General Medical and Complementary Practitioners Working Together

The Epistemological Demands of Collaboration

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A developmental framework is used to explore the process of collaboration between general and complementary medical practitioners in the British National Health Service, using conversations from a co-operative inquiry. It is argued that the conversations through the inquiry show the practitioner's increasing capacity to work across diverse paradigmatic frames and strongly suggests that multidisciplinary collaboration is a matter of epistemology as well as of interpersonal competence and group development.

Robert Kegan (1994) has suggested that the mental demands of modern and postmodern life are such that we are "in over our heads": There is, at least in some portion of our lives, a mismatch between the complexities of our culture's "curriculum" and our capacity to grasp those complexities. In Torbert's (1987, 1991) terms, many situations require a quality of response of which only those at later stages of ego development are capable.

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In this article, the ego developmental framework applied by Torbert to organizational issues is used to explore questions of collaboration between different primary health care disciplines in the U.K. National Health Service (NHS). Over the past 15 years, there has been a developing interest in the potential contribution of complementary medicine—practices such as acupuncture, homeopathy, and osteopathy—to primary health care. I have been privileged to work with groups of very talented practitioners, using co-operative inquiry, to explore ways of working together and to build theories and practices that will enhance collaboration (Reason, 1991; Reason et al., 1992). Complementary medical practices draw on paradigms of health and healing quite different from those that inform the Western biomedical model, and so collaboration in the fullest meaning of that term involves reaching across different worldviews. As a consequence, medical and complementary practitioners attempting to work in a multidisciplinary way quite often will find that they are "in over their heads" because all their training is oriented to their working within, rather than across, paradigms.

Drawing on developmental theory (Kegan, 1980; Loevinger, 1976), Torbert identifies a series of frames that govern the perspective through which persons construe their worldviews. These frames follow in a developmental sequence so that each successive frame is more encompassing than the previous one: It includes the perspective of the previous frame together with a new set of possibilities. In addition, although persons at earlier stages are not aware how mental frames construct their world, for persons at later stages the framing process itself becomes progressively more explicit, conscious, and intentional. Thus, the Opportunist sees the world in terms of self-interest and may use medical practice for personal aggrandizement. The Diplomat wants to fit in with social rules and expectations and may "play the role" of doctor. The Technician sees the world through the internal logic of her or his discipline and will frame practice exclusively through the constructs and metaphors of allopathy or homeopathy or acupuncture. The Achiever integrates these perspectives, seeing the world in terms of overall system effectiveness, but she or he is still guided by an implicit and relatively unconscious set of mental frames. At the later Strategist and Magician stages, as the framing process becomes increasingly conscious, it becomes increasingly inclusive; thus, the late-stage medical practitioner, although rooted in one discipline and practice, may seek to incorporate the insights of other disciplines and be far more able to engage in interdisciplinary collaboration, for the Strategist realizes that all frames are relative and potentially valid and relevant.

> With this realization, the Strategist, unlike the Achiever, is open to the possibility of "reframing" his or her viewpoint and purposes in a situation . . . consciously seeking and choosing new frames that accommodate the disparities, paradoxes, and fluidity of multiple frames. (Fisher & Torbert, 1995, p. 72)

Although the Strategist's emphasis is on finding the right frame, on being in the right mind, so to speak, the Magician becomes concerned with developing a *reframing mind and spirit*, so that presuppositions are continually overturned, situations are continually seen afresh, and life becomes a process of learning.

Torbert's stages of managerial development are echoed within developmental literature generally. Kegan (1994) argues that the emerging demands of the postmodern context "require an order of consciousness that is able to subordinate or relativize *systemic knowing*" (i.e., within-frame knowing) in what he calls "trans-systemic knowing" (p. 317). And from another field, Gregory Bateson's (1972) account of different levels of learning and communication in particular differentiates between what he calls Learning II, which is learning within a frame (i.e., within a system of alternatives from which a choice can be made), and Learning III, which involves a corrective change in the system of sets of alternatives from which the choice is made. Thus, Learning III involves a shift of comprehension and of consciousness similar to the shift from Achiever through to Strategist and Magician.

Thus, my purpose in this article is to use Torbert's developmental perspective to explore how complementary and medical practitioners frame their practices within an interdisciplinary context. My contention is that there was a development in collaboration and interdisciplinary competence during the inquiry process and that this development can be understood in terms of a shift toward the reframing mind of Strategist and Magician. I shall support my argument using audiotape transcripts of the meetings of the co-operative inquiry referred to above. If this model appears helpfully explanatory, it would provide a basis to guide interventions in this arena—and in others where collaboration across diverse worldviews is required. However, I shall first describe the setting within which this work took place and briefly outline the co-operative inquiry method used.

THE INQUIRY SETTING

The research took place in an NHS General Practice in central London that aims to develop and assess innovative approaches to primary health care. Thus, for example, the work of the practice is the subject of continuous audit: Comprehensive patient computer records are maintained that provide accurate information on the clinical, social, and economic aspects of the practice. Practitioners meet regularly to discuss issues in the practice, and patient groups of various kinds have been established.

One outcome of these discussions and reflections has been the articulation of a model statement of practice that sets out a number of working principles, one of which is to offer an interdisciplinary approach to primary healthcare. Over the years, interdisciplinary practice at the General Practice has taken several different forms. When the inquiry that underpins this article was conducted, five complementary practitioners—a homeopath, an osteopath, a practitioner of acupuncture and traditional Chinese medicine (TCM), a psychotherapist, and a masseuse—held sessions at the practice, seeing patients referred by general practitioners (GPs) and taking part in the development of the practice.

In the autumn of 1989, a new research clinic, based on this earlier work, was established to explore issues of interdisciplinary practice. At this clinic, patients, referred by

their GPs, were seen for assessment by the complementary practitioners. Following this assessment, patients met with the clinical teams, with their GPs in the role of advocate, to hear feedback from the practitioners and together to agree on a management plan that would include appropriate complementary treatment. The practitioners agreed that they would explore the process of the clinic using co-operative inquiry to identify and learn from the opportunities and problems facing such a venture.

CO-OPERATIVE INQUIRY

Although this is not the place for a detailed description of co-operative inquiry, which is fully explored elsewhere (Heron, 1996; Reason, 1988; Reason & Rowan, 1981), a brief description will help orient the reader to the origin of the conversations that inform this article. In traditional research, the roles of researcher and subject are mutually exclusive. The researcher contributes all the thinking that goes into the project, while the subject contributes the action being studied. In co-operative inquiry, these mutually exclusive roles give way to a relationship based on bilateral initiative and control so that all involved work together as co-researchers and as co-subjects. As co-researchers, they participate in the thinking that goes into the research—framing the questions to be explored, agreeing on the methods to be employed, and together making sense of their experience. As co-subjects, they participate in the action being studied. The co-researchers engage in cycles of action and reflection: In the action phases, they experiment with new forms of clinical practice; in the reflection phase, they reflect on their experiences critically, learn from their successes and failures, and develop theoretical perspectives that inform their work in the next action phase.

The inquiry team for this research consisted of the three practice GPs and the five complementary practitioners. I was facilitator of the inquiry group, initiating the others into the inquiry approach and helping them make sense of their experience. Patients were not included as members of the inquiry group because the focus of research was collaboration between practitioners; naturally, patients were present during the actual clinics and were fully consulted at those times of direct involvement in the project. The inquiry engaged in five cycles of action and reflection: Each action phase consisted of two or three clinics attended by up to four patients; each reflection stage consisted of a 3-hour meeting at which the experience of the previous clinics and the experience of the whole venture to date were discussed in detail. Both the meetings with the patients in the clinic and the reflection meetings were tape-recorded, and the transcripts were circulated to the clinicians, who were thereby able to reflect more thoroughly on their experience.

The outcomes of the inquiry were published in the medical press (Reason, 1991; Reason et al., 1992), and some of the learning from the interdisciplinary team was reviewed by David Peters (1994). To write this article, I have revisited the transcripts some 5 years later, bringing the perspective of Torbert's developmental theory. The article is written entirely on my own initiative, not in consultation with members of the clinic, and so is not part of the co-operative inquiry process. It is an exercise in the development of theory that informs my own practice.

The members of the inquiry group quoted in this article are referred to as

Anthony: acupuncturist and TCM practitioner
George: osteopath; George is also a qualified GP
Paul: GP
Diana: homeopath
John: GP
Sally: GP

LOOKING AT THE TRANSCRIPTS

I went through all the tape transcripts looking for examples of Technician, Achiever, and Strategist conversations. I expected that from a Technician perspective, diagnosis and prescription would be defined entirely by the normal practice of the discipline; it would be technically defined rather than problem oriented. (I did not find any examples of the Technician frame in the cooperative inquiry transcripts.) Achiever behavior would be firmly within-paradigm, but would be oriented to problem solving and concerned with longer term possibilities. I expected to see a transition phase between Achiever and Strategist in which there would be dialogue across paradigms but little integration. In the Strategist position, I expected to see a novel integration of paradigms in a way that appeared particularly appropriate to the patient and her or his predicament. Any Magician perspective would be indicated by a great concern for the nature of framing and reframing as a continual learning process.

ACHIEVER

> The Achiever is passionate about accomplishing goals. . . . [The] Achiever frame . . . focuses not just on how things work on the inside, but on how to be effective in one's wider surroundings. . . . [However, the] Achiever's effort to achieve is made in terms of his or her pre-established framework. The Achiever is not prepared to question the validity of the frame itself. (Fisher & Torbert, 1995, p. 71)

In the early days of the inquiry clinic, the perspective of the clinicians seemed to be focused on the question, "What can my discipline offer?" For example,

> Diana (homeopath): [To patient] There are pollens and dust and things you know you are sensitive to and there's something homeopathically we can do to reduce that hypersensitivity and prevent you needing drugs.

I count this as an Achiever statement because it is based on an understanding of the patient's long-term needs. It is located entirely within the homeopathic paradigm, making the contrast (and comparison) with allopathic drugs; it makes no attempt to explore a multidisciplinary perspective with other clinicians present, nor to involve the patient's framing of the situation.

But the circumstances of the clinic and the co-operative inquiry, plus the intention to develop an interdisciplinary practice, meant that the group soon started looking over the edges of their paradigms. The following conversation extracts (edited from one of the clinic sessions with the patient) appear to me to show the clinicians speaking from different paradigms, speaking to and hearing each other, and seeing the parallels, but without any real integration of interdisciplinary practice:

> Anthony (TCM): [To patient] I was trying to understand the relationship of the pain you were having to other cycles in your life and your general levels of energy and how one reflected the other. . . . I look at pain as being obstruction; either it's obstruction of energy, in which case there is a sense of bloatedness and fullness that people describe, or it's obstruction in stagnation of blood.
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> George (Osteopath): [Speaking from a biomedical perspective] But that's exactly right, quite literally it's the stagnation of blood. . . . With endometriosis you get these endometrial cells in other tissues and it may well be from embryonic life. So really there's a very unusual parallel between the Chinese interpretation and the biomedical interpretation.
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> George (Osteopath): [Speaking from an osteopathic perspective. To patient] The facet joints are overstimulated and with all the proprioceptors are ready to take those joints into spasm. . . . The quadratus lumborum and the erectus down that right side are very tight and tense restricting side bending. . . . You have three lumbar vertebrae that are facilitated, irritable and overactive. . . .
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> Diana (Homeopath): I also tend to feel that the deposits might well be reabsorbed under homeopathic treatment. . . . I take Anthony's point that it's a long history that you have. . . . My approach would be to try and rebalance the hormones, in such a way as to reduce the deposits themselves.

We have here four perspectives on the patient—TCM, allopathic, osteopathic, and homeopathic. They are each being articulated by an experienced practitioner, speaking, as I read it, from within their worldviews. They are interested in the views of the others at least in an intellectual sense, and they seem to politely support each other. But there is no sense either of collaboration or of a transdisciplinary understanding: They are not building on each other's views in an interdisciplinary sense but, rather, using each other's views to bolster their own perspectives.

TRANSITION BETWEEN ACHIEVER AND STRATEGIST PERSPECTIVES

> It is the ability to see many meanings simultaneously that can drive the Strategist to develop an encompassing frame that makes order out of chaos, rather than take the easier way out by adopting one of the earlier, simpler frames. (Fisher & Torbert, 1995, p. 78)

At a later reflection meeting, the discussion broadens out to explore more fully the process in which the clinic is engaged. John and George define the transition:

John (GP): It sounds as if we are positing two possible hypotheses about the clinic. One is that if you are clever enough and able to understand the patient's disease process and you can identify the right treatment drawing on a whole range of therapies . . .

This first statement frames the Achiever perspective that there is one right way of diagnosis and treatment.

John (GP): [continues] . . . The other hypothesis is that . . . the dynamic the patient forms with their illness and with the therapist is of such importance that unless that is understood, acknowledged, and discovered within a clinic, then we are missing out on a major part of what the problem is about.

This second statement reaches toward a Strategist perspective in which every situation demands its own framing.

George (Osteopath): So you are saying one interpretation of the clinic is defining the pathology and something that will meet it. Whether it's a diagnosis in clinical terms or one in energetic terms, we've got those two pieces of the jigsaw and they fit. Then the other aim of the clinic is a sort of subtext about this multidisciplinary work, that you get together a bunch of nonpsychologically naive therapists and if you do it well you can demystify the process and give someone power over what's going on and the symbol their disease represents. I think we would like to be able to do both—subtle energetic and brilliantly physiological therapy, and demystify the process and show the symbols.

George repeats John's analysis in his own words. He also deconstructs the implied either-or choice within which John construed the situation, showing that the Strategist perspective includes the Achiever.

However, working within multiple frames is difficult. It is easier to fall back onto the lowest common denominator of a taken-for-granted model than to move on to a complex and contingent interdisciplinary understanding. In the case of this clinic, there is a continual danger that the group will talk in a shared psychosocial language about stress and difficult life situations to the detriment of careful diagnosis in terms of the different complementary disciplines. The allopathic model (which forms the basis of the NHS) and the psychosocial model (to which all group members subscribed as part of their perspective) dominated conversations, which meant both that the power of the individual therapies was lost and that finding a genuine multidisciplinary approach was difficult. At one stage, the group spent some time in a lively discussion of different ways of treating bronchitis.

Anthony (TCM): [Breaking in loudly] Bronchitis, for Christ sake! What am I talking about? There is no such thing as bronchitis in Chinese medicine!

At a later discussion, they struggle with the nature of their collaboration.

George (Osteopath): It's a bio-psycho-social clinic . . .

Now, this is interesting and difficult. One might say that the bio-psycho-social view is transdisciplinary. But it is also one of George's favorite phrases, so we might also construe it as reflecting an Achiever worldview.

> George (Osteopath): [continues] . . . and there is an etiological theory bound up in the bio-psycho-social view of medicine. And that is where the struggle is. Do we look at etiology as something that grows out of a person's psychodynamics and social predicament or is there something quite separate, which is about their "energy"? And then, no, it isn't either-or anyway. Somehow psychodynamics and social predicament are wrapped up in "energy" in a way that we all find it very difficult to define. . . . And so, in a way, there isn't a split, but there's often a sense of confusion and frustration that we can't quite find out how our different healthcare models interlock. . . .

This second part of the statement seems to frame more authentically the current predicament of the group: how to take into account both the shared psychosocial perspective and also honor the different models of healing. He continues to show how there is a struggle for whose language, whose paradigm, will frame the discussions and the difficulty of holding multiple frames.

> George (Osteopath): [continues] . . . . Sometimes it's either-or and there's a power struggle. [Mimics the conversation] "Obviously this is a psychosomatic condition engendered by this person's life experience and current predicament." "No, it isn't! It's a question of miasmic influences and their inability to work with calcium." "No it isn't! It's a structural problem and basically if you can only get their alignment together . . . " "No, it's a stress problem and we can only give them coping skills." "No, Chinese medical diagnoses expresses their inner and outer condition and what we need to do is use herbs and needles." When we get a really good consultation all of those things are true. . . . I wonder sometimes why we slide into this either-or position.
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> Paul (GP): . . . My perception is that any problem can be looked at in 100 different ways and if you have 100 different models with 100 different therapists then you have 100 different perspectives. That is interesting, but what is useful is which of those will help the patient most. That is the crunch question. It seems to me that we are all so blinkered by our own particular discipline that we all think our discipline can do the best. So therefore it seems not unreasonable to say to patients who have their own innate wisdom, "What do you think?" So that was one of the reasons why I pushed very hard to give the patients as much say as they could.

Here there is a problem of interpretation. Paul's contribution could be the articulation of a Strategist perspective, especially as it points out that given the contingent nature of framing, framing needs to be a participative process (i.e., including the patient). But a Strategist characteristically strives to find the uniqueness of a situation, and Paul often takes this line. He has been accused of trying to empower the patients at the expense of his complementary colleagues. Maybe this is better understood as a pragmatic Achiever perspective.

George (Osteopath): But in a way, if you had it working, it's a marvelous ritual. We each of us see the patient and each of us are more or less inflamed by our sense of what we can do for them and the patient then matches their subjectivity to your subjectivity in a sense, and says, "That woman over there has got the juice for me, she is going to cure me, she will cure me." . . . That would be a wonderful thing.

On several occasions, George makes a visionary statement that helps the group reach toward genuinely interdisciplinary practice. But the reach is as yet beyond their grasp, and there is an ever-present danger of falling backward into one limited perspective. There is a continual argument in support of the unique perspective provided by each separate complementary medical model and a plea not to lose them by lumping it all together in a biosocial model.

Diana (Homeopath): I think in a sense complementary medicine is lumped in with psychosocial models and stress management and is thereby marginalized. . . . "Oh yes, we know about all that and it fits in with psychosocial model and stress management and so on." . . . But there is still a vast difference in terms of therapeutics. . . . I think that GPs . . . once they reject the idea of the "magic bullet," they then swing the other way and reject any kind of medical intervention that isn't fairly vague and all encompassing.

Again, this is difficult to categorize. Clearly, it is important not to lose the unique perspective of the different disciplines; that is not the quality of a multidisciplinary perspective. Yet Diana makes this point often and complains that her perspective is not properly honored. My own interpretation of this is that the group as a whole was in a state of transition. We did not have the mental tools to understand what we were doing, and we had not made the required epistemological leap. Diana's contribution is important in asserting the need to honor the contribution of the different individual healing disciplines.

At a later meeting, the team saw the importance of this, experiencing how different paradigms would differentiate symptoms in different ways. They are discussing their response to a patient who had been experienced as very diffuse and undefined both in personality and in symptoms and the anxiety they had felt about this.

George (Osteopath): There was also an unusual issue for the clinic . . . in that I really found myself wanting to grasp for a diagnosis, for an orthodox medical diagnosis. And that's unusual because we normally have some sort of orthodox diagnosis for the patient or we're happy to say, "Well this is nonspecific, an undifferentiated illness." In her case, it was very differentiated and the rash was very unusual and atypical of anything I'd ever seen. It certainly stopped me going forward into trying to make a more holistic diagnosis. I felt I was stuck at a biomedical level and I couldn't digest any more. . . . Maybe it was something about the impenetrability of this patient as well as the undiagnoseability of the condition. . . .

Anthony (TCM): I wonder if that's why I wrote my etiology and diagnosis on the board, as if to carve this loose, formless thing on stone and actually put it there. Because it was a very straightforward differential diagnosis in TCM terms, but I had to put it on the board.

George is prepared to notice and explore his own discomfort at considerable length, to notice the many factors in the situation that gave rise to anxiety—notably the difficult skin condition, the diffuse character of the patient, and Anthony's clarity from a TCM perspective. Anthony had stood up in the clinic and written his TCM diagnosis on the whiteboard. This willingness to stay with the ambiguity and recognize the difficulty of framing, to wonder reflectively about one's own framing, is characteristic of the Strategist perspective.

There was a discussion of whether it was important to read across from one diagnosis to another:

> George (Osteopath): I thought she'd got dermatitis epicaformis. I still think she may, but it's atypical. . . .
> Anthony (TCM): Yes, but that's wind heat . . . [laughter].

The humor in the situation that notices George's discomfort in the face of Anthony's clarity is a metacomment on the situation that again suggests a Strategist framing.

The lack of ability to define in terms of biomedicine makes George at least anxious. Note Fisher and Torbert's (1995) comment:

> The Strategist frame is not without potential shadows and turmoils. The ability to see multiple frames and to choose a new frame creating new meanings, may leave the person feeling virtually paralysed for moments before taking action. (p. 78)

> George (Osteopath): I don't know. This is making me very anxious because it feels like two different parts of me that aren't really having a conversation. One of them is about making this type of biomedical diagnosis, although I understand that really it's a ritual, it's a binding and containing thing; and another part of me that feels what you need is to understand the container, the larger container of the person, a sort of social, karmic, structural . . .
> Diana (Homeopath): . . . If you can't come up with a normal conventional diagnosis then . . . I diagnose homeopathically. But I also like to translate it across in more Western terms. If I can't put a name on it, then it seems as if I can at least understand the tissues involved and the processes and get into it that way. . . . That's quite useful and I think you still feel anchored then.
> George (Osteopath): This rash wasn't diagnosable. It wasn't typical of anything, any of the vesicular eruptions. . . . It made me very nervous.
> Sally (GP): Ah yes. As you talk I was just wondering what the function of diagnosis was. And how much of it is about a label—yes, recognition of patterns and then moving on to another cluster of patterns which is about treatment or suppression of symptoms or whatever you want to call it. . . . And at some level I think diagnosis is irrelevant. I think it's just a series of words that are different in different orientations to describe what's subjectively observed. But in terms of the whole process it's sort of irrelevant.

George is noticing his difficulty, recognizing that he wants to pin down what at least part of him knows is contingent. Diana's comment attempts to take the conversation back onto safe Achiever ground by offering a clear frame—albeit a sophisticated one—that will resolve the anxiety. But George won't have it. Sally's comment speaks

more from a Strategist frame, which carries a tone of curious wondering in it. As I remember the situation, there was a tone of anxious amusement in this conversation.

MAGICIAN

> The transformation from the Strategist stage, like that of all developmental transformations to later stages, is a movement from *being* something to *having* that kind of thing. This time the transformation is from *being in the right frame of mind* to *having a reframing spirit*. A reframing spirit continually overcomes itself, divesting itself of its own presuppositions. (Fisher & Torbert, 1995, p. 177)

Toward the end of the co-operative inquiry, we reviewed what we were learning from the whole process. We wrote an article together (Reason et al., 1992) describing a clinical model for interdisciplinary practice that, by identifying the different possible frames and their relationships that an interdisciplinary team needs to encompass, can be seen as articulating a Strategist perspective. At the end of the article, I think we also began to articulate the Magician perspective as we wrote about the need for a new language for this work, which might "look to ceremonial and ritual processes for inspiration, creating what might be termed a transitional space or an alchemical vessel" (Reason et al., 1992, p. 164). Having defined an interdisciplinary model that was a useful logical and analytical tool, we tried to go beyond it.

> However, careful diagnosis and analysis need to be linked to subjective considerations which the team encapsulated in the question, "Who has the juice for this patient?." This notion of *juice* is not just about having the most appropriate treatment, or about empathic relationships and a good bedside manner. It is about a personal integration of the specialised skills of a discipline with an understanding of the patient's predicament and containing these within a healing relationship, so that empathy and personal expression are channelled through the healing discipline. (Reason et al., 1992, p. 164)

One of the team offered a vision of future interdisciplinary work that I believe offers a glimpse of the Magician or beyond, for it suggests that to really work together the business of framing and reframing, or moving between paradigms, is a continual creative act.

> George (Osteopath): If we're going to build bridges of understanding between us they are going to be highly imaginative. They're going to be full of gesture and color and form, because the language will be words that will evoke a felt sense. When we have hit the spot, when someone has said something about their explanation, it's been something that has hit you through the right brain, more intuitive and imaginative.

The appeal to the imagination, and to all the analogical communication that holds our worldviews in place, is an appeal that articulates a Magician's worldview in which the very process of framing and reframing our reality is a centrally important process. Again, George is good at offering a visionary statement; the extent to which he or the group has learned to practice in this manner is another thing!

REFLECTIONS

It does seem that the conversations that formed the co-operative inquiry can be seen as taking place within a moving frame, shifting from paradigm-centered discussions (Achiever) toward some kind of transparadigmatic and trans-systemic form (Strategist/Magician). It is clear that this transition is not straightforward, particularly with such complex material as interdisciplinary medical practice. The following comments provide a reflection on the process of using Torbert's framework and its implications for collaborative practice.

First, in exploring how to apply the developmental framework to the transcripts of co-operative inquiry, I found quite often that I needed to recall the context of the discussion in order to make an interpretation of the developmental level at which I wished to place any particular comment. In at least two cases, comments that standing alone might appear to reach across paradigms and thus characterize the Strategist perspective, appeared, when I remembered that they were things that person said frequently (and thus were less fitting the uniqueness of the moment), more within frame and thus more typifying the Achiever or Technician stage. Clearly, as with all such frameworks, care needs to be taken in making explicit the bases on which interpretations of conversations are made.

Second, the developmental perspective is commonly taken to apply to individuals. In the tradition of Loevinger, Kegan, and others, Torbert writes of the frames of individual managers and in his research expresses concern that there are so few managers beyond the Achiever stage. However, I found that I wanted to write about the quality of conversations in the group as a whole as much as the quality of individual contributions. I would argue that an appropriate unit of analysis may be the conversation as well as the individual. Maybe we should think of the developmental process as applying to the culture of the family, group, and organization as much as to the individual.

Certainly, if we look at practice-based theories of group development we can see a similar pattern of increasing complexity and flexibility of interaction. For example, Srivastva, Obert, and Neilson (1997) offer a developmental model of group behavior, describing how group interaction develops from early stages in which each person anxiously guards her or his own identity and seeks confirmatory links with the similar other, through a stage in which group members, while joining in cliques based on similarity, engage in conflict with group members perceived as unlike them, fighting as it were for the soul of the group. But if these stages are successfully negotiated (and we can see them echoed in Tuckman's [1965] popular forming, norming, and storming stages), group members may reach toward an interdependency in which each person's perspective and contribution is understood and valued—which has close parallels to the Strategist perspective that sees all frames as having value and relevance.

I would argue, however, that what happened in the inquiry group cannot simply be explained in terms of group development. A group of Diplomats or Technicians might learn to work together with good interpersonal communication, high trust, and interdependency. But they still would not have the capacity to work across frames of understanding, which characterizes late-stage responses. On the other hand, a group of individual Strategists need a "developed" group culture to provide a community of

inquiry; otherwise, the individual capacity for late-stage responses cannot be realized in practice. Furthermore, the development of an inquiring group culture is likely to facilitate—at the very least—the emergence of late-stage behavior in many people who one might otherwise describe as Technicians or Achievers.

So Torbert's developmental framework is enormously helpful in making sense of our experiences, for it helps us to see that the difficulties that exist in interprofessional practice are not simply those of poor communication, or a refusal to collaborate, or an inability to develop trust. They do not necessarily have to do with power and professional competition, although these too may be relevant. The developmental framework helps us see the extent to which effective interprofessional collaboration is significantly an epistemological as well as an interpersonal issue that concerns the capacity of the group to support individual members' abilities to suspend attachment to their own frames and to begin to peer into the frames of their colleagues. For as Bateson (1972) points out, the movement toward these later stages is a pretty tall order because it involves going beyond the bondage—and thus beyond the safety—of a particular paradigm and, importantly, also beyond the taken-for-granted sense of self because the self is, after all, a pattern of characteristic ways of understanding and acting in the world.

Finally, Torbert's framework can also lead to some creative thinking about how to facilitate an interdisciplinary inquiry group. Because the problem of paradigmatic misunderstanding and conflict is based in fundamental differences in how the world is framed and because it appears that it requires interaction of the quality of Strategist/Magician for collaboration across frames to take place, it follows that a style of facilitation needs to be developed to encourage the emergence of this kind of interaction. I put forward the following propositions as worthy of consideration.

1. The process of co-operative inquiry itself facilitates the emergence of late-stage behavior. I was fascinated, revisiting these transcripts and in other co-operative inquiry groups, to see how often participants refer to the process of inquiry itself as a developmental process. It seems to me that one fundamental characteristic of an inquiry group that helps members move toward an attitude of reflective inquiry is the iterative structure of cycles of action and reflection.

I would argue that these cycles provide a discipline and a container for the development process, moving people away from the linear cause-and-effect thinking that is typical of the Technician and Achiever into a cyclical, ecological mode. The world becomes more complex and interconnected; assumptions that are taken for granted in early cycles are called into question when critically honed against experience. Thus, research cycling is an emergent discipline, akin to martial arts or meditation: The learning is in the process, not in any goal or outside purpose.

Experience with inquiry groups suggests that the inquiry group needs, certainly in the early stages, a fairly formal structure of inquiry cycles with regularly scheduled meetings for reflection—although as the process of research cycling is internalized, a less formal approach is possible. Certainly, the clinical inquiry that is the subject of this article worked within a very formal cycle—three clinics followed by a reflection session. In some ways, it is ingenuous to emphasize the importance of inquiry cycles in a

journal article in the 1990s (for didn't Kurt Lewin advocate something very similar in the 1940s?). It is both terribly obvious and simple, almost naive to write about. Yet the cyclical nature of knowing offers a fundamental truth it seems easy not to see.

2. The inquiry might begin with exercises that explore transparadigmatic thinking. This might provide some experience of mind-stretching. For example, Houston (1982) describes a mental gymnastic she calls "Left Brain/Right Brain," which offers a way to awaken a fuller use of mental capacities and, in particular, to release the brain from constricting rational modes of thinking.

> By reorchestrating psychospiritual and neural functioning to bypass the cerebral, cultural and psychological reducing valves, we discover that we are naturally attuned to the source, or matrix, of reality. We discover at such times that we are both/and, implicate and explicate, uniquely our own and yet containing information of the whole. (p. 193)

I have used this exercise extensively myself, in an informal inquiry group of colleagues and with groups of undergraduates and of middle managers. I believe that although Houston's language is flowery it points to some of the possibilities we are seeking, and the exercise itself does offer some significant opportunities for moving out of constricting thought patterns.

3. The inquiry might experiment with diverse forms of expression. The interactions of the inquiry group described in this article were primarily verbal: We sat around a table and talked about our experiences at the clinic. In a future inquiry, we might do well to consider emphasizing more our presentational knowing.

> Presentational knowing . . . clothes our encounter with the world in the metaphors of aesthetic creation. Presentational knowing draws on expressive forms of imagery, using the symbols of graphic, plastic, musical, vocal and verbal art-forms, and is the way in which we first give form to our experience. . . . These forms symbolize both our felt attunement with the world and the primary meaning which it holds for us. (Reason, 1998; see also Heron, 1996; Heron & Reason, 1997)

Individual practitioners might, for example, use drawing, clay modeling, or movement to communicate the relationship of their disciplines to the patient's needs. The group as a whole might make a drawing or a collage to explore in presentational form similarities and differences in understanding. We might use psychodrama (Hawkins, 1988) to enact a patient's predicament. Such activities would serve to loosen the hold of articulated frameworks and provide a nonpropositional channel for dialogue.

4. Practitioners might offer guided experiential introductions to their disciplines. At certain times in the inquiry, something occurred that seemed to help the group develop a "feel" for a practice. For example, when the acupuncturist diagnosed a patient as suffering from "damp heat" and explained graphically what he meant, or when he illustrated his diagnosis by drawing a picture of a patient's tongue on the whiteboard, the whole group was drawn experientially, to some degree, out of their own frames and into the thought patterns of TCM. At such times, the practitioners are speaking of their disciplines in a language "full of gesture and color and form" evoking

"a felt sense," as George put it. The inquiry facilitator would do well to be on the lookout for and encourage such "windows" into a practice. Furthermore, it might be possible to invite each practitioner to devise an activity that would experientially initiate colleagues into some of the mysteries of her or his practice—learning to take each other's pulse in TCM or articulating joints in osteopathy.

5. Introduce the theory of framing and invite the co-researchers to inquire into it. The suggestions made so far assume that the facilitator has primary responsibility for managing issues of framing, while a sophisticated group quite clearly would be able to grasp the ideas and use them in an inquiry into their own process, noticing times when group members were speaking within frames and across frames, challenging and supporting their colleagues as appropriate.

6. Inquiry group members assume the mantle of Magician. We have often introduced the role of devil's advocate into co-operative inquiry processes. In this role, which draws its name from the process of investigating proposals for beatification in the Catholic Church, a group member takes responsibility for challenging untested assumptions, collusions, and other noninquiring behavior within the group for a period of time. We might be able to open up the possibilities of working across frames by inviting group members to take turns to act in the Magician's reframing mind and experiment with "clownish tumbling," with the "wandering and unpredictable twists and turns and 'magical' outcomes when experience is engaged with reframing mind" (Fisher & Torbert, 1995, pp. 176-177).

CONCLUSION

My contention early in this article that there was a development in collaboration and interdisciplinary competence during the inquiry process and that this development can be understood in terms of a shift toward later stages of ego development is broadly supported by the evidence. I would argue that although the early stages of the inquiry can be seen as a diverse group of practitioners working side by side, at the later stages there is a greater sense of integrated practice. In particular, we learn that collaboration involves epistemological sophistication as well as group development. These propositions clearly merit further exploration in other interdisciplinary groups; such exploration would be helped by a judicious use of some of the interventions outlined above.

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