POWER AND CONFLICT IN MULTIDISCIPLINARY COLLABORATION

SUMMARY.

A multidisciplinary clinic was established in an inner city general practice. Using the approach of co-operative inquiry, the clinicians involved explored their joint practice to better understand the nature of multidisciplinary practice. This paper focusses on issues of power and conflict which arose in the course of this work, and makes suggestions for future practice.

In this paper I want to explore some of the group and interpersonal issues which arise when general medical and complementary practitioners work together. Particularly I want to look at this in terms of power and power conflicts, and to attempt to understand some of the deep-seated causes of misunderstanding which may arise between practitioners who are good working colleagues and who hold each other in considerable respect.

However, before exploring these issues of power and conflict I shall first describe the setting and briefly discuss co-operative inquiry, which was the method used for this inquiry.

Marylebone Health Centre

Marylebone Health Centre (MHC) is a General Practice established in 1987 working within the NHS in Central London. As part of the Marylebone Centre Trust, MHC aims to develop and assess innovative approaches to primary health care. Thus, for example, the work of MHC is the subject of continuous audit: comprehensive patient computer records are maintained which provide accurate information on clinical, social and economic aspects of the practice. Similarly, 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 statement of practice called the Marylebone Model. This model sets out a number of working principles which underpin the work of MHC, and includes two statements of interest to our present concern: offering a multidisciplinary approach; and empowering people to take control of their own health and well-being.

Thus a multidisciplinary approach is an important part of the Marylebone Model of primary health care and over the years multidisciplinary practice at MCT has taken several different forms. At the time of writing five complementary practitioners -- a homeopath, an osteopath, a practitioner of traditional Chinese medicine (TCM), a psychotherapist and a masseuse -- hold sessions at Marylebone Health Centre (MHC), seeing patients referred by general practitioners and taking part in the development of the practice. A series of multi-disciplinary clinics were held which are described and evaluated in Wallstein et al (21).

In the autumn of 1989 a new MHC Research Clinic, based on this earlier work, was established to explore issues of multidisciplinary practice. At this clinic patients, referred by their GP, are seen for assessment by the complementary practitioners. Following the assessment the patients meet with the clinical team, with their GP in the role of advocate, to hear feedback from the practitioners and together agree a management plan. The idea behind this joint meeting, which was a bold step in its own right, was to see if it was possible to empower patients by involving them in decisions about their healthcare.

The MHC Research Clinic was planned to be the subject of a clinical trial to determine its impact on practice issues such as attendance at the Centre and prescription rates, as well as on patient well-being (4). In addition, it was decided that the clinic should also be explored by the clinicians involved using co-operative inquiry, in order to identify and learn from the opportunities and problems facing such a venture.

Co-operative inquiry

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 (14, 17) these mutually exclusive roles give way to a relationship based on bilateral initiative and control, so that all those 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 experiences. 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 stage they reflect on their experience critically, learn from their successes and failures, and develop theoretical perspectives which inform their work in the next action phase.

Ideally in co-operative inquiry there is full reciprocity, with each person's agency, their potential to act as self-directing persons, fundamentally honoured both in the

exchange of ideas and in the action. This strongly contrasts with traditional approaches in which all agency is held by the researcher and the subjects of the inquiry are treated as objects. Co-operative inquiry is one method of several which are informed by a radical participatory worldview (see, for example, 10, 18, 19). While there is not the space within this article to explore these issues fully, it should be noted that because of the emphasis on self-reflective agency, this is a method particularly suitable for practitioner research and for the development of innovative approaches to practice.

The inquiry team for this research consisted of the practice GPs and the five complementary practitioners, with the Director of Clinical Research (the author of this article) as facilitator. The inquiry engaged in five cycles of action and reflection between November 1989 and June 1990. Each action phase consisted of two or three clinics attended by up to four patients; each reflection stage consisted of a three 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 meeting with the patients in the clinic and the reflection meetings were tape recorded, and the transcripts circulated to the clinicians, who were thereby able to reflect more thoroughly on their experience.

Among the guiding assumptions of co-operative inquiry is that valid knowledge is formed in action and for action (7, 12, 14). It follows that the outcomes of the inquiry importantly include the group members' experiential or tacit understanding of the process of multidisciplinary practice; their individual and collective practical knowledge, which include the skills of collaborative practice they developed together; and the conceptual knowledge of the issues involved in this multidisciplinary process. All these forms of knowledge are valuable and important outcomes of the co-operative inquiry process. A written article can only address the last of these three forms of knowing. While this paper addresses specifically issues of power, as full an account as possible of the inquiry has been provided in a working paper (15).

A further issue in reporting co-operative inquiry concerns ownership of any reports which are made. While an inquiry group may be able to prepare a report to which every member subscribes, individual members may also wish to make individual reports in papers such as this one. In addition, it will be clear that each member of the inquiry group will speak from their unique personal perspective. I believe it is important that any report purporting to come from a co-operative inquiry group includes a statement of how it was written and to what extent it represents the shared views of the group. Thus this paper was written by myself as single author; it is based firmly on the work of the inquiry group, and has been discussed in detail at a meeting with most of the inquiry group members. While many of their comments have been incorporated and they agree broadly with the content of this paper, the theoretical reflections on the work are entirely my own responsibility.

Power, empowerment and power conflicts

The inquiry group, in its reflection meetings, agreed that issues in the management of power were central to the conduct of the clinic. Of particular interest was the question of whether the attempts to empower patients was leading to disempowerment of complementary practitioners.

The empowerment of patients.

The Clinic was established with the clear intent of empowering patients to make their own health choices. The GP who initiated the clinic felt that the arrangements in the earlier multidisciplinary clinics, in which the practitioners discussed the patient's case in private before suggesting a treatment package, was fundamentally disempowering and that it was wrong for the patients to be told what was good for them on a "Doctor knows best" basis. It was also argued that it is fundamental to the treatment of patients with chronic conditions that they experience the capacity to do something about it themselves.

On the other hand, it was argued that patient choice is meaningless unless based on knowledge and understanding of the options, which was clearly often not the case with patients at this clinic. But since it was often impossible for anyone, even the most knowledgeable practitioner, to make a fully informed choice about the appropriateness of different therapies to a particular patient, it may make much more sense for the patient rather than for the practitioner to make the choice on the basis of their own subjective wisdom.

In the event we agreed that, even with the (for some) dramatic intervention of inviting the patients to discuss and agree their treatment with the group of practitioners, we did not actually make much impact on their sense of empowerment.

Power and disempowerment of practitioners

One of the questions which arose very early was whether in attempting to empower the patient the process of the clinic was disempowering the complementary practitioners. The meeting with patients was a rich and complex event, which required considerable skill and understanding to work well. On a few occasions the intent was met, and the patient appeared to leave with a fuller understanding of their predicament, a sense of empowerment, and a sensible management plan. On some occasions the meeting was simply flat and embarrassing. Other occasions were confused and unsuccessful, with the clinicians left feeling upset and sometimes angry.

One source of difficulty was that the complementary therapists felt unsure of their ground, unsure of the extent to which they could use their clinical expertise and unsure of when this would be seen to be disempowering the patient. They were uncertain how to describe the possible benefits of their therapy to the patient, and about the extent to which it was acceptable for them to disagree with their colleagues in front of the patient. In addition, there was always the possibility that, in offering an alternative form of treatment, they would be experienced as criticising the GP's treatment strategy over several years. There was at times a sense of considerable anxiety, with the all practitioners feeling unsafe, awkward and de-skilled.

Whether this was an intentional strategy of the general practitioners (conscious or unconscious) or simply an unintended consequence of the clinic structure was fiercely debated:

> CP1: ... on a fundamental level (it's) about safety... (to GP) Do you have an agenda about making us feel unsafe....?
>
> CP2: (amid laughter) You like to make us squirm!
>
> CP1: .... If that is part of the experimental model, let's get it on the table! You want to empower the patients and disempower the practitioners. I think you can empower the patients without disempowering the practitioners. I think there has to be a balance struck, or else the dynamic of this meeting will always be difficult....

And it was argued by the complementary practitioners that their power was legitimate and not to be discounted lightly:

> CP3: I know knowledge is power, but knowledge is being somehow used pejoratively here.... I've studied, for Christ sake, there is stuff that I know, and how is it going to be put into practice here....?

A vignette

It may help to offer an example of conflict as it occurred in the clinic, and how different layers of conflict reverberate with each other. The clinic session in question took place at a particularly busy time, when all practitioners were feeling more or less harried. The clinic was full, with four patients attending that afternoon, which always added the pressures of timetables and keeping in touch with a lot of diverse information. There was further awkwardness because the first patient had been referred by a GP with whom relationships were uneasy, and who had not been referring to the clinic very regularly.

The second patient appeared on the surface to bring structural problems to the clinic which needed osteopathic treatment: release of tension in the lower spine would improve circulation and diminish back pain, as well as maybe helping with pain in the knees. However, from the perspective of the TCM practitioner, supported by the homeopath, there was stagnation of energy in the whole body due both to initial weakness and also the incidence several years earlier of typhoid and malaria. From this perspective the question was not simply structural, it was energetic, emotional and spiritual as well. The conflict was between a view of someone simply needing some adjustment, and of a deeper constitutional deficiency requiring energetic work. There was considerable confusion in the debate about which form of treatment to adopt, because there seemed to be no framework, conceptual or intuitive, which encompassed all the different possibilities. This confusion added to the prickly feeling between the clinicians that day.

The third woman had been experienced by all practitioners as difficult to work with, and had in addition arrived late and then harshly criticised one of the practitioners for giving her very little time. She had complained to her GP about this, rather than directly to the person concerned. Dealing with this added to the awkward atmosphere.

Finally, the fourth patient who attended appeared very passive and unclear about what she wanted, so that it was difficult to reach a decision about appropriate treatment. The GP concluded that, because of this indecisiveness, she should not be offered treatment at this stage. The complementary practitioners reacted strongly against this, seeing his attitude as unprofessional and almost sadistic, in that he had not responded to her need for help. He in turn felt that the CPs were inappropriately "rescuing" the patient and not confronting her with the possibility of taking charge of her predicament.

There had been hints of this difference during the meeting with the patient; they emerged more explicitly (and quite explosively) immediately afterwards; and were explored in depth in the subsequent reflection meeting. At that time it was realized that, in addition to the various group and interpersonal issues that were influencing the situation, there was a difference in clinical understanding of the patient's condition:

> GP: I think the thing I remember most about that clinic was that after she'd gone I commented on the fact that I felt we should have left her untreated and you said that you thought that was a bit sadistic. And I thought about that afterwards and... I assume it was because you felt that you had something very clear to offer and that you could treat her indecision as well as her physical symptoms. I was feeling that here was a woman who wasn't putting out anything at all. It was very clear that she didn't want to take a position on anything as I saw it and I

would therefore have waited until she moved in some direction. That, it seemed to me, was a reflection of two very different models.

> Homeopath: Yes, that indecision would be seen as a homeopathic rubric, in other words a basis for a prescription, and was in a hierarchy of symptoms, in her case, a very highly marked symptom, and therefore from a homeopathic management point of view would have to be covered in any prescription. But it wasn't just the indecision. It was mirrored right through her case, if I remember.... there were a lot of ill-defined symptoms... and very changeable. It was a very changeable picture and had a very yielding manner. But from a homeopathic point of view it was quite a clear picture....

Similarly the disagreement over the second patient became clearer much later as we prepared this paper:

> TCM Practitioner: I remember having a disagreement with you (the osteopath) over patient X who came in with the sore knees... You talked about the structure of her back in relation to her neck, and I talked about other things, seeing it much more as an emotional and depression illness (with) stuck liver and heart... I felt that structure followed on from what was going on inside (which is not always the case). And I criticised you because of how absolutely structural, how unbendingly structural, you were with her, and didn't see any of the other stuff....

(I need, in passing, to make two important qualifications to these examples. First, while in the main example I have given the clash was between the homeopath and the GP, there were equally heated debates between other clinicians in the group, particularly the homeopath and the TCM practitioner. Second, the members of the group were adamant that they could not be defined simply as osteopath or psychotherapist, each called on a wider range of skills than is simply encompassed by the label of their discipline.)

Experiences of the clinic in the light of models of power

I want now to reflect on these experiences in the light of some of the commonly used models of power that a group facilitator might use to understand what was happening. In making these reflections, and in focussing to some extent on the conflicts which arose in the group, I want to emphasize again that this group of practitioners were intimate colleagues who by and large liked and respected each other. Despite this, conflicts emerged which were not easy to manage.

<u>French and Raven</u>

French and Raven's model of the bases of social power (5) is a basic but still useful starting point. From their analysis, we can identify *reward* power, as in the ability to provide material or non-material benefits (wages, gifts, approval, love); *legitimate* power, as in the ability to validate or approve behaviour based on acceptance of cultural values and social structure; *referent* power through association or access to a high prestige group; *expert* power in giving advice or help based on particular skills or knowledge; and finally *coercion*, power based on physical force.

We can use this framework to look at the processes involved in the clinic and see that the senior general practitioners (who are responsible for the management of the Health Centre and the policy of the Trust), are in a powerful position in relation to the complementary practitioners. They hold reward power in that they control the work contracts, and thus whether the CPs continue to work at the health centre. In addition all GPs hold reward power as gatekeepers for the clinic in that they that control access to patients. All GPs hold legitimate power, since they are generally recognised in society as the senior and most prestigious of the healing professions. However, this legitimation is ambiguous: for some CPs there is considerable prestige and kudos to be gained in working for a well known "holistic" general practice; others are attacked and criticised by their complementary colleagues for joining the "establishment". Finally, GPs also have expert power based on their professional training and experience in family medicine; they might be described as "expert generalists".

In contrast the complementary practitioner hold primarily expert power, in that they offer skills and competence in their specialized fields of practice. When they experience this expert power as misunderstood and as challenged by the attempt to empower patients at their expense, they naturally respond with vigorous resistance.

This relatively simple analysis based on French and Raven's categories shows that there may be a fundamental power imbalance in a multidisciplinary team. This should lead us to look for ways in which this imbalance may exacerbate differences of opinion or perspective within the team, making them more intransigent. The creative management of differences is of course of particular importance in multidisciplinary teamwork, and so ways must be found to explore these issues and to share power in appropriate ways, and care must be taken not to attack the power bases of any of the practitioner groups. If this is not possible to remove the power imbalances, the group must develop a sophistication such that it is able to attend to and manage them effectively.

<u>Power and group process</u>

A second way of looking at power and power conflicts in a situation such as this is to turn to theories of group process and group development. Generally speaking it is

agreed that groups develop through a series of phases in which certain issues of relationship are dominant and need resolution, often through a crisis in the life of the group. Srivastva et al (20) see group life as primarily concerned with issues of identity and influence. They describe how in the initial phase of group life each member is essentially alone, wondering with considerable anxiety which other members are similar and dissimilar to themselves. This phase gives way to a phase of pairing, in which people reach out to the most similar other, moving away from those they experience as dissimilar. The primary issues here are of *inclusion* and *exclusion*.

If these phases are successfully negotiated, these pairings join together in offensive and defensive cliques, and the group may enter a phase of considerable conflict as these cliques vie for control. This struggle may be very important for the effective life of the group, as fundamental issues of principle and practice are thrashed out. The primary issue here is *influence*.

Again, if these phases are successfully negotiated the hard differences between the cliques will begin to dissolve, and the group will have an opportunity to move into a situation in which all members have an acceptable position and effective voice within the group. The structure of the group can now be seen as a complex network of inter-relationships based on a deep understanding of members needs and their offerings, and tasks are shared on the basis of skill. The primary issue now is the development of *intimacy*.

Srivastva and his colleagues are at pains to point out that, even though the development of a group can be seen as proceeding through phases in which certain issues become salient, nevertheless all these issues are present to a greater or less extent in the life of the group at any particular time. And it is certainly so for the multidisciplinary group at MHC. Issues of inclusion were evident in concerns about being liked or disliked by colleagues, and in concerns about whether one's clinical skills and the practice one represented was being honoured and properly used. To some extent the group could always be characterized as a group of separate practitioners, each with their own skill looking for membership. Issues of influence were expressed in the conflicts about the nature and purpose of the clinic: to some extent the cliques developed as complementary practitioners against the GPs, and this masked some of the conflict between the complementary practitioners themselves. And issues of intimacy were expressed in the very genuine regard members of the group had for each other both as individuals and as clinicians, although this was hindered by lack of in-depth understanding of each other's practice.

So from a perspective of group process and development a multidisciplinary team is a very complex animal. Our stance as a co-operative inquiry group helped us to attend to these issues of process, although it is very clear that we could have profitably spent even more time on them than we did. We would recommend that

any group of diverse practitioners intending to work together attend very closely to these questions of group process.

Organizational Conflicts

A third way to look at questions of power is in terms of the wider organizational processes and the place of the inquiry group within these. There was continual debate at MCT about the role and value of complementary disciplines within general medical practice, and about the appropriate allocation of resources and about competing demands on funding. At times these debates were experienced as battles for survival.

The struggle for definitions of reality

However, these perspectives on the power issues within the group do not go far enough or deep enough; there are other more subtle issues to attend to. Listening one day to the tape of a reflection meeting as I prepared it for feedback to the group, I thought to myself, "I can see the different power bases, I can see the interpersonal, group and organizational conflicts, but something else is going on as well!" I was struck that there was some underlying and unexpressed conflict. My notes at the time read:

> My feeling on going through these tapes is that there is a power struggle for defining what this clinic is all about. Yet this power struggle is kept under the table. If it is about empowering the patient, does this imply that the GPs... want to disempower the CPs....? Again, if it is about a psycho-dynamic rather than a clinical intervention, this again disconfirms the CPs clinical skills. But if it is a clinical setting, does this mean that the GP risks being overshadowed by the CP practice..... What happens, I think, is that the discussion flip flops between the different definitions of what the clinic is all about... because this is the fundamental ground of conflict. The conflict is about practice, about skill, and ultimately about self worth . I think the very design of the clinic has pointed to this fundamental subscript... I think therefore that any future clinic, or any model we would offer to the medical and complementary community, would have to take this essentially covert conflict very seriously indeed.

In order to understand this kind of covert power struggle we may turn to Lukes (11) who discusses three dimensions of power. At a very simple level power can be seen in terms of who gets their way when a disagreement arises: who can make decisions when there is an overt conflict of interests? But this is an over-simplified view, since power is frequently exercised through "non-decisions", for example by preventing issues coming to a public forum for debate and thus "fixing things" beforehand. In this second dimension, power can be defined in terms of who can control the

agendas for public debate, as for example the orthodox medical establishment has attempted to control the debate on complementary practice (3).

However, both these are inadequate views of power for three reasons. First, power not only arises in decision making or non-decision making, but in the overall bias of a social and political system toward consideration of certain issues and the exclusion of others. Second, power is not only associated with observable conflict, but may also be used to shape desires and opinions and so stop conflict from arising. Third, power is not only present when there are grievances and differences, since it may be used to shape the way people see their world so that they may accept things as they are because they see no alternative, or because they accept that the way things are is natural and unchangeable.

It seems to me that Luke's third view of power may help us get a perspective on the power conflicts in the multidisciplinary group. I think it is arguable that there is an underlying power struggle going on for who was to define reality for that group. And by that I mean not just an argument about role and purpose of the clinic, not just a struggle for self-esteem and recognition by others, although these are both important. I mean a struggle about the ground on which any discussion in the clinic is conducted: whose worldview, whose ontology and epistemology, as well as clinical method, would dominate; and whose would be relegated to a subordinate position. This kind of struggle clearly falls within Luke's third dimension. The possibility of its resolution lies in the ability of the group to develop a framework of ideas shared among the participants, but this is not at all easy.

The point about this struggle is that it is inchoate, confusing, and almost inexpressible. We do not have the language (yet) to explore these issues clearly, and in another paper (16) we have argued that further co-operative inquiry into clinical models in this kind of setting is needed in order to develop such a language. But the struggle surfaces now and again, as in the examples above: the whole group gets into a difficult argument because there is no framework for agreement; or clinicians from different disciplines clash because while they may agree about what the patient needs, they interpret those needs through quite different frameworks, and bring to the situation fundamentally different assumptions about what an intervention may do.

The symptoms of such a power struggle are the feelings identified above that beyond the interpersonal disagreements and the structural differences something else is around (although these more superficial conflicts will multiply the effects of the deeper ones). People will suddenly find themselves in conflict which they did not expect. They will not be able to express themselves in words clearly. They will feel their world is taken over. I think this might well be called a *paradigmatic* power struggle.

Bateson's theory of Learning

We may gain some further illumination on this notion of paradigmatic power by borrowing from Bateson's discussion of logical categories of learning and communication (1). Bateson bases his work on the theory of logical types, the notion that no class may be a member of itself, and thus that a "chair" and the "class of all chairs" are at different levels of logical typing. He argues that many errors of understanding and of communication are caused by failure to see that phenomena are at different logical levels. Using this perspective to discuss the nature of learning, Bateson uses the curious term Zero Learning to describe a specific response, as when I "learn" from the clock striking that it is six o'clock. Learning I involves changes in Zero Learning, as in habituation and rote learning. Learning II is a change in the process of Learning I, a change in the set of alternatives from which the choice is made, and is therefore about learning how to learn:

> ... the phenomena of Learning II can all be included under the rubric of changes in the manner of which the stream of action and experience is segmented or punctuated into contexts together with changes in the use of context markers. (1)

For example in acupuncture, Learning I might be exemplified by knowing where to insert needles to "cure" particular symptoms; Learning II would involve a wider and deeper understanding of the theory of Chinese medicine and an ability to apply creatively to a particular patient.

Beyond Learning II, Learning III involves a corrective change in the system of sets of alternatives from which the choice is made. So if Learning I is habituation, Learning II is learning to punctuate and conceptualize experience so that a system of practice can be formulated, then Learning III is about moving beyond a system of practice, learning that alternative systems of practice are available and that it is possible to move between them. This means, following our example, being able to see Chinese medicine as one of a set of alternative healing disciplines, to understand their relationships, and being able, in the end, to choose which perspective to take without diluting any of the individual perspectives.

Learning III is *not* simply moving from one system of practice to another:

> ... it is necessary to distinguish between mere replacement without Learning III and that facilitation of replacement which would be truly Learning III (1)

Nor is Learning III a compromise between systems, or a reduction to a "lowest common denominator". Rather it is a shift of comprehension and of consciousness that permits a more encompassing view of practice.

Now Bateson points out that Learning III 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:

> If I stop at the level of Learning II, "I" am the aggregate of those characteristics I call my "character". "I" am my habits of acting in context and shaping and perceiving the contexts in which I act. Selfhood is a product or aggregate of Learning II. To the degree a (person) achieves Learning III, and learns to perceive and act in terms of the contexts of contexts, (their) "self" will take on a sort of irrelevance. The concept of "self" will no longer function as a nodal argument in the punctuation of experience. (1)

Learning III, in the context of multidisciplinary groups, concerns the ability to develop and work with *meta-frameworks* which encompass the different clinical frameworks of the group members show their relationships and enable clinicians to move with some ease between them. Bateson's analysis suggests that in seeking such a meta-framework we need to look for a quite different quality of conceptualizing from the frameworks of individual practices.

Discussion

This issue of the management of paradigmatic conflict has serious consequences for multidisciplinary collaboration, and not just in the field of primary health care. The perspective presented in this paper suggests that multidisciplinary practice is very difficult, that it requires highly evolved practitioners who are in significant ways non-attached to their paradigms of practice and to their Self. More than this, it requires a social setting which supports and encourages such detachment: an evolved multidisciplinary group.

We really do not know much about the design and maintenance of such settings, although studies of some religious institutions might help (6). However, if we consider again the phases of group development discussed above, it would seem that a group whose members are engaged primarily in the self-oriented anxiety of *inclusion* or the power struggles of the *influence* stage is unlikely to support the necessary capacity for detachment. Such detachment is more likely to be nurtured in a mature group well into the *intimacy* stage of group development.

We can also say is that if there are serious imbalances in the bases of power as in the French and Raven analysis (and currently power imbalances between established

and complementary medical practice are clearly present and significant), then the development of the group is likely to be hindered. In particular I would suggest that struggles over legitimacy and formal power, or even simply the presence of formal power differentials as in a bureaucratic style of organization, tend to freeze the development of groups in all organizational settings. They become cautious committees rather than creative teams, "intermediate" groups as Randall and Southgate (13) describe them, unlikely to be destructive, but unlikely to be creative either, and certainly unlikely to evolve a culture which will support Learning III.

I would also argue that the presence of conflict at the level of Luke's third dimension of power, or what I have termed here paradigmatic conflict, is likely to repeatedly throw the group process back to concerns about the earlier issues of inclusion. Group members may from time to time feel they are accepted and appreciated members of the group, able to move freely into the contentious space of a group in the influence stage; then the strange misunderstandings that derive from the lack of a shared framework will result in feelings that, "I don't really belong here..." These feelings may have almost the formal characteristic of a double-bind (2, 9): one message from the group tells me I am valued and appreciated; while another demonstrates I am totally misunderstood; and I cannot speak clearly about these confusions.

I suggest that there are two possible strategies for working with the impact of these conflicts on the life of a multidisciplinary team. Let me call them the "realistic" strategy and the "idealistic" strategy.

The realistic strategy involves accepting that these conflicts will exist and that they will have a limiting impact on the life and work of the group. In order to mitigate their impact, the group will have to pay considerable attention to its process and to the organizational setting in which it works. It needs to find the language to recognise this kind of conflict, to learn to stand back when it arises, and begin to find words to express what is going on. Otherwise what will happen is that the differences may be put down to personal or professional pathology, and the people involved -- often the complementary practitioners -- may be seen as too difficult to manage by those who hold formal power.

The idealistic strategy aims to move beyond the conflicts to a higher level of group operation. The group and the managers of its organizational setting would make every effort to ensure that structural power differences were removed, and to create an environment in which the group could develop open relationships. The group itself would devote time to those disciplines which help cultivate non-atttachment -- meditation and other "mindfulness" exercises. It would devote time to seeking ways of exploring the paradigmatic differences through imaginal and meditative exercises such as those described by Jean Houston (8). These might facilitate analogic and "right brain" thinking which may be less attached to an immutable sense of Self, and enable practitioners to find and share images of their healing process. This would add a second and powerful communication channel to the overstrained verbal

channels, and maybe through that facilitate new mutual understandings analogous to Learning III, for as Bateson points out,

> ... no amount of rigourous discourse of a given logical type can "explain" phenomena of a higher type. (1)

The realistic strategy lies within the competence of any reasonably sophisticated group of practitioners, although competent group facilitation is probably essential if it is to be successful. The more ambitious idealistic strategy can only be sketched out as a possibility at the moment, and clearly requires considerable developmental work before it could be fully implemented.

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