minutes or in the large group Vision Sessions. Still, the following is one of examples found. A quote from the 2012 Vision Session, “Make no judgments where you have no compassion,” was used in a session that focused on compassion.

Voicing. Isaacs (1999) used the term *voicing* rather than talking or advocating as a way to differentiate this aspect of dialogue from other ways of talking. Voicing is an aspect of saying what needs to be said in a group, as distinct from talking or speaking, in that those methods are also used to demonstrate knowledge, share expertise, or advocate for a position. Voice serves to answer the questions, *What purpose would this statement have? What contribution to the whole will this make?*

Examples of voicing are evident in Vision Sessions, and approximately half of the narrative of Vision Sessions was coded as voicing. Voicing overlaps with action theories frequently. As shown in the coding, aspects of voicing can be action based, often times to create a shared field and environment, as well as understandings and assumptions.

Coherence. Coherence in dialogue refers to understanding, alignment, and synchronization (Bohm, 1996). Gunnlaugson (2006, 2007) has described it as alignment of thought, vice, behaviors, and viewpoint. Coherence as an aspect of dialogue was also coded in 29 narratives. Coding this aspect of dialogue required a comparatively lengthy segment of

information. One example of narrative that provided explanation of coherence was seen in the 2008 Vision Sessions. The presentation during this Vision Session linked together the emerging megatrends in health care, including expanded coverage, aging demographics, and the increasing transparency of quality and experience data, as well as the hospital's decision to enter a large construction project to provide a shared understanding of the impact of the current situation with preparation for these evolving trends.

Emergence. Emergence is an important aspect of transformation, which is a complex process that does not lend itself readily to the project management approach. Typically, project management has a specific desired outcome. In contrast, transformative process change may have a more generalized direction, and the specific desired outcome may be difficult to articulate. Emergent practices include a probe or stimulant, a sensing or reflection, and a response (Bushe, 2013). A probe could be an inquiry or a question; it is anything that stimulates thought. Reflection is a process supportive of attaching meaning or understanding to the thought. A response can be described as the change that occurs as a result of the probe and reflection and can be manifested in thinking, conversations, values and beliefs, and actions and behaviors.

Emergence was also infrequently coded with only nine examples. A clear example of emergence as a result of dialogue was seen in the 2010 Vision Session. During this session, a lightning round of conversations occurred related to strategies to mitigate mandatory changes in health care. These ideas were documented and shared and built upon by the next group. The team utilized methodologies associated with brainstorming to flesh out a picture of thoughts about what the desired future organization could look like. The dialogue centered on an ideal and allowed for the suspension of practical realities.

Generativity. Emergent processes can, but do not necessarily, result in generative ideas. Dialogue is generative; it creates new ideas and ways of thinking (Bushe & Marshak, 2009). Generative dialogue (GD) creates “not yet embodied tacit knowledge” (Gunnlaugson, 2007, p. 44). Generative qualities of dialogue were also coded infrequently. An example of the generative qualities of dialogue occurred when the Operations team held strategic planning sessions where each member brainstormed a vision the desired vision for the hospital and then followed up with goals. The strategies that required collaboration and identified co-dependencies generated a new conversation on how future strategic planning should evolve. This was a new way of thinking for the Operations team that also created a new level of understanding.

Container. The container for dialogue was coded 19 times. One example was the use of the round tables during the breakout sessions. These tables were purchased specifically for these sessions. Container can be created framing and welcome as was in the opening of the session in 2009 which started with *Welcome to Vision 2009* and the narrative “We are so pleased to spend this time with you. We come together once a year to examine how far we’ve come and determine where we need to go . . . to achieve our Vision.” These two sentences used the plural “we” or “our” five times. This repetition of the plural creates a container where inclusion is the expectation.

The planning for the Vision Session in 2010 was documented in the June 6 minutes preceding the sessions. The following narrative offers an example of the decisions made regarding logistics for an event that create the container:

A review of the 2010 Vision Session was conducted. Everyone was asked to sign up to help facilitate 5-7 staff sessions with the goal of no one needing to actually do more than 5 (there will be two people assigned to each session). The director session will be on Monday, 6/21, from 2-5 p.m. and Tuesday, 6/22, from 9a-12n.

In this decision-making meeting, the container for the Vision Session was designed to provide a

consistent level of facilitation by members of the executive team, structuring opportunities for small group interactions within a larger group. Use of executives as facilitators creates a container where there is access to decision-makers, establishing an expectation of communication across traditional levels of hierarchy. The limited number of meetings assigned to each executive creates a container where executive relationships are not limited to direct reporting relationships, creating a culture of communication with any member of leadership. Both of these examples show how simple details are woven together to create the container and how decisions made about structure, leaders, and verbiage as well as other element combine to construct the container.

Level of Participation

Fischer (2011) identified five levels of participation, from Level 0 through Level 4, in the context of social media. These levels of participation were applied to the documents decisions and messages in the context of a hospital. These levels were often coded with a dimension of dialogue, another quality of dialogue, or an element of action theory. There are no examples where a Level of participation was coded without an overlap or overlay of another code. The five levels are rated from 0 to 4, with the lowest level of participation being 0. Level 0 is described as that of an unaware consumer, whereas level 4 is the meta-designer (Fischer, 2011).

Level 0 participation, the unaware consumer (Fischer, 2011), was only coded twice; one was in reference to the topic of flu management during operations minutes. This level of participation does not have knowledge of the impact of decisions. Level 0 relates to flu management when an individual may not have knowledge of communicability and prevention techniques for influenza. Improving the prevention of influenza transmission required a higher

level of participation than that of the *unaware consumer*. This situation illustrates an identified rationale for developing strategies that might increase the level of participation.

The level of participation might be coded when providing information to a group when culture and context are not known. This type of situation may have occurred, but was not documented in the documents reviewed.

Level 1—the consumer is aware of the possibilities—was coded at the first Vision Session where the voting machines were used. This session introduced interactive voting as a methodology for employees to provide real time feedback by “voting.” The first question asked: “How are you feeling today?” Selection choices were: (a) surviving, (b) fair, (c) good, and (d) great! This was a first introduction for employees to provide immediate and relatively anonymous feedback directly to the executive team. The group was becoming aware of the possibilities of feedback of this nature. This methodology created the possibility of dissenting voices with a margin of safety.

Level 2 and Level 3 were the most frequently coded levels of participation for the Vision Sessions. These levels of contributing and decision-making, collaborating, facilitating, organizing were the targeted behaviors of participation for the Vision Sessions.

A representative example of Level 2 participation, that of the contributors and decision-makers (Fisher, 2011), can be found in the 2012 Vision Session, which featured a discussion about compassion and lessening patient anxiety. One participant stated, “Our words and nonverbal behavior have a great impact on patient and family anxiety.” This statement included a request for staff to think about how they contribute to anxiety and how they convey compassion based upon their verbal and non-verbal communications. The decisions made

regarding interactions, helpfulness, and compassion were the focus of this conversation. Twelve examples of Level 2 participation were documented during the Vision Sessions.

Level 3 participation was coded 26 times in Vision Sessions and 14 times during the operational minutes. Level 3 participation is that of the collaborator, the facilitator, and the organizers (Fischer, 2011). This level of participation was coded during Vision Sessions. One example is as follows: “Strategic Consumer Marketing: What’s New? “How you can be part of it?” These questions were followed with conversation supportive of collaboration.

The meta-design found in Level 4 participation (Fischer, 2011) was coded in the Operations Committee minutes, specifically related to the development and alignment of goals supportive of new program initiatives such as corporate development and the pursuit of Magnet status. The sharing of the meta-design level of participation was seen in Vision Sessions during the development of organizational goals and design of shared-decision-making. The sharing of this level of participation by leaders in an organization might provide further insight into development of dialogue through high levels of participation.

Vision Session Patterns

The messages coded during the Vision Sessions yielded multiple codes for most of the passages. A combination of action theory and dimension of dialogue was coded most frequently and provided concrete examples of dialogue and participation. Common coding had an action theory of a shared field combined with the dimension of dialogue code of respect. This link might also indicate some relationship between these two elements. Does the act of creating a shared field of understanding have a dimension of respect imbedded? Logically, the desire or decision to share a common field of understanding at some level acknowledges that the recipient of the communication is deserving of this effort This is in contrast to situations where leadership

may be directive without providing sufficient information for better understanding; this also can be a demonstration of respect.

Integration, Patterns and Messaging

This research explored the types of decisions that support dialogue and a culture of participation by identifying actions that aligned with dimension of dialogue (Isaacs, 1999), action theories of dialogue (Isaacs, 2007), and levels of participation (Fisher, 2011). Utilizing these three theories during the research and coding revealed a level of integration that was not evident in the initial research of the individual theories (see Figure 3).

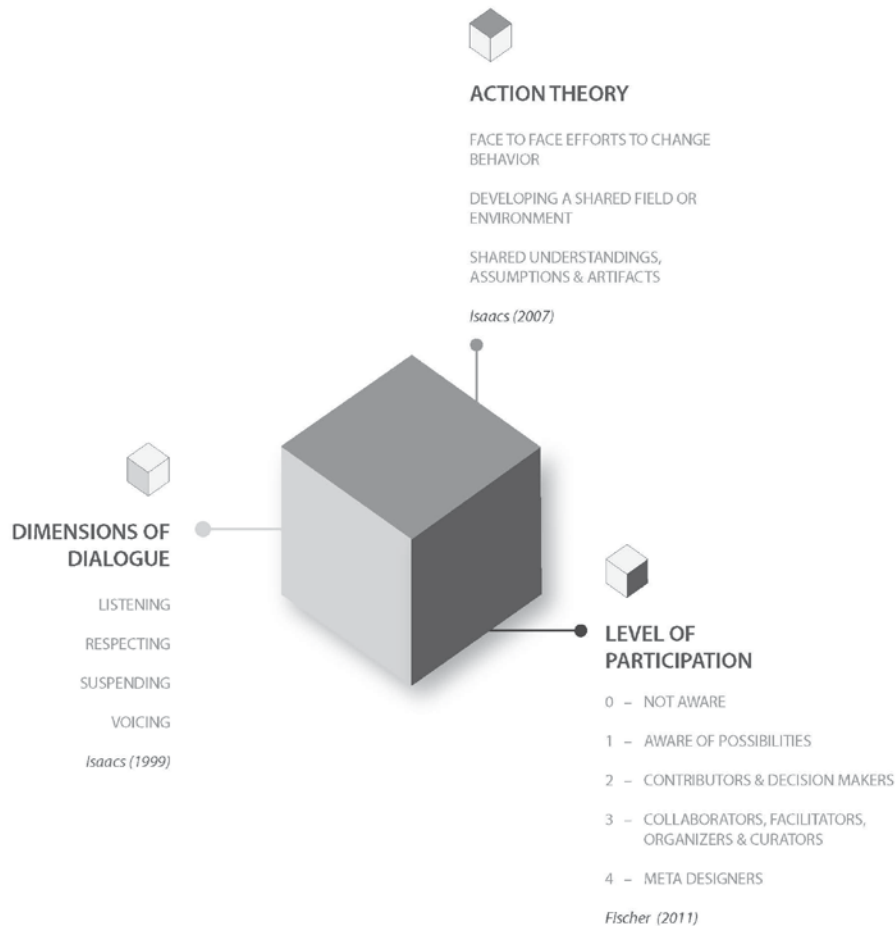


Figure 3. Dimensional model for the practice of dialogue.

Also, a pattern of the decisions emerged from the analysis: listening as a prerequisite to decision formulation, the prolonged decision, and the decision message. This pattern may have

been impactful in supporting the emergence of a culture of dialogue and support, and when combined with listening and respecting may provide a formula for supporting dialogue.

Listening and Respecting Relationship

Operational meetings minutes frequently referenced the request that the team go to the various departments to obtain feedback prior to making a decision. This activity serves dual functions. First, it creates an opportunity to listen to a larger forum for feedback. This approach can have an added benefit of testing the leaders' assumptions, demonstrating respect for the staff members, and creating a shared field of knowledge by foreshadowing that a decision will be made. The prevalence of listening by actively engaging staff and other leaders on a specific topic may be foundational to the methods that this institution used in supporting dialogue and a culture of participation.

Coded from Operations Minutes, the following excerpt describes a respectful discussion of how information from an employee satisfaction survey was heard.

Employee Satisfaction Survey – Quarterly articles in Employee Edition about what we have been doing with the data. Success stories could be told. Another thought is how employees treat co-workers. It would be better to see a work product that a group did with the data they received from the survey and share the success stories. [Name deleted] will bring the numbers on the results for the question having to do with whether you think anything will be done with the data.

Respect is also seen with the other two aspects of dialogue, voicing and suspension. The foundational use of respect in these process may indicate that in addition to being a dimension of dialogue, respect may be a basic requirement in the dialogue and integrate with all aspects.

Delayed Decisions

The pattern of requesting feedback at the departmental level has the additional impact of slowing down the decision-making process. Most decisions were only delayed by several weeks, but that delay may have had several advantages. More members may have felt that they

contributed to the process and thus have had greater buy-in to the change. As noted, a sense of foreshadowing may facilitate psychological adaptation to the change. The subtle difference between communicating a decision and then obtaining feedback versus asking for feedback, listening, and then communicating the decision is a repetitive process, perhaps even the practice of this executive team.

Messaging of Decisions

The third pattern that emerged in the review of the data was the documentation of how a decision would be shared and explained, and potential issues mitigated. The operations minutes frequently outlined the communication language that would be utilized in the decision rollout. Communication strategies generally fell into the three action theory categories.

The Feedback, Delay, Messaging Sequence

This ordered sequence was used in many types of decisions regarding topics such as Human Resources, financial decisions, and quality initiatives in this institution. While never addressed as a desired process, it was noted as the prevalent the style and may uniquely support a dialogical process and participation. While not attempted, it is plausible that altering this sequence would not have the same outcomes and would likely create a very different culture. One might speculate that proposing a decision and seeking feedback in response could create a more critical response and a culture that is less open to participation.

One caveat is that this sequenced process requires patience, openness, and a non-directive leadership approach, and may not be quite as simple to implement as it appears. These three actions are in themselves not challenging, but the ability to manage them with an underlying element of respect requires a distinct set of skills. In listening for feedback, openness to the ideas of other portrays respect. Delaying a decision can be frustrating for an executive team and

is similar to the delayed gratification associated with maturity. Moreover, the emphasis on messaging requires a respectful, rationale-based construct that implies that the receiver of the message has the capacity to understand and the freedom of thought to understand and accept the decision as positive.

Approaching dialogue and participation from documents rather than interviews or observation of dialogue may be a bit unconventional and counterintuitive in terms of research that adds to the understanding of dialogue. While not focused on leadership, both the decisions that were made by leadership over this lengthy period of time provided a peripheral glimpse at the leaders that might not be visualized in a shorter study or from lived experience observations. Additionally, the review of these minutes highlighted patterns that were not evident at the level of lived experiences.

Observations from the coded data include the repetition of an initiative or concept over the entire 7-year period. One example of this is the reoccurrence of the development of and communications about shared decision-making councils over the span of this project. Early decisions were related to structure and reporting mechanisms, then to training, roll-out, and later to sustaining the councils by re-training, providing resources for their initiatives, and creating access to the senior leadership structure in the organization.

Operation Minutes: Decisions to Message

The connection between decisions made and message to explain the message were present throughout the 7-year period, demonstrating a consistent use of and commitment to the principles associated with a practice of dialogue and a culture of communication. Beyond the consistent use of and commitment to principles associated with dialogue, a series of conversations over this number of years related to topics of importance to the members provided

a unique container in which for dialogue to occur. The act of convening an important meeting where senior leaders meet three times per month for many years to talk about items of importance in itself provides a container for dialogue to occur. The minutes provided the story of the evolution of decisions and the unfolding of new structures and programs, documenting a generative process. Observation alone was not likely to reveal the generative processes at work. It was not evident as a participant in the process during these sessions, but it was revealed in seeing the patterns and threads of decisions that linked together to produce something new. The best example of this was the evolution of the shared decision council structure. It started as a requirement of nursing in order to meet the Magnet designation and grew to include all of the departments, then evolved with house-wide councils that evolved from the stated values. This evolution was generated from the series of meetings with a core group of the same leaders in the same room at the same time over the better part of decade in a series of conversations that at times transitioned into dialogue and metalogue (when conversation goes beyond shared understanding to a place where shared thinking develops a new culture); what was produced over this lengthy time was the generative process of cultural change.

Vision Session: Messages

The Vision Sessions conveyed the larger messages that were provided to all employees during these same 7 years and thus reflect the decisions made. For instance, a great deal of information was provided during the initiation of the shared decision-making structure. Interestingly, much of the coded information from the Vision Sessions contained multiple aspects of coding for each items. Many passages contained a dimension of dialogue, an action theory associated with dialogue, and a level of participation. This frequent association of codes

raised the question of whether it might be helpful to use these three theories intentionally in communicating a message effectively.

Three Dimensional Integration of Theory

Utilizing the three models of dimensions of dialogue, action theories of dialogue, and levels of participation provides three different tools that, when combined, paint a detailed picture of the practice of dialogue and culture of participation, perhaps providing a three dimensional way to approach the implementation of dialogue as a methodology to influence culture or practice. Both culture and practice have abstract qualities that benefit from an approach that has multiple perspectives.

In this case study, a single topic of communication or decision-making had multiple codes. One example of this can be found during a discussion of standards of behavior in the Vision Session. The following passage had codes that reflected dimension of dialogue, respecting and voicing; the action theory of shared field of environment; and Level 2 and 3 participation.

ACCEPTABLE BEHAVIORS

Demonstrate our Culture of Compassion at every opportunity by being sensitive to an individual's unique needs.

Display professionalism. Work cooperatively, putting personal feelings aside.

Acknowledge all people with a hello, nod or smile, when passing by in hallway, elevator or lobby, or entering a patient's room, or when ever approached.

Demonstrate friendliness, respect personal space, and be aware of body language.

Treat all equally and be sensitive to individual needs.

Offer help and assistance to co-workers, patients, visitors, physicians and volunteers when in need. Utilize the chain of command and ask for assistance when you need help.

Notify supervisor or manager of abusive, disruptive, or disrespectful behavior. Provide support by being present, ask for a third party facilitator to help resolve issues, hold others accountable for standards.

UNACCEPTABLE BEHAVIORS

Rush through work without engaging the patient, family member, co-workers or volunteers.

Berate; use demeaning language or sarcasm; name call or make snide remarks; gossip; back-stab; maintain grudges.

Ignore other people; Walk down the hall talking on your cell phone and not acknowledging others; Perform tasks without making eye contact or conversation.

Bully; threaten; taunt; scapegoat; humiliate, or give the “silent treatment”; display aggressive and intimidating body language (raised eyebrows, rolling eyes, making faces, turning away, deep sighs, refusing to make eye contact, slam doors, slam charts on desk or throw small objects)

Discriminate against anyone; converse in a different language in front of others (except with patients in their native language); make negative comments; adopt a superior attitude; be insubordinate; speak negatively about, or have a derogatory nickname for others.

Let others suffer by not helping; ignore anyone who needs help, tell someone “It’s not my job”; “I’m not your nurse”; “You are not my only patient”; “I’m too busy”; “I’m floating – this is not my unit”; complain without offering solutions and blame others; endanger patient or employee safety.

Allow a situation to escalate by ignoring it, avoiding it, or fueling it; leave anyone alone and vulnerable; complain to others and allow repetitive, disruptive/abusive and bullying behavior to continue without taking any steps to prevent future occurrences; ignore unacceptable behaviors of others.

A single decision had the potential to connect with several dimensions of dialogue.

Respecting and listening were coded throughout the Vision Sessions. The same topic of communication also can relate to multiple action theories and in some cases behaviors of all three action theories were in play at the same time: face-to-face behavior change, creating a shared fields and shared understandings, and revealing assumptions. The same communication might have a variety of levels of participation, with Levels 2 and 3—contributors, decision-

makers, collaborators, and facilitators—being identified in the aforementioned narrative. Using these three models together might be helpful in creating organizations with a culture of participation that support a culture of dialogue through intentional messaging.

This approach's three-dimensional perspective might provide additional insight to leaders in crafting their message. For instance, in the study data, one aspect of demonstrating both respect and a shared field of environment and directed to Level 2 participants was embedded in an exercise for the audience to vote (provide an opinion) on various priorities. This exercise was coded as respect, providing for a shared field, and Level 2 participation. Design that might be directed toward addressing assumptions could refocus the communication.

Themes

Two distinct themes emerged from this study. The first theme is how dialogue is defined and used dialogue in practice needs further development integrating on existing theories. Second, a rethinking of the sequence of communication, feedback, and decision-making is needed in order to create more deliberation time for the suspension of assumptions that allow for the emergence of dialogue.

Chapter 5

Conclusion, Discussion, and Recommendations

The Study Problem

This study was conducted to review the decisions and messages and other aspects of dialogue that were crafted by leadership in support the practice of dialogue and a culture of participation in order to solve the complex problems that a hospital faces. Review of three theories relating to (a) dimensions of dialogue (Isaacs, 1999), (b) action theory supportive of dialogue (Isaacs, 2007), and (c) levels of participation (Fischer, 2011) were applied to these decisions and messages to reveal themes. In addition to these three theories, other qualities of dialogue were coded, such as: the container for dialogue, support for emergence and generativity, and coherence. The qualities and theories of dialogue were studied during a 7-year period that also coincided with decisions to implement three large initiatives—(a) corporate training, (b) shared decision-making councils, and (c) pursuit of Magnet designation—all with their multiple aspects of organization change.

Conclusions

Four conclusions were derived from the two themes that were found as a result of the data analysis. The first themes that the use of dialogue in practice can be best supported with the integration of multiple theories rather than application of a single theory. The second theme is the observation of an emerging pattern that provide a subtle but effective sequence of communication, feedback, and decision-making as a successful methodology. The four conclusions from these themes are as follows.

Conclusion 1. A single theory of dialogue is not sufficient to include all the complexities of the dialogic process, and the integration of these three theories informs leadership in the

development of effective actions that support dialogue. In 1999 Isaacs published his theory of dimensions of dialogue and then in 2007 he published the complementary model that identified action theory. Adding levels of participation adds another complementary perspective. The use of complementary models increases the perspective and insights, thus providing layers of insight that might not be derived from a single model (Cairney, 2013). Dialogue both supports the use of multiple perspectives and is supported by the use of multiple perspectives in the use of three theories to provide a three dimensional perspective.

Application of more than one theory can provide a deeper understanding of the application of the theory to the practice of dialogue. Practice by virtue of its emerging and generative growth is complex, representing dimensions of new knowledge, application of language and common, and evolving language (Wenger, 2002). A single theoretical approach can oversimplify the complexity of practice, making it difficult to apply findings successfully.

Application of the three models supports a three-question approach in the development of messages for the workforce. The first question relates to the action theory and asks, Which of the action theories most accurately describes the goal of this communication? Activities logically follow from the answer; for example, if the answer is to create a shared field, then the meeting or presentation might focus on the provision of data, facts, or general information, followed by follow up questioning to determine understanding. In the situation where the goal is to address underlying assumptions, biases, or beliefs, then the communication format might be better served with open inquiry in small groups so that beliefs may be uncovered prior to the provision of additional information.

The second question that informs leadership is, What dimension of dialogue might best be utilized to achieve the goal and is supportive of the action theory? The selection of the

dimension of voicing may not be as effective for uncovering underlying assumptions as the utilization of respecting and listening, but it may be useful in creating a shared field.

The third question is, What is the expected or desired level of participation both during and after the communication? Is the level of participation to raise the awareness or to create facilitators to drive some of the changes? A goal of awareness might include reflective exercises, whereas participation at the level of facilitation might require practice sessions, simulation or role-play.

When used in conjunction with one another, these three theories provide for a series of questions that leaders can use iteratively in order to be more effective in developing dialogues that can help in understanding the complex issues in a hospital. The understanding of the problems is foundational to focusing efforts on the appropriate solutions (Graben, 2012).

Conclusion 2. An effective model for communication must include, at a minimum, an aspect of action theory, a dimension of dialogue, and a level of participation. This is by no means the extent of potential models that might be applied to implementation of dialogue for the purpose of resolving larger problems. Identification of the absence of or deficient use of any of these three theoretical aspects provides a direction for corrective action.

The concept of integrating the three models was identified when the researcher noted that some passages were coded for all three theories. In multiple narratives, a decision or message was coded with the combination of a dimension of dialogue, a specific aspect of action theory, and a utilized or expected level of participation were overlapped partially and at times in entirety. Potentially this tri-theory approach could enhance success or organization change initiatives.

As described in the first conclusion, the leadership questions associated with each of these theories provides the iterative questions to fine-tune a message in order to be most effective

in driving the necessary change initiatives. Absence of any of these three aspects eliminates the focus of the message and results in messages not being effective in support of improvement initiatives.

Conclusion 3. Delaying decision-making in order to obtain feedback is good for the emergence of dialogue and deliberation. A pattern of feedback, delayed decision, and messaging was found in reviewing the dimensions of respecting and listening, which was often coded consecutively in Operation Committee minutes during decision-making passages. This pattern was revealed in the frequent correlation of coding both listening and respecting for the same passages. The sequence may have significance in that the request for feedback precedes the verbiage about the need to delayed decision. Additionally, the messaging and the decision occur at the same meeting. Discussion about the message can also be intertwined with the decision-making.

The delay of decision-making by leadership stands in contrast to some behaviors of leaders who are expected to rapidly synthesize and analyze situations and make informed, sound decisions. Decisiveness is a practice of management (Cashman, 2012). Delays may be frustrating for leaders who are accustomed to a rapid decision-making process.

When applied to the graphic of conversation by Schein (1993), the opportunity for dialogue exists at the point of deliberation. Delaying decision allows for the natural emergence of dialogue, and the act of making a decision has the effect of impeding dialogue and the shared understanding that follows.

Conclusion 4. Expansion of the deliberation time is a mechanism that helps the group to suspend assumptions. The concept of suspension is not practiced frequently. (Dialogue training sessions associated with this hospital reflect this challenge.) Ideological training in bias and

assumptions does not identify a mechanism has not suggested group actions that might enhance the practice of suspension. Delaying decisions is a practical approach to encouraging a group to experience suspension (see Figure 1).

During deliberation, if a team can maintain the humility to identify that they lack full knowledge or understanding, then the request for further information pushes toward suspension. The point of decision pushes the conversation into discussion and debate, thus eliminating the point of dialogue. The practice of decision-making at this hospital may be a practical, concrete methodology that might be used to move conversation into suspending and maintaining the possibility of entering into dialogue. Suspension can be a complex and abstract concept to explain and operationalize. The sequence used in this hospital may assist those seeking to support dialogue and provide a clear process that can be applied to multiple decisions.

Cashman (2012) has described the delay or slow down of practices as *stepping back* or taking a pause. This verbiage may lessen the possible stigma associated with delayed decision. The stepping back or pause may connote more control by a leader than does delayed decision. Delayed decision may be seen as *kicking it down the road* rather than dealing with the issues at hand. In this case study the rationale for delaying the decision was framed by the request to gather feedback, thus the decision will be postponed pending the time needed for inquiry and feedback. Framing the delay for decision in a positive manner could be important in not undermining leadership or refraining from inadvertently portraying leadership in a weak light.

Other Implications

Large initiatives. Large initiative implementation in an organization can be considered burdensome and frustrating with the anticipation of a slow-paced implementation phased over many years. Perhaps due to this complexity and prolonged decision-making processes, large

initiatives, such as the pursuit of Magnet status, implementation of shared decision-making, and the development of a corporate training program serve as unique opportunities for the practice of dialogical skills. Large initiatives, by virtue of their complexity and the extended time to implement, has a quality of emergence. It is illogical that a project plan will include all of the foreseeable environmental changes over a multi-year project. As these external changes impact an internal change initiative, the opportunity exists to realign, readdress, and refocus. These iterative processes support some of the iterative nature of dialogue and provide the opportunity for participation.

Providing an opportunity for participation may also be applied to social change and clinical treatment initiatives. Collaboration and participation are important components of success (Quinlan, Kane, & Trochim, 2008). Perhaps a small shift in how such an undertaking is viewed might be impactful.

Messaging. Asking for feedback provides information that allows for consideration of messaging at the time the delayed decision is made. Consideration of the message integrated into the decision may have impact on the decision that is made. Simplistically, if the decision cannot be explained, rationalized, or communicated, then perhaps it should not be made, it should be delayed further, or an alternative might need to be considered. The deliberation over the feedback allows for consideration of a variety of opinions and ideas that sometimes stand in opposition to the final decision that is revealed during the request for feedback. The construction of the message provides the *why*. There is power in answering the question of why a decision has been made (Cashman, 2012). If there is no *why*, then perhaps no decision is made.

Document review. Document review over an extended time frame can provide insight into cultural norms and practices. Available source documents such as meeting minutes may be

overlooked in review of cultural practices, such as dialogue. These documents provide a structured approach to insights into practices of dialogue and bring forward patterns that might not be evident in the lived experience, but may emerge when documented in the repetitive nature of committee minutes. The feedback, delay, message pattern is an example of a pattern that was revealed from a review of coded data related to listening. Document review has the capacity to provide detail that might not be available from recall in other approaches to research related to cultural and behavioral subjects, such as interviews.

Recommendation: A Formula for Dialogue

Distilling this research into a simple formula sequence includes the delayed decision-making sequence layered with listening and respecting through each element. The following steps provide a possible *how-to* approach for supporting dialogue through the decisions made at this hospital and may be helpful to others attempting this practice.

1. Delaying the decision is the first critical component to listening. At the point of decision, the deliberation is complete and the conversation moves into discussion and debate. Delaying the decision may be challenging for executives who may be skilled at quick decision-making and have received praise for doing so.
2. Rationale for the delay in making a decision may be framed by inquiry or another positive frame such as a *pause* (Cashman, 2012). The decision is delayed in order to gather opinions or determine if consensus is required. Feedback is invited and a tally might be used to ensure that feedback is obtained from a variety of sources. At this hospital, the minutes reflect that each member of the decision-making body was requested to obtain and report feedback on an issue.

3. A polling method by which each member is requested (perhaps required) to report back supports listening.
4. Listening is done in a manner that is respectful. All feedback is considered valid and is received as only feedback. Listening does not stimulate debate.
5. The message that accompanies the decision reflects the listening. Contrary views considered, and are addressed respectfully in the message.

While these steps are independently simplistic, when combined and repeated, they may form a powerful sequence for supporting dialogue and a culture of participation. This formula is based upon the observed practices at one hospital and has not been tested to determine if utilizing it has impact on the continued development of dialogue and participation.

Limitations of the Research

There are assumptions and biases in this research. The first assumption is that historical content documented in the form of minutes accurately reflects the events in the Operation Committee minutes and the documentation accurately represents what was said during the Vision Sessions. This assumption is somewhat mitigated by the minute approval process and review of the minutes align with recollection of the researcher.

The second assumption made is that the theory of participation developed for social media can be used to provide a level of participation applicable to behaviors described in minutes and presentations. The assumption is based upon the translatable nature of participation as a general practice. This assumption is supported in that aspects of business that have been described using experiences from sports and war are commonly applied to the corporate world (Clancy, 1999)

The researcher used the documentation provided, but due to having participated in all of the documented events cannot exclude the influence of memory on the coding process and may bring her own bias into the coding process. This experiential knowledge may also provide a better understanding of the context of the events. This also brings forth the basic assumption that a researcher can maintain some level of objectivity when researching in one's own institution. As an internal consultant, this research may have influenced the memory and perceptions.

Using documents to review topics of dialogue and participation has limits. Interpretation of information is based upon the verbiage supplied and the interpreted meaning without the benefit of asking the participants for clarification.

The messages that were part of the Vision Sessions were coded using the theories of dialogue and participation and not the body of knowledge associated with communication. Further review of coding from Vision Session from the perspective of communication theory might provide additional insight into positioning the messages.

Qualitative coding of data can be inconsistent. If documented differently, similar events can result in inconsistent coding. This study mitigated this possibility as much as possible by utilizing minutes that had the same recorder for the entire period of time and abstracted the Vision Session dialogue in a single setting to provide a level of consistency.

Future Research

On a broad level, further research of the application of three theories related dialogue in other hospital and organizations could provide additional insight and specific methods of successful utilization. Application of these three theories from an integrated approach might provide more specific knowledge of whether a specific action theory or dimension of dialogue might be best utilized to best move up a level of participation. An effective combination might

discover opportunities for voicing in face-to-face action in order to develop facilitation as a level of participation. Further study of the integration of these theories might shed light on practice change.

Application of the theory of level of participation as studied in social media is an additional tool to measure participation in other contexts. It would be interesting to utilize Fischer's (2011) levels of participation in other institutions. This research might provide language that might provide better insight into participation in other settings.

The sequence formula that describes this hospital's practices of supporting dialogue could be tested in a variety of environments and organizations to determine whether it might have similar benefits outside of its existing culture. Perhaps a tool to assess perceptions of the use of dialogue before and after an intervention using the formula could provide additional information. This sequence could potentially have other subtle steps that might also emerge with additional research.

Future research could provide insight into whether this sequencing of listening, delay, and messaging has the potential to be implemented in other teams and whether this helps support dialogue and create a culture of participation. Does the sequence matter as long as the elements are all present? Are there other successful ways to frame delay of decisions rather than a request for feedback? Are there negative aspects of decision delay? If so, what are they?

Further study of the relationship between decisions and messaging may be explored to determine co-dependent variables and influence. Does the focus on the messaging at the time of decision-making have impact on the decision and the success of the implementation of the decision?

Finally, a study designed to review the aspects of respect and the integration as a meta-construct in dialogue. Respect was seen as an underlying quality in dimensions of dialogue and in the sue of action theory associated with dialogue.

Conclusion

This research provided insight into an executive team in the decision-making process and uncovered a pattern that the team utilized. This pattern is listening (inquiry), delay of decision, and message construction. These three steps are based upon a foundation of respect and have been utilized for years at this institution, where it has enhanced the support of dialogue and a culture of participation and has become a practice that is part of the culture of this organization. This sequence may be useful to other executive teams in their journey to support dialogue and to increase participation in an organization.

Additionally, this research combined and applied the model of a culture of participation that was initially used in computer sciences and social media literature (Fischer, 2011). This model, when combined with Isaacs's (1999) models of dimensions of dialogue and action theory of dialogue (Isaacs, 2007), might serve as a three-dimensional perspective of how to position messaging around change initiative and decisions made. It provides additional insight into whether the combination of the two Isaacs (1999, 2007) models and one Fischer (2011) model provide a guide for creating messages that drive participation.

This study provided an in-depth review of large initiatives and how they may be viewed by the practice of dialogue in a hospital setting. It provides insight into how further research may be conducted into the practices of dialogue and support of a culture of participation that might be utilized by others pursuing these topics.

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APPENDIX A

Source Documents

OC012512.min.txt
OC012611.min.txt
OC021809 min.txt
OC030310.min.txt
OC032112.min.txt
OC041608.min.txt
OC042011 min.txt
OC050212.min.txt
OC050411 min.txt
OC051513.min.txt
OC051607.min.txt
OC061610.min.txt
OC082113.min.txt
OC090308 min.txt
OC091907.min.txt
OC092210.min.txt
OC100307.min.txt
OC102313.min.txt
OC102611.min.txt
OC110310.min.txt
OC110508 min.txt
OC120209.min.txt
OC121907.min.txt
Vision 2008.txt
Vision 2009.docx
Vision 2009.txt
Vision 2010.docx
Vision 2011.docx
Vision 2012.txt
Vision 2013.txt
Vision 2014.txt

APPENDIX B
Permission Letter

BRANCH MEMORANDUM
[REDACTED]

May 21, 2014

Faculty
Pepperdine University
24255 Pacific Coast Hwy
Malibu, CA 90263

To whom it may concern:

Debby Kelley has permission and approval to research dialogue and participation at [REDACTED].

She will have access to appropriate records and materials as needed.

Sincerely,

[REDACTED]

[REDACTED]
President and Chief Executive Officer

[REDACTED]

APPENDIX C

IRB Approval

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

July 2, 2014

Debra Kelley

Protocol #: N0614D02
Project Title: Retrospective Case Study of Dialogue Practice

Dear Ms. Kelley,

Thank you for submitting the Non-Human Subjects Verification Form and supporting documents for your above referenced project. As required by the Code of Federal Regulations for the Protect for Human Subjects (Title 45 Part 46) any activity that is research and involves human subjects requires review by the Graduate and Professional Schools IRB (GPS-IRB).

After review of the Non-Human Subjects Verification Form and supporting documents, GPS IRB has determined that your proposed research activity does not involve human subjects. Human subject is defined as a living individual about whom an investigator (whether professional or student) conducting research obtains (1) data through intervention or interaction with the individual, or (2) identifiable private information. (45 CFR 46102(f)).

As you are not obtaining either data through intervention or interaction with living individuals, or identifiable private information, then the research activity does not involve human subjects, therefore GPS IRB review and approval is not required of your above reference research.

We wish you success on your non-human subject research.

Sincerely,



Dr. Thema Bryant-Davis
Chair, Graduate and Professional Schools IRB
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Mr. Brett Leech, Compliance Attorney
Dr. Kay Davis, Faculty Chair

s. (45 CFR 46.102(d)).

APPENDIX D

Data Collection Form

Date	Meeting/Training	Documentation	Evidence coded	Theme	Action Theory	Comment

The evidence codes will be aspects of dialogue are 1) dimensions of dialogue 2) container, 3) coherence, 4) emergence 5) generative and the evidence coded in participation will be reflective of level of participation and are 6) level 0, 8) level 1, 9) level 2, 10) level 3 and 11) level 5.

The themes that have been pre-identified are dialogue and participation (with evidence codes 1-5 reflect dialogue and evidence codes participation).

The action theory aspects coded will include: (a) face to face efforts to change behavior; (b) the shared field or environment, which includes co-created meanings; (c) and understandings, assumptions, and artifacts in addition to the physical field for dialogue and for participation the action theory will be coded as d) meta-design, d) collaboration and e) social creativity.

APPENDIX E

Coding Scheme

All Codes

Action theory

- Face to face behavior changes

- Shared field or environment

- Understandings, assumptions and artifact

Coherence

Container for dialogue

Dimensions of Dialogue

- listening

- respecting

- suspending

- voicing

Emergence

Generative

Initiative

- Magnet Designation

- Professional Development/TMU

- Shared Decision Making

Level of Participation

- Level 0 unaware consumers

- Level 1 consumer aware of possibilities

- Level 2 contributors and decision-makers

- Level 3 collaborators, facilitators, organizers and curators

- Level 4 meta-designers