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The Emerging Discourse of Transdisciplinary Neurorehabilitation:
Building Healthcare and Health Capacity on the Moral High Ground

by

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Abstract

This 2-year comprehensive case study is the first of its kind to uncover the mechanisms through which a transdisciplinary neurorehabilitation team operationalizes the population health goal of increasing personal and family capacity. Data collection strategies included audio-taped interviews and focus groups, field observations and document analysis. A lengthy analysis was required to identify and unravel the emerging discourse of transdisciplinary practice from the traditional discourse of medicine. A transdisciplinary meta-narrative was constructed using interview and focus group data followed by interpretative repertoire analysis. The analytic approach allowed for a nuanced description of transdisciplinary practice to emerge. The interpretative repertoires coalesced around six discursive topics: the traditional model, creation of the clinic, transdisciplinary leadership, team membership, therapeutic interventions and physician practices.

Results of this study demonstrate how this rare transdisciplinary healthcare team integrates a population health lens, salutogenic theory and transdisciplinary philosophy to maximize the capacity of individuals and families to take control of their health and health circumstances. The team also works collaboratively with family members to help clients reintegrate into their home, workforce and community and reduce reliance on family and the healthcare system. Finally, the study demonstrates how transdisciplinary practice, longevity, a shared ethos and an organization-wide orientation to salutogenesis are resources for organizational efficiency and employee health.

The transdisciplinary team studied for this project is an example of a theoretically grounded and radical alternative to the existing health services paradigm. A transdisciplinary approach may be the nascent solution needed to curb the soaring cost of chronic illness in Canada.

In loving memory of my late father John F. Baird

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Chapter 1

Introduction

In 1977, the World Health Assembly envisioned ‘health for all’ by the year 2000. However, the cost of healthcare, chronic illness and disability in Canada has more than doubled between the target date for universal health (i.e. the year 2000) and 2013. Rather than health for all, Canadians have witnessed the per capita costs of health services swell to an all-time high of \$6100.00 for the 2013 fiscal year (Canadian Institute for Health Information, 2013) (see Figure 1.0). Skyrocketing operational and capital expenditures, pharmaceutical and technological advancements and a steadily growing population are just some of the factors attributed to the 350% increase in healthcare expenditures since the mid-1970s. It is questionable if the healthcare system can sustain this degree of financial strain in light of the added expenditures related to chronic illness and functional disability as the population ages.

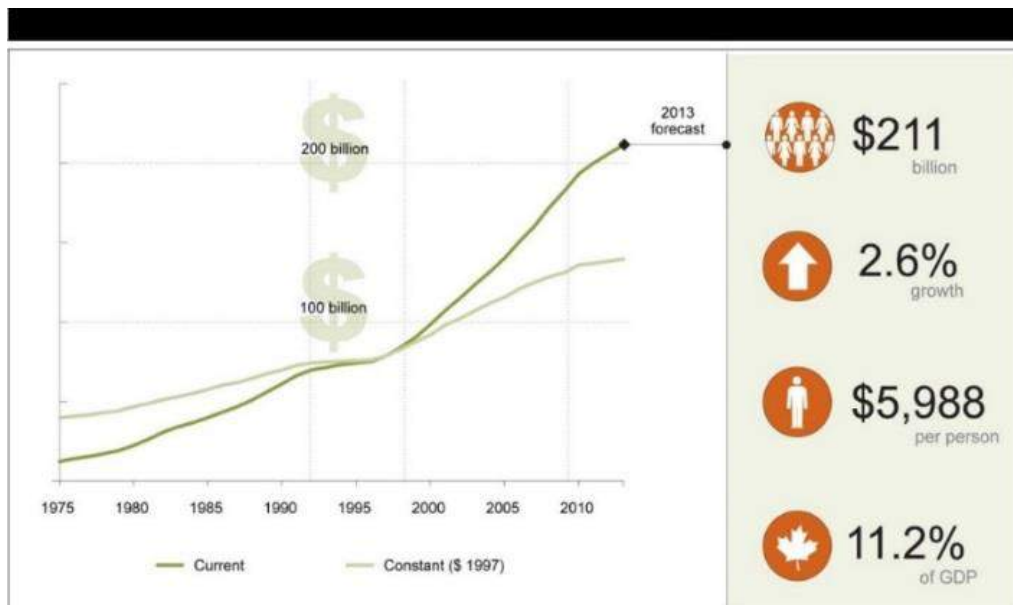


FIGURE 1.1 PER CAPITA COST OF HEALTHCARE 1975 TO 2013 (Adapted from: CIHI, 2013)

Given the current state of healthcare in Canada, several questions immediately come to mind: Is \$6100.00 per person the most it will cost to help each and every Canadian citizen become healthy enough to achieve and sustain “*socially and economically productive lives*” (WHO, 2006, pp. 2) and “*maintain as normal a place as possible in the community*” (WHO,

1985, pp. 15)? Are we making headway towards health for all, running in place or circling too high atop the airport to see there might be an alternative approach? Some of the answers to these questions can be found in the history of healthcare reform in Canada.

The History of Healthcare Reform in Canada

Marc LaLonde was one of the first key players in the Canadian healthcare reform arena. The LaLonde report (1974) hailed in a new era for health. He challenged the existing medical paradigm and introduced the first of the 12 determinants of health (DOH). His report spelled out the reasons why access to healthcare services alone did not and could not significantly improve the health of Canadians. Biological factors, an individual's social and environmental context and personal health practices play a greater role in sustaining a person's overall health and well-being. While the new health-promoting gaze was able to glimpse into each patient's unique health circumstances, healthcare providers could not fully understand or address the complex, multi-level multidimensional reasons why particular individuals succeeded, failed or did not attempt to maximize or sustain health.

Shortly after the LaLonde report, healthcare reform was ready to proceed on a global scale following the International Conference on Primary Healthcare in Alma-Ata, Kazakhstan (WHO, 1978). The declaration of Alma-Ata urged governments and healthcare providers to adopt an ideal(ized) model of primary healthcare touted as the best way to protect and promote the health of all people. However, while the declaration of Alma-Ata outlines multiple examples of community-based programs needed to promote health, prevent illness and maximize "*community...self-reliance*" (p.2), it does not provide any tangible details or recommendations with which to promote and maximize individual health and self-sufficiency. Further, the declaration does not address how healthcare providers might assist individual or families with complex health and health circumstances if their challenges differ from the shared problems and needs of the community at large.

By the mid-1980s it became apparent that health promotion and illness prevention initiatives were not creating the self-determined self-reliant communities or individuals the government had hoped for. A new discourse of health capacity building began to emerge in response to the public's lack of engagement. The healthcare sector needed strategies to

encourage patient engagement and sustainable change. Capacity building efforts would eventually evolve under the purview of allied healthcare professionals in primary healthcare settings and other community-based facilities.

However, chronic illness services and health capacity building efforts across North America also shifted to community-based ‘physician’-led primary healthcare practices in the 1980s (Renders et al., 2009). By the mid- to late 1990s, this chronic care service delivery model came under considerable scrutiny. Primary healthcare teams were highly underequipped to provide effective self-management programs, education and support services or to institute best-practice guidelines for medical management (Wagner, Austin, & Von Korff, 1996). Some argued primary care doctors were still trained to manage illness independently with an acute care approach. Traditionally trained under-resourced physicians had no choice but to resort to ‘symptom swatting’ in chronic illness management (Scheff, 1984). Physicians themselves argued they had little time to spend with clients and families or collaborate with other healthcare providers. Antiquated office processes and technologies systems were not designed to provide more comprehensive service delivery (Wagner et al., 1996; Grumbach & Bodenheimer, 2004). Further, there was no best-practice service delivery model to provide guidance needed to transform practice.

Wagner et al (1996) suggested a more detailed map might help primary healthcare teams conceptualize how the principles of primary healthcare could be used to transform their existing practices. The authors recommended collaborative team-based problem solving, patient involvement, targeted goal setting, integrated self-management programs, computerized information systems, care coordination and routine, physician-initiated follow-up. It was hypothesized this revised approach would result in “*improved functional and clinical outcomes*” (Barr et al., 2003, p. 74) through system-wide changes in the healthcare sector (see Figure 1.2). However, the new framework to guide primary healthcare transformation outlines the necessary system components, but does not explain how client-provider-team relationship should unfold or strategies to activate the informed patient.

Glasgow et al. (Glasgow, Tracy Orleans, Wagner, Curry, & Solberg, 2001) revised the model five years later. They maintain their version better reflects the need for inter-sectorial

collaboration as well as environmental and community-related factors that impact health. They believe the model was better equipped to revision, plan and deliver community-based preventative services. It was also hypothesized that the model would help develop health programs to finally tackle and reduce the burden of chronic illness on the acute care sector and primary healthcare physicians (Wagner et al., 1996; Hung et al., 2007) by the inclusion of the principles of population health.

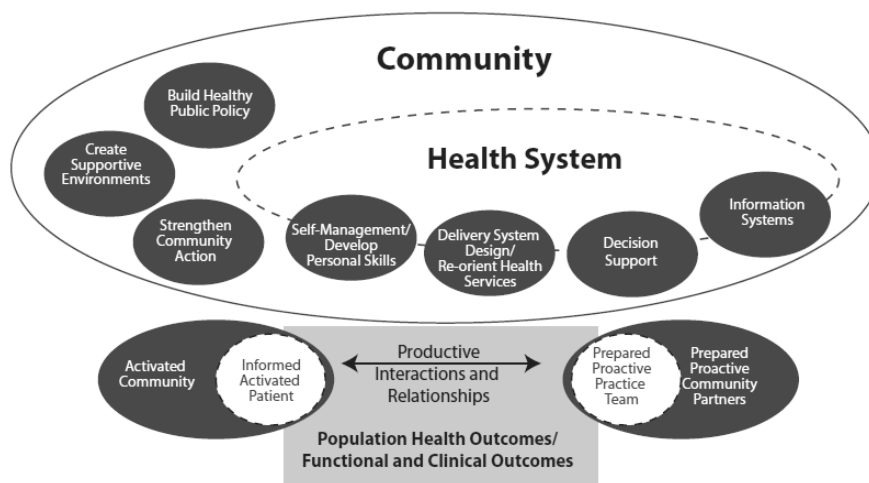


FIGURE 1.2 EXPANDED CHRONIC CARE MODEL (Adapted From: Barr et al, 2003)

The current version in the Chronic Care Model (Epping-Jordan, Pruitt, Bengoa, & Wagner, 2004), the Innovative Care for Chronic Conditions (ICCC) framework (see figure 1.3) uses Bronfenbrenner's (1977) ecological framework to position the healthcare sector as a meta-system. The authors contend their approach provides practitioners a more explicit description of the collaboration required at all levels, including the acute and community-based sectors, community partners, patients, families and government (i.e., policy makers). There were, once again, few directions about how those key relationships might unfold from a pragmatic perspective. Hroschikoski et al (2006) also report the lack of specific directions for implementation of the CCM model results in little tangible change in chronic illness management. Furthermore, providers studied were unable to transfer and replicate changes recommended from successful implementation of the model into their own healthcare settings.

Evaluation of the model has been challenging due to disparate implementation strategies and lack of standardized assessment measures. While electronic medical records and

appointment tracking systems have improved practical inefficiencies in the system, the effectiveness of practice change, collaboration or other chronic care interventions (e.g., self-management programs) is not clear (Renders et al., 2009; Ouwens, Wollersheim, Hermens, Hulscher, & Grol, 2005).

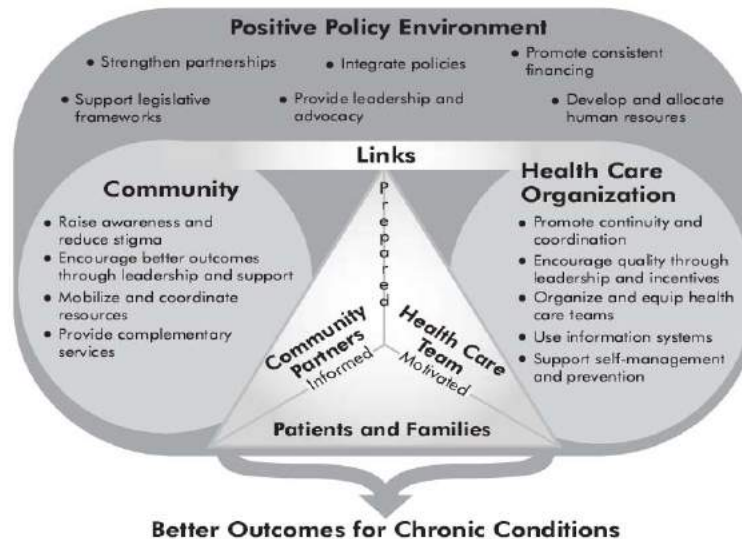


FIGURE 1.3 ICCC FRAMEWORK

By 2011, health reform measures had not significantly improved the health of the population or the efficiency of healthcare services (Wise & Nutbeam, 2011). Some critics argued health promotion and primary healthcare programs were still ineffective because healthcare delivery models informed by the principles of primary healthcare (WHO, 1978) were not being implemented in a systematic manner. Other opponents maintained the systematic, standardized approach to chronic care delivery and chronic illness prevention fails to take into account local, contextual differences and contingencies at the program level (Greenhalgh, 2009). Some believed the approach was adopted prematurely, before sufficient evidence was available to support practice change.

For example, the Health Council of Canada (2007) recommended the implementation of a successful chronic illness prevention model that, “*After 12 years of sustained effort...[had] put the brakes to the persistent increase in new cases of diabetes in a First Nations community*” (pp. 8). However, this recommendation was made after earlier publications reported the initiative was not entirely successful. The program was endorsed as providing the basis for widespread change

to treat and prevent chronic illnesses initially improved the diabetes profile of the community. However, improvements were not sustainable over the long-term (Potvin, Cargo, McComber, Delormier, & Macaulay, 2003; Paradis et al., 2005).

The Health Council of Canada's most recent publication, 'Progress Report 2013: Healthcare renewal in Canada' (Health Council of Canada, 2013) reveals that Canada is still not becoming healthier as a nation. Some segments of the population (i.e. rural and aboriginal communities) still do not have sufficient access to primary healthcare providers and there is too much context-specific variability in healthcare settings to endorse a one-size-fits-all group-based approach. In short, \$6100.00 per person may still not be sufficient to ensure that each and every Canadian citizen will become healthy enough to achieve and sustain "*socially and economically productive lives*" (WHO, 2006, pp. 2) "*maintain as normal a place as possible in the community*" (WHO, 1985, pp. 15).

Reorienting the Health Reform Gaze

There have been several positive steps to improving the efficiency and effectiveness of the Canadian healthcare system. For example, provincial governments are working towards reducing the cost of brand name pharmaceuticals and increasing the use of generic medications, 23% more physicians are using electronic medical records and scheduling systems and funding has been put into place to increase service integration and collaboration (Health Council of Canada, 2013). Are these measures sufficient to offset the \$21.6 billion dollars in direct and indirect costs associated with long- and short-term disability that have contributed the current \$6100.00 per capita cost of healthcare?

Healthcare reform efforts have historically focused on re-orienting the system rather than re-orienting the healthcare reform gaze. A physician-led approach to primary healthcare, healthcare reform and team practices driven by the principle of primary healthcare set out in the declaration of Alma-Ata have also constrained healthcare transformation and failed to improve the health of this country. According to the Health Council of Canada (2013), the current approach to healthcare reform has not fully fixed the ongoing weakness and inefficiencies in the system. The Council speculates that health has not improved because of excessive program-level variability and the challenges associated with evaluating disparate healthcare teams and delivery

models. If we cannot define or evaluate teams or reframe the chronic care service delivery model as something other than a collaborative medical-population health approach, chronic healthcare programs may remain ineffective at the level of the individual?

I propose that the reason chronic care programs have not been able to reduce the burden of chronic illness on the acute care sector, primary healthcare system and the Canadian economy is because there are no tangible exemplars available to help providers create the social (i.e. organizational) conditions or client-provider relationships to successfully engage or active the patient. It appears as though the healthcare reform gaze sees through an ecological lens at the level of the system. However, there is an inconsistent understanding of the importance of an ecological (i.e. big picture) understanding of how the complex, interactive nature of health determinants impact an individual's multi-level multidimensional life and health circumstances. Healthcare research and provider practices continue to focus on pathology and medical treatment rather than individual and family health capacity building and self-reliance.

The population health promotion (i.e. determinants of health) gaze glances into the client's life and health circumstances but targets interventions at the community-level. Meso-level interventions aimed at improving the general health of a community fail to take into account the uniquely situated health challenges facing individual community members. Group-based approaches (i.e. exo-level) are similarly oriented to the shared health challenges of a specific high-risk patient population. This gap in healthcare services may simply not assist individuals to free themselves from their reliance on the healthcare system and family members.

According to Engeström and Miettinen (1999) and LaLonde (1974) individuals, families and communities, roles and relationships, health, illness and recovery exist and are (re)constituted in the context of dynamic, evolving social relationships structures and circumstances that shape, and are shaped, by the interactions of the participants. Fairclough (2005) also suggests organizational effects (e.g., patient outcomes) are produced through a complex interplay of communication (language), social interactions and organizational structures (team structures). Therefore, it may be possible to provide a richer understanding of a healthcare team's role in the recovery and capacity building process by studying the dialogue, interactions and processes through which a multiple disciplinary healthcare approach is enacted.

Scholars such as Schwamm et al (2005) also suggest that a transdisciplinary, rather than multi- or interdisciplinary, teams have the best potential to address complex, multi-dimensional health issues more efficiently and efficiently. From a transdisciplinary perspective, the knowledge and understandings that patients and family members contribute to a comprehensive understanding of their unique circumstances and therapy effectiveness in the real world is otherwise inaccessible to members of the health care team unless they are invited onto the team as equally contributing members.

I suggest that the impact any multiple disciplinary team has on healthcare costs, physical outcomes, health and well-being and self-reliance is, and will remain, speculative until the discourse and dynamics of the client-provider and healthcare team interactions become the object of inquiry for each and every type of healthcare team.

Purpose of the study

This study is not designed to compare the efficiency or effectiveness of multidisciplinary, interdisciplinary and transdisciplinary team practice in chronic care. Instead, this comprehensive two-year case study is to uncover the mechanisms through which one type of team, a transdisciplinary neurorehabilitation team, operationalizes the population health goal of increasing personal and family independence and health capacity.

Significance of the Research

This project will be the first of its kind to use a case-study approach to instigate the nuances of a radically different approach to community-based chronic care; transdisciplinary neurorehabilitation. Conceptualizing the healthcare organization as a complex adaptive system (i.e. the context of healthcare), will allow me to study the day-to-day work and social interactions within a specific, socially constructed transdisciplinary language (Gegan, 1999/2009: Kegan & Lahey, 2003). By studying language, practices and social interactions, this study may uncover the mechanisms through which a transdisciplinary team works to increase the capacity of an individual and his/her family to manage their evolving health issues on a day-to-day basis, in the context of the clients own personal circumstances, foster independence, enable reintegration into the community and workforce and reduce reliance on the health care system. . Therefore, the results of this study may finally reveal how client-provider relationships enhance client

engagement and activate the patient and expanding the definition capacity-building to include interventions and professional relationships at the level of the individual and family.

Introduction to the Chapters

Chapter two is a critical review of the existing literature. I provide an overview of societal discourses in general and a critique of how prevailing biomedical discourses constrain opportunities to transform the existing chronic care services delivery model specifically. I discuss discourses of transdisciplinarity, empowerment, salutogenesis and individual and family-level capacity building as discourses and practices that could constitute a different version of social reality and a new health services delivery model for community-based chronic care.

Chapter three outlines the study methodology and ethical considerations for this case study including data collection strategies and analytic approach. This chapter provides a detailed description of the analytic method I used to uncover an alternative discourse of healthcare that challenges the existing biomedical approach to neurorehabilitation.

Chapters four provides an analytical overview of how participants portray the traditional model of neurorehabilitation. The emerging repertoires reveal how the discourse of medicine orients providers to practices that privilege the biomedical gaze and exclude a population health and ecological perspective of health and recovery. Participant's less-than-favorable depiction of former colleagues, administrators and the work environment set the stage for a nuanced and inspiring description of an alternative model of healthcare.

Chapter five provides a historical overview of how the transdisciplinary team was first envisioned and created over 30 years ago. As participants, including founding members of the team, describe how and why the team and organization was created, they continue to compare and contrast their new world with the old. In doing so, the emerging discourse of transdisciplinary 'thinking', 'doing' and 'being' come into view against the backdrop of the biomedical model. I have created pictorial diagrams of the traditional and transdisciplinary practice models throughout chapters four and five. Visual images in chapter five are particularly useful to understanding the linkages between the ontological and epistemological tenants of transdisciplinary philosophy, ecology theory, the population health (DOH) perspective and transdisciplinary team practice.

Chapter six introduces the emerging discourse of present-day transdisciplinary team leadership. This chapter traces the evolution of the Clinic's leadership team and the transformation of a once hierarchical structure to an organization grounded in equality, collectivism and empowerment. The transdisciplinary practice model is update to reflect the team's new and highly efficient organizational structure.

Chapter seven presents the emerging discourse of transdisciplinary team membership. The team contrasts the traditional work environment and professional relationships with a social environment grounded in a shared ethos of humility, personal and professional regard, social support and reciprocity. They portray themselves as a team united by a desire to serve the greater good: A goal that can only be accomplished by the creation and preservation of social harmony.

Chapter eight illuminates the discourse of transdisciplinary therapy. As in the previous chapter, this section provides a detailed description of 'what' is being accomplished in the context of interpersonal relationships (e.g. professional intimacy) as well as the in depth details of 'how' these relationships unfold. Participants also describe how their client-centered, context-embedded capacity building practices promote an orientation towards health, well-being and independence. Client and family engagement are also portrayed as an essential component of organizational efficiency and therapeutic effectiveness.

Chapter nine introduces the emerging discourse of the transdisciplinary physician. This chapter highlights the personal qualities needed for physicians to become successfully integrated into the transdisciplinary team. Physicians who resist the traditional knowledge/power hierarchies have been able to co-create a de facto governance model that promotes disciplinary equality, liberates professional practices, enhances knowledge generation, promotes innovation and improves organizational efficiency. A phenomenon I call 'transdisciplinary blindness' describes how the more powerful biomedical discourse can completely eclipse a transdisciplinary physicians clinical and administrative gaze, reorienting them to a purely biomedical approach. The challenges facing novel community-based facilities during regionalization and healthcare reform are also highlighted.

Chapter 10 summarizes the key findings of the case study and engages a salutogenic reading of the transdisciplinary team's therapeutic relationships and capacity building practices.

Finally, Chapter 11 reviews my own personal reflections, theoretical and methodological conclusions and implications for future research, practice and scholarship.

Chapter 2

Critical Review of the Literature

This chapter represents a comprehensive and critical review of the chronic illness service delivery literature. I begin with an overview of the dominant biomedical discourse. The review of this literature includes examples how this discourse has the power to shape and sustain a traditional medicalized approach to healthcare research, reform and provider practices. I then introduce discourses of empowerment, salutogenesis and transdisciplinary philosophy as alternatives to a biomedical approach. Finally, I provide an overview of healthcare team research in the chronic illness and recovery literature and highlight the challenges associated with defining and evaluating the effectiveness of transdisciplinary team practice.

The Power of the Biomedical Discourse

Broader societal discourse (e.g. feminism, racism and medicine) are more than just the words, phrases, similes and metaphors we cobble together to speak. They are commonly understood, taken-for-granted ways of 'being', thinking and 'doing' in our society and the world. They orient us to certain modes of dress, conduct, values and beliefs. They can call on us to assume positions of power commensurate with our knowledge, power and/or status in society. For example, a physician in a traditional hospital setting might invoke the formal discourse of medicine (e.g. language, tasks and attire) to assume a position of power over the patient's health and decision-making. A patient aligned with the discourse of medicine may take up the traditional patient role without a second thought. Alternatively, persons who resist the traditional role of patient might seek out healthcare providers willing to negotiate a more balanced power relationship.

Professional identities and practice are also reconstituted within the social and disciplinary contexts in which occur. Within disciplines and the organizations where healthcare providers work, *“discourse functions to structure systems [of practice]...such that certain conceptions of reality are organized into everyday practices, while other[s]..are organized out”* (pp. 34). Discourses are vehicles through which a discipline conceptualizes and legitimizes practices, determines what counts as knowledge and defines, constrains and protects disciplinary boundaries (Mumby & Stohl, 1991).

The discourse of medicine orients traditional healthcare providers and researchers to a relatively stable set of ontological and epistemological perspectives. What is the nature of reality? Are there single or multiple realities? How can reality be known? What problems can be solved and by whom? What pieces of the puzzle will be excluded in the solving? What commonly held assumptions can be contested? The discourse of medicine and the agents of power that govern over the rules and conventions scientific inquiry are the powers that sustain a prevailing version of socially acceptable reality and practices.

Greenhalgh (2009) suggests the challenges facing chronic illness management and prevention programs are related to the application of the biomedical approach regardless of the theoretical model or framework used to guide transformation. The delivery of chronic care services may be conceptualized as occurring within a complex interactive system (i.e., ecological model) (Epping-Jordan et al., 2004), but the gaze remains focused on disease pathology. However, there may be more profound issues with the biomedical approach than merely its focus on illness and standardize approach to treatment.

For social constructionists, the biomedical model is viewed as a regulatory regime in which disciplinary knowledge and power structures design and maintain healthcare practice and processes according to historically entrenched traditions (Usher & Edwards, 2011). Medicalized/medicalizing discourses with the power to delineate disciplinary boundaries, knowledge and scope of practice can restrict the clinical or health-promoting gaze and constrain possibilities to develop new or even unconventional interventions. *Alternative perspectives “go unheeded or are bludgeoned because they are critical”* (Gergen, 2001, pp. 57).

According to Gergen (Gergen, 2001), authoritative professional discourses function paramorphically. In other words, the healthcare system may appear to be undergoing a process of metamorphosis as healthcare delivery models evolve and healthcare teams claim new identities such as multi-, inter- or transdisciplinary. However, the day-to-day conduct of the healthcare providers themselves does not substantially change. Patients, family members and other members of the healthcare team are invited to participate, but their voices “*co-exist in relative isolation*” (pp. 126) alongside the reified medical discourse. Decision-making, choice, creativity and adaptation are limited by the inflexibility of best practice guidelines and the

rigidity of chronic care programs, processes (Kernick, 2002). This is inherently problematic if the evolving and expanding model for chronic illness simply reflects a more detailed but well-disguised version of the medical model. Reshuffling existing health services will not transform healthcare if the revised version of the ideal(ized) practice model is still driven by a self-limiting paradigm.

Theoretical frameworks.

According to Merriam (1998) theories derived from a particular body of literature are representative of disciplinary orientation. Theoretical frameworks are discourses and provide insights into how disciplines conceptualize and frame problems that inform research and practice. They are a disciplinary research tools for explaining and predicting, but are best used to guide theory-based interventions rather than constrain practice and opportunities for innovation. Healthcare providers ought not be constrained by the limitations of the imposed on them by theoretical maps any more than the discourses that shape their world view (Ceruti, 1987). Models and frameworks are portions of a much larger and evolving representations of a client's psychological and psychosocial well-being. They provide a practical tool for research and practice but are, in-and-of-themselves, an incomplete perspective of health, illness and recovery (Devins, 1994). The degree to which any given framework facilitates or constrains provider practice is related to a myriad of factors, including the broader paradigmatic (philosophical) perspective providers and their respective disciplines bring to research endeavors or to patient encounters.

Chronic illness and rehabilitation research.

The power of the medical discourse can also sustain the focus of chronic illness and rehabilitation research on symptom management, restoration of physical capacity and group-based health promotion and prevention programs (Blumenthal, 1994; Borneman et al., 2008; Catanzaro, 1993; Doolittle, 1992; Duncan, Min Lai, & Keighley, 2000; Schover & McKee, Jr., 2000; WHO, 1985). According to Marvin Moser (2002), research focused on physical outcome was, at one time, helping healthcare to make headway in some areas. For example, the pattern of hypertension had improved, patients were being treated earlier, physician education programs were effective and 90% of systolic and diastolic blood pressures had, on average, been reduced

to goal levels established by the American Heart Association. However, national surveys also reported that almost 65% of hypertensive patients were not being treated effectively (unreferenced). Dr. Moser is unsure if such abysmal results were associated with “*physician lack of interest, lack of time, ...lack of appreciation of the importance of SPB and risk...or lack of patient adherence...[and] knowledge*” (pp. 26). Regardless, he advocated for improved physician education, lowering overall expectations for improvement, and increasing availability of patient education materials.

Dr. Moser is not alone in his conundrum. The healthcare research literature is replete with examples of quantitative research with uninterpretable results, statistically significant or otherwise. For example, Wyer et al (2001) conducted a randomized control trial (n=87) to evaluate the effectiveness of a theoretically-based letter of invitation on attendance in cardiac rehabilitation. Letters contained statements intended to influence attitudes towards behaviour, subjective norms and perceived control over one’s disease. Patients in the intervention group were more likely attend the rehabilitation program (p value =0.04) and to attend for the entire 6-week duration (p value=0.04). However, the authors were unable to provide substantive rationale for the increased attendance (Jeng & Braun, 1997; Redeker, 1988; Redeker, 1988).

Researchers interested in the relationship between structured programs and chronic illness outcomes have focused on the impact of theoretical constructs such as health literacy and knowledge (Linde & Janz, 1979; Raleigh & Odtohan, 1987; Warsi, Wang, LaValley, Avorn, & Solomon, 2004), self-efficacy (Carroll, Rankin, & Cooper, 2007; Gortner & Jenkins, 1990; Millen & Bray, 2009; Reo & Mercer, 2004; Weeks et al., 2002), illness beliefs (Blanchard et al., 2003; French, Cooper, & Weinman, 2006) and social support (Allison & Keller, 2000; Hellman, 1997; Luszczynska & Cieslak, 2009). Devins (1994) suggests quantitative research over-emphasizes distal outcomes (i.e., compliance), circumventing understandings of more fundamental psychosocial issues that influence the recovery process in chronic illness.

Overall, these studies have contradictory results or small to moderate effect sizes (i.e., magnitude of differences is not clinically relevant). Theory-based interventions to improve patient outcomes are often multi-faceted in nature and the mechanisms through which any given aspect succeeds or fails is generally speculative (Luszczynska, 2006; Millen & Bray, 2009;

Mhurchu, Margetts, & Speller, 1997; Wyer et al., 2001). Quantitative research approaches to predict or improve compliance and program attendance or to test novel interventions continue to dominate this field of research in spite of their limited success.

Patient Care.

In the context of provider-patient interactions, a purely biomedical approach may sustain a view of the client's reality as *"motionless, static, compartmentalized and predictable"* (Friere, 1972, pp. 57). Clients may not find well-intended conventional wisdom and prescribed standardized interventions understandable, meaningful, manageable or applicable to his or her uniquely situated life circumstances. The subjective experience of the client and family and context-related aspects of illness and recovery may be discounted (Antonovsky, 1979) if *"nothing is beyond the dichotomy of sick/well, disability, handicap [and] treatment"* (pp. 44). Patient's may be labelled non-compliant (Harris, Ekoq, Zdanowicz, & Webster-Bogaert, 2005; Paterson, Charlton, & Richard, 2010) even if they do not have the capacity or resources to adhere to treatment plans and/or behavioural modification programs prescribed by the medical expert (Greenhalgh, 2009).

Rather than participating in a dialogue of health, illness and recovery that facilitates meaning construction, the client's voice may be subjugated to the medical monologue (Gergen, 2001; McNamee & Gergen, 1992), *"obliterating identity and..invit[ing]..lethargy"* (Gergen, 2001, pp. 126). Gergen suggest a standardized, group-based or medicalized approach to health education and or chronic illness management may actually undermine efforts to actively engage clients in treatment and recovery decision-making.

Providers who approach clinical practice from a primarily positivist empiricist perspective may also advocate interventions based solely on objective findings (i.e., physical outcomes, questionnaires) guided by sound empirical research (Bryman, Teevan, & Bell, 2009; Pilkington & Bournes, 2005). Critics of a purely reductionist approach (i.e., positivism-in-practice) contend the application of quantitative findings without a deeper understanding of locally situated social processes and multiple mediating contingencies cannot explain or predict individual behaviours (Nash, 2003). Conversely, providers whose practice is primarily informed by the interpretivist paradigm might only focus on the understandings and meanings patients and

family members ascribe to their health, illness and recovery experiences (Bryman et al., 2009). Constructionism-in-practice may not have the tools to corroborate subject information with measurable outcomes.

An alternative to working within a particular paradigmatic camp is a hybrid approach. Providers incorporate elements of both the objectivist and interpretivist stance. For example, developers of the patient-centered perspective (Stewart et al., 1985) advocate for a blended approach to invites the patient and family members into the clinical encounter as active participants in knowledge generation and care planning. Interventions are still informed by objective findings but are foregrounded or back-grounded as circumstances warrant.

Client-Centeredness.

The discourse of client-centeredness health arose in the 1970s. Client-centeredness is an orientation to care grounded in patient empowerment, power-sharing, and a holistic (mind-body) approach (Stewart et al., 1985). The patient-provider interaction provides a space to co-create shared understandings about contextual issues surrounding the client's health, illness and recovery. Management plans are the result of an integrated, shared understanding of the client's health-related issues. An objective, biomedical focus in the patient-provider relationship is considered insensitive and incompatible with a holist approach. A blending of objectivity and subjective understandings is suggested (Stewart et al., 1985).

However, the definition and operationalization of a patient-centered approach remains highly contested. These same authors later claim the healthcare community misunderstood their previous publication. Client-centeredness does not mean providers share **all** information or decisions with the patient (Stewart, 2001). This revised view suggests the degree to which decision-making is shared should be guided by the patient but ultimately determined by the healthcare provider, as evidenced in the use of the term "*responding appropriately*" (pp. 455) in the medical best interests of the client. Healthcare providers still retain the power when and if to fully disclose their own bigger picture understandings and subjugate client's and family's treatment decisions when deemed necessary.

Still, Stewart et al. (1985) and other more recent authors still underscore the importance of the provider's in-depth contextual understanding of health, illness and recovery. They stress

the importance of including family perspectives to better understand the multifaceted and multidimensional factors impacting health and well-being. Family member reaction to illness can influence multiple factors that orient clients towards health, independence and personal feelings of well-being (Wishnie, Hackett, & Cassem, 1971). Alternative perspectives can add valuable insights for providers, patients and family members alike in terms of the patient's health and recovery, family dynamics, stressors, strengths and coping strategies. Additional information may assist providers to recommend appropriate institutional and community-based recovery resources (Stewart et al., 1985).

In-an-of-itself, a client-centered approach to care does not dictate the use of a particular theoretical framework or paradigmatic stance. The degree to which a provider invites the patient and family members to be involved in intervention planning and decision-making may be differentially influenced by a number of factors including disciplinary training and affiliation with a multiple disciplinary team.

Alternative Discourses in Recovery

Febrega and Manning (1972) contend that the traditional biomedical approach to rehabilitation and research positions the process of reconstructing one's own reality, sense of self, and life circumstances within the realm of external, quantifiable forces (e.g., theory-based instruction manuals and rehabilitation teams). As a result, this paradigm may confer and maintain responsibility and accountability for health and recovery in the medical domain. Provider-driven solutions located within a medical discourse are underpinned by a model of universal truths that privileges provider understandings and decontextualizes treatment choices (Fruggeri, 1992). Client understandings and possibilities for action become constricted as does the belief in their capacity for choice and self-determination. Clients and families are “...indirectly..furnish[ed with] a lesson in inferiority,..[as though] incapable of comprehending reality” (McNamee & Gergen, 1992, pp. 171)

To determine if there is alternative, more inclusive way of conceptualizing recovery outside of the dominant medical discourse in chronic illness, a review of the mental health literature was undertaken. In the early 1970s, the psychiatric patients' liberation movement played a pivotal role in changing the way in which the mentally ill were treated by society and

while institutionalized (Chamberlin, 1990). Since the 1920s, psychiatric patients have been denied basic human rights, discriminated against and stigmatized. Their subsequent uprising not only gave voice to their experiences, but provided valuable insights about how best to facilitate recovery. Individuals and healthcare teams who provide support and understanding and who foster hope, self-determination and self-actualization are now seen as essential elements of care (Frese & Walker Davis, 1997). The psychiatric consumer movement also shifted the way in which recovery is framed within the psychiatric and mental health communities. *“Recovery is best understood as a process, not an outcome”* (pp. 244).

The mental health literature is replete with theories of recovery in which empowerment is central to the development of independence, confidence and a sense of personal control (Bury, 1982; Fisher, 1994). Researchers have demonstrated that empowerment is not conferred directly by rehabilitation professionals. Rather, empowerment is attained through a largely self-directed process of discovering a more active self (Davidson & Strauss, 1992). Clients take control over their own circumstances, develop coping strategies and mobilize resources.

For example, in a qualitative study to explore the construct of empowerment, Young & Ensing (1999) interviewed 18 participants, all of whom were diagnosed with a severe psychiatric illness but were living independently in the community. The authors report that the concept of empowerment is two-fold for participants. An attitude of self-assurance, persistence and determination is coupled with participants taking control of activities to cope with and manage their life challenges and circumstances. An empowerment approach enhances the capacity of clients to redefine themselves and to draw on their inner strengths and resources. A discourse of resilience and hardiness has also emerged more recently in the stress management and psychology literature (Lindström & Eriksson, 2011).

The depiction of chronic illness, rehabilitation and recovery in the mental health literature is in stark contrast to that of cardiac, stroke, and musculoskeletal rehabilitation and cancer care. For example, Deegan (1988) claims that recovery is *“the real life experience of people as they accept and overcome the challenges of the[ir] disability”* (pp. 54). This is a clearly distinct unit of inquiry that is both deeply personal and highly contextual, but not addressed by many

theoretical frameworks used in a biomedical approach to chronic illness recovery research to date.

Health teams and patient empowerment.

Client empowerment is “*the investment, endowment, or enabling of [clients] ...with the authority and strength to effect health-related decisions, behaviours, and interventions*” (Stewart, 1990, pp. 1143). While there is an expansive literature on power sharing and empowerment in areas such as mental health, education, addictions etc., research focusing on empowerment of patients and families in the context of a transdisciplinary health team could not be located.

Ochocka, Nelson and Janzen (2005) conducted an extensive review of the patient empowerment literature. They report that studies on empowerment of patients and families tend to focus on barriers to patient-provider collaboration or potential benefits of client empowerment strategies, as opposed to the processes through which power sharing occurs. This literature is also replete with descriptions of healthcare provider roles purported to empower clients such as counsellor, facilitator, resource marshal and enabler (Gibson, 1991; Hildingh, Fridlund, & Segesten, 1995). However, processes through which these roles result in empowerment remains speculative unless the dynamics of the client-provider interaction is the object of inquiry.

For example, Paterson, Charlton and Richard (2010) used a grounded-theory approach to understand how providers worked to empower clients to self-manage Type 1 diabetes. Thirteen of the 22 clients interviewed stated that “*empowerment is a great buzz word that is really hard to actually do*” (pp. 577). Some practitioners who claimed to engage in collaborative partnerships overtly discounted the experiential knowledge of clients, appeared skeptical of client understandings or become angered by the client’s attempt to present an informed perspective. Clients also thought that practitioners used a number of tactics that, ultimately, excluded them from final decision-making in their care. For example, some providers quizzed clients on their knowledge of diabetes and the pharmacokinetics of insulin until they were able to elicit an incorrect answer. This maneuver was interpreted as a purposeful act to reestablish authority in the decision-making process. The authors contend that there may be cause for concern if the

way in which health practitioners talk about empowerment (i.e., the empowerment discourse) is actually “*empty rhetoric*” (pp. 579).

Similarly, Curtis and Harrison (2001) sought to understand the psychological effects of healthcare provider discourse by examining the dialogue and interactions between clients and healthcare professionals in a drug and alcohol rehabilitation facility. In that study, professionals from varying disciplinary backgrounds categorized clients (i.e., good, bad and drunks), withheld pertinent information to their recovery and betrayed client trust and confidence when workplace conduct came into question. The authors report that the way in which health providers talked about and interacted with clients and other staff members marginalizes and disempowers clients. Their analytic method was also able to facilitate an understanding of how these interactions may have jeopardized the health, well-being and recovery of patients by undermining their self-esteem.

By focusing on the ways in which health, illness, recovery and personal identities are represented through talk (i.e., discourse) and enacted by healthcare providers in practice settings, Paterson et al. (2010) were able to articulated the mechanisms through which social identities, power relationships and health issues were (re)constructed in the context of client-provider relationships. Both of these studies uncovered the ways in which client-provider interactions can thwart a client’s perceived capacity to self-manage chronic illness or undermine beliefs that their health and recovery is meaningful and worthy of pursuit. By studying the ways in which client-provider relationships are talked about, understood and enacted (i.e., discursive strategies), it may be feasible to determine if power is actively conferred to clients (Spreitzer & Doneson, 2005) by a transdisciplinary team or if power sharing and empowerment evolves through a more self-directed process (Davidson & Strauss, 1992; Young & Ensing, 1999).

In the health promotion literature, the concepts of capacity and capacity-building are linked to community development and community empowerment initiatives. For instance, in the Ottawa Charter for Health Promotion (1986), capacity building is associated with the key strategy of ‘strengthening community action’. Labonte & Laverack (2001) operationalize capacity building as efforts directed towards improving a “*community group’s abilities to define, assess, analyze and act on...concerns of importance to their members*” (pp. 115). This

definition also includes supportive measures that enhance the ability of health professionals to sustain community group efforts and bolstering the capabilities of health or government organizations to support health professionals or community groups directly. From a health promotion perspective, capacity building is a complex, multi-level construct essential for sustainable, people-centered community development.

However, the Oxford Committee for Famine Relief (OXFAM) extends the concept of capacity building to include the idea that “*all people have the right to...[be the] authors of their own development*” (Eade, 1997, pp. 2) to determine their own values, envision their own future, prioritize their needs and be supported in meeting those requirements. Implicit in this interpretation of capacity building is the notion that efforts ought not be limited to community level interventions; rather, while an understanding of the social context remains germane, strengthening the capacity of individuals and families so that they are better positioned to “*shape the forces that affect their [own] lives*” (pp. 3) is also introduced. Social contexts and circumstances not only shape the experience of an individual, family or community, but are also shaped by the social practices of the participants themselves. Individuals and/or groups and their social contexts are mutually constitutive.

Salutogenesis: A constructionist approach to rehabilitation.

Antonovsky (1979; 1987) proposed that the way in which individuals, families and communities view their life circumstances impacts their ability to manage challenges and stressors. He coined the term ‘salutogenesis’ (that which gives birth to health) in 1979 during his quest to better understand why it was that some individuals could remain healthy while others became ill when faced with similar circumstances. Antonovsky was not convinced that an illness-focused, secondary prevention approach to chronic illness would help clients attain or sustain an orientation toward health and recovery. The biomedical approach focuses on risk factor modification. A salutogenic approach compels providers to remain squarely focused on the myriad of factors (i.e. health determinants) that help different people to manage and cope.

Antonovsky calls factors that promote well-being and maintain health ‘generalized resistance resources’ (GRRs). The breadth of potential GRRs available to each individual allows providers the freedom to engage with clients as uniquely situated individuals using an all-

encompassing approach to holism. Antonovsky's approach is consistent with WHO's (1985) recommendations for an individualized approach to rehabilitation. The model is also aligned with a population health approach to health promotion at the level of the individual and family as well as the community and policy levels. A salutogenic approach frees providers from the limited gaze of traditional frameworks to explore all of the social determinants of health (DOH) (Antonovsky, 1987).

Antonovsky proposes that the way to determine how health is attained and maintained is by understanding how an individual, family or group engages coping resources (GRRs) to make sense of and manage life events. Over time, the successful implementation of GRRs during times of stress may result in an overall sense of confidence in one's ability to "*cop[e] with the innumerable, complex stressors confronting [them] in the course of living*" (Antonovsky, 1993, pp. 725), a construct which Antonovsky refers to as 'sense of coherence' (SOC) (Antonovsky, 1979; Antonovsky, 1987). One's sense of coherence includes feelings that one's life and life challenges are:

- (1) Comprehensible – stimulus from the internal and external environment are ordered, expected, and understandable. One can cognitively make sense of the situation and plausible implications.
- (2) Manageable - the resources needed to cope with circumstances are readily accessible to meet needs/requirements or they are attainable.
- (3) Meaningful – having a sense that life is worthwhile. Situational demands viewed as being credible and provide the motivation to engage resources to overcome life's challenges (Antonovsky, 1987).

SOC as a health promoting resource, may result in the successful maintenance of personal balance and a strengthened sense of resilience in the context of stressful events and complex and challenging life circumstances. Antonovsky's SOC theory embraces many of the constructs implicit in the mental health literature (e.g., self-determination) and transdisciplinary philosophy. It takes into consideration the interplay between a wide array of factors that influence a client's day-to-day life circumstances.

Antonovsky (1979) calls for shared decision-making, client advocacy and negotiation of goals, interventions and engagement of GRRs. Clients and families are supported throughout therapy but the ultimate goal is to foster independence once an attitude towards health is consistently maintained. He envisions salutogenesis-based practice as involving relationships and practices oriented towards client and family capacity building. However, he does not elaborate on *how* this might be fully accomplished in the context of the provider-client-family relationship. Further, Antonovsky's writings hint at but do not fully invoke an alternative discourse with which to re-orient healthcare providers to an ecological, salutogenic and/or population health approach. However, the discourse of transdisciplinary philosophy offers up a way a tangible way forward.

Transdisciplinary philosophy.

The emerging idea for transdisciplinarity team practice first appeared in the writings of Jean Piaget, a Swiss philosopher and psychologist (Nicolescu, 2007). Piaget envisioned multiple disciplinary healthcare teams might one day adopt the collaborative and reciprocal approach to knowledge generation used by the academic research community. Transdisciplinarity requires an organizational approach that relaxes traditionally-defined disciplinary roles and delineated knowledge boundaries. Piaget also recognized transdisciplinary practice requires healthcare systems to cease the continuous cycling of healthcare reform. This can only be accomplished if the system can reach an undefined but essential threshold of stability (Piaget, 1972). Piaget's vision hinted at guideposts for the development of transdisciplinary-friendly organizations but did not provide any further direction.

Basarab Nicolescu is one of the most prolific writers in the field of transdisciplinary philosophy. He champions Piaget's vision for transdisciplinary practice in healthcare. However, his publications do not provide a detailed description about how to build a transdisciplinary organization or create transdisciplinary practice interventions either. Instead, Nicolescu focuses on the differences between classical logic (i.e. 'A' is not 'non-A') and transdisciplinarity from a philosophical perspective.

To fully comprehend transdisciplinary philosophy, it is essential to first understand how Nicolescu differentiates between the 'real' and 'reality'. Real things are tangible and

measurable. The realness of an object can be reduced to the molecular levels into which a person can gaze and understand (i.e. subjective objectivity). On the other hand, reality cannot be drawn, measured or touched. It is an ethereal construct that goes beyond what we collectively construct and agree to as the essential 'isness' of the complex world in which we all live. The real and reality co-exist in the same time and space. However, reality can only be understood to the point where complexity defies the objective description of our social world (i.e. objective subjectivity).

The outside world (i.e. the real) is the transdisciplinary object. Individual or shared (i.e. inner world) perceptions of the client's reality represent the transdisciplinary subject. A hidden but essential third term, the transdisciplinary subject-object, signifies the interaction between perceptions of reality and the tangible aspects of the outside world. The transdisciplinary subject-object is an inextricably fused continuously evolving entity constituted by individual and collective perceptions of a client's interaction within their uniquely situated life circumstances (i.e. meta-system). The interaction term brings the subject and object together as a single entity but still allows teams to see the distinctions between the two (Nicolescu, 2012).

Bronfenbrenner's (1977) Ecological Model (see Figure 2.1) provides an ideal theoretical framework to understand the nature of a transdisciplinary subject-object. The theoretical underpinnings of the model reflect the mutually constitutive nature of interdependent relationships at each level of the client's reality. The multi-dimensional (i.e., vertical and horizontal) aspects of the complex life circumstances (i.e. meta-system) are symbolized by concentric circles representing the micro, meso, exo and macro-levels of the meta-system. Bronfenbrenner's framework invites us to substitute the traditional medical paradigm of disjunction, reduction and unidimensionality for one of unification. This different way of conceptualizing the relationship between the subject and object allows healthcare teams to "*distinguish without disjoining [and] associate without reducing*" (Morin, 2008, pp. 6). In other words, a healthcare team does not need to isolate the client from the context of his or her personal life realm to understand either. In fact, a transdisciplinary team can simultaneously consider the client in the context of multiple interdependent yet disconnected life realms (i.e. life, family, work and community). Knowledge generation and understandings are enhanced when the team can consider the client as an actively engaged participant in the bigger picture.

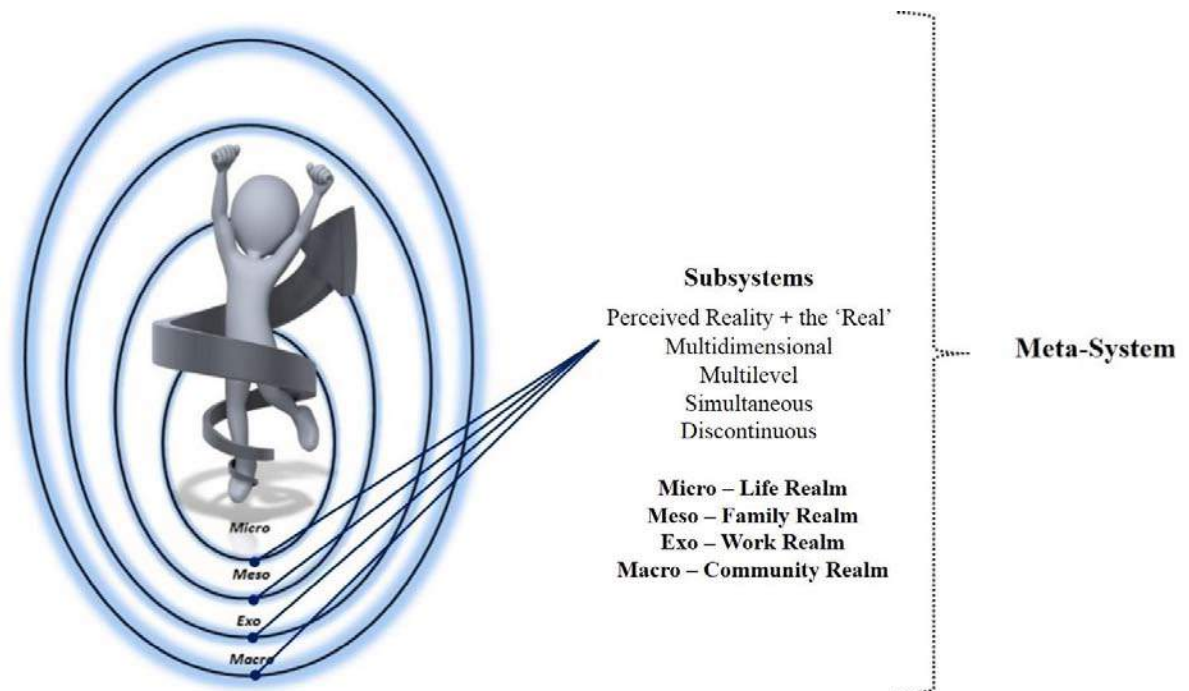


FIGURE 2.1. TRANSDISCIPLINARY SUBJECT-OBJECT (Adapted from Bronfenbrenner, 1977)

The transdisciplinary subject-object comes into view when the downward looking medical gaze harmonizes with the multi-directional, multi-dimensional health promoting gaze from below (i.e. a determinants of health perspective). Unique perspectives and understandings of team members, clients and families are blended together when they engage in collaborative dialogue. This allows team members who function from purely reductionist or constructionist paradigms to see and understand each other and the client from a hybrid paradigmatic approach. A blended approach uses classical logic (i.e. 'A' is not 'non-A': 'This' is not 'That') to understand simple questions and transdisciplinary logic to understand complexity. Together, the team can see the elemental parts as part of an infinitely complex integrated whole.

Transdisciplinary knowledge creation and practice appears to be relatively simple. However, some traditionally trained healthcare providers might resist the temptation to transcend disciplinary knowledge/practice boundaries without a more thorough description of the three axioms of transdisciplinarity philosophy and their application to healthcare practices.]

Three Axioms of Transdisciplinary Philosophy.

Ontological axiom: multiple levels of reality.

Transdisciplinary teams conceptualize a client's meta-system as a series of overlapping and interconnected sub-systems. Multiple sub-systems simultaneously co-exist on an infinite number of planes but are discontinuous. The 'real' and perceived realities continuously interact with adjacent dimensions but are still distinctly separate entities. For example, if you try to picture the differences between home life and work life, you might be able to appreciate the nature of the disconnection between the two. Different rules apply when we step into and out of different life realms.

Irrespective of perceived and real discontinuities, the existence and evolution of any one level of a client's reality (i.e. subsystem) is based on a relationship of interdependence with all others. The evolutionary nature of our day-to-day reality reflects the interactive and interdependent nature between objective and subjective reality (Nicolescu, 2011). Realities are always already self-generating and recursive across, between and beyond each plane of existence (Nicolescu, 2008).

Logical axiom: the logic of the included middle.

The logic of the included middle is an essential component of transdisciplinary thinking and provides a theoretical foundation for the integration of disciplinary knowledge and multiple levels of reality in a simple but coherent fashion (Nicolescu, 2008). The introduction of the term 'T' in Figure 2.2 represents the unification of multiple disciplinary knowledge and the co-creation of shared understandings. This is accomplished by included rather than excluded middle thinking. This space is called the 'Zone of Transdisciplinarity' which I refer to as the 'T-Zone'. All team members have unlimited access to a holistic multi-focal gaze, cross-disciplinary knowledge and understandings 'in the zone'. It is the site of disciplinary equality where blending and unification of perspectives helps the team co-create new knowledge and co-evolve new understandings of a client's subsystems and life world (i.e. meta-system).

'T₁' (see Figure 2.3) symbolizes the reconciliation and unification of mutually exclusive or antagonistic disciplinary perspectives by included middle thinking. It indicates the team has

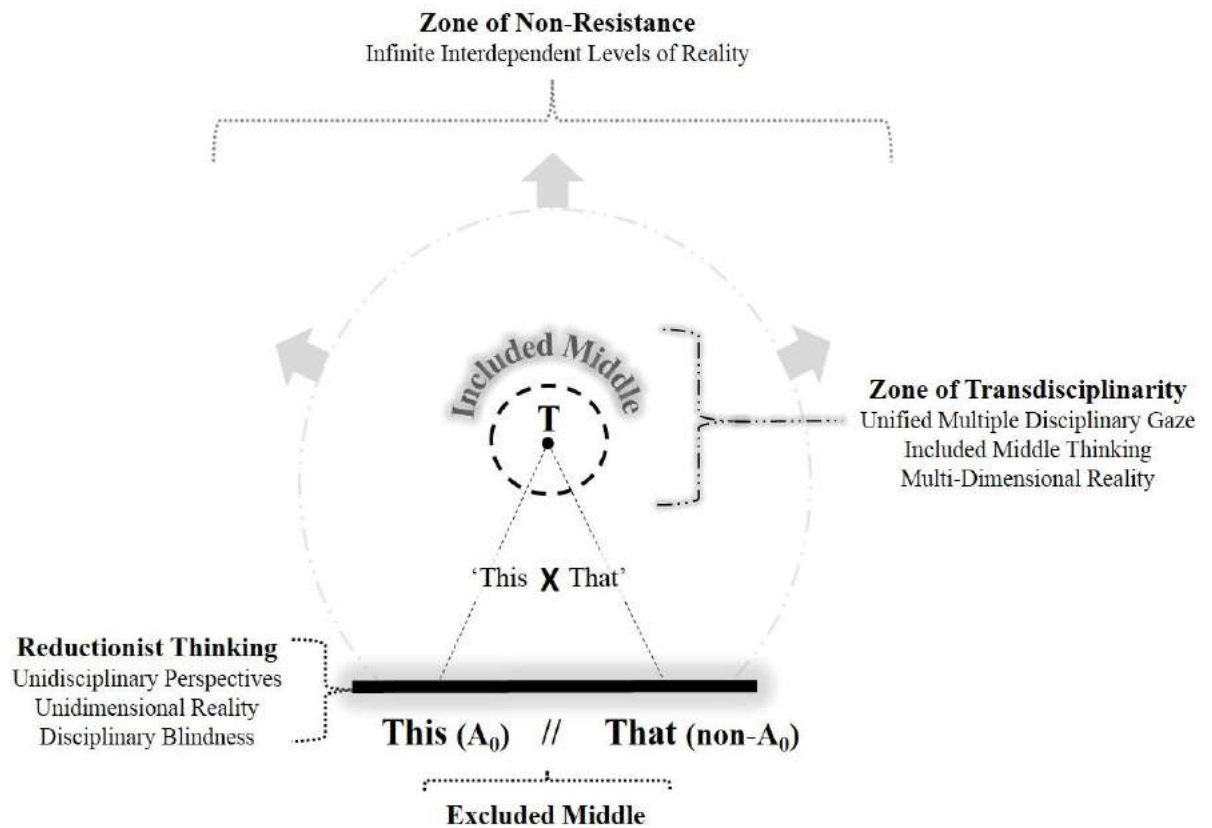


FIGURE 2.2. LOGIC OF THE INCLUDED MIDDLE

successfully moved beyond an ‘either or’, ‘this or that’ reductionist paradigm, relieved the tension created by opposing views and overcome the resistance to defend and retain a privileged or unidisciplinary perspective. For example, the team may have come to the realization the client’s reality is better understood by blending a little bit of perspective ‘A’ (a physician) and a lot of perspective ‘non-A’ (a therapist).

Each new level of understanding is more than the sum of disparate disciplinary perspectives. It is multiplicative (Nicolescu, 2002). ‘This’ multiplied by ‘That’ = an exponentially larger transdisciplinary perspective. As the team learns, co-evolves new understandings and integrates new knowledge, the tensions between two previously agonistic disciplinary perspectives and/or teammates fade. Dichotomies still exist. However, the resistance to overcome exclusionary thinking and enter into the T-Zone dissipates over time.

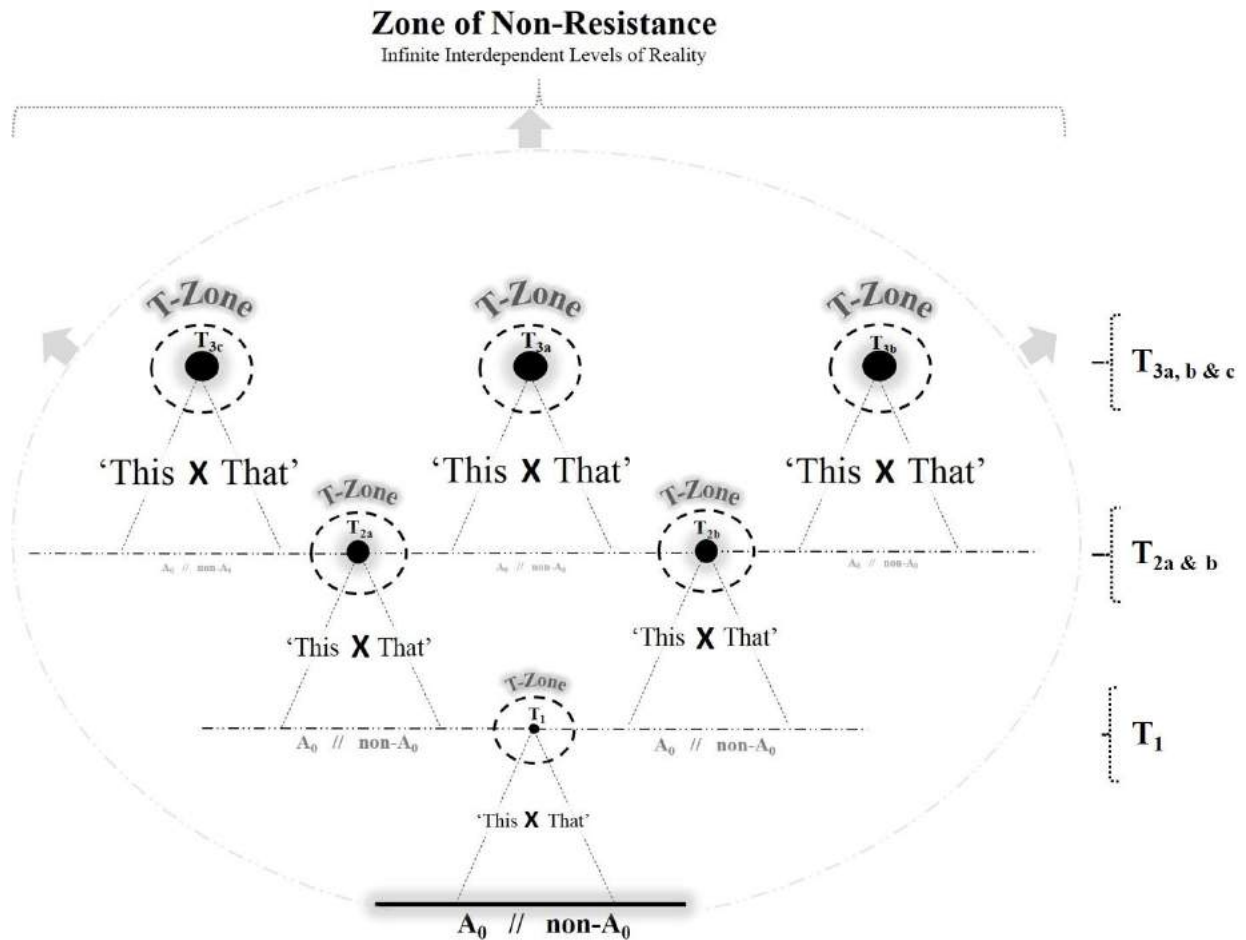


FIGURE 2.3. INFINITE T-ZONES IN THE ZONE OF NON-RESISTANCE

An infinite number of transdisciplinary subject-object interactions and subsystems can be understood in an infinite number of spaces between the disciplines (i.e. T-Zones). They co-exist in the infinite realm Nicolescu calls ‘Zones of Non-Resistance’ (Nicolescu, 2002; Nicolescu, 2011; Nicolescu, 2007; Nicolescu, 2008). The co-existence of the real and the social in the same time and space allows team members to conceive of and locate an infinite number of seemingly antagonistic pairs. Reconciliation and unification of ‘this or that’s’ at each lower level helps the team gain access into and understand adjacent and higher levels of the client’s realities (i.e. A_2). The process is infinitely iterative and unites the flow of energy and knowledge coherently across endless levels of reality. Access to an open infinite structure of thinking precludes the possibility

of a closed unidimensional theory or perspective (Nicolescu, 2002; Nicolescu, 2007; Nicolescu, 2008; Nicolescu, 2012).

Some might argue that this definition of reality and knowledge generation undermines the possibility of defining a distinct object for study. To not do so would sustain focus on objects within one level of reality and “*an endless chain of binary opposites...[in which] compromise can only be unstable*” (Nicolescu 2008, pp.87). Nicolescu argues the lines of demarcation between the disciplines create an illusion of bounded mutually exclusive disciplinary knowledge/practice communities. However, the spaces between the disciplines are only accessible to providers, clients and family members who are able to overcome their resistance to knowledge/power boundaries and enter into a new realm of ontological and epistemological freedom in between.

Epistemological axiom: complexity.

Multiple levels of reality are interrelated through the complexity of their interdependencies. Therefore, knowledge and understandings about each level of reality are equally complex and intertwined with knowledge and understandings about adjacent levels of reality. Complex thinking allows the team to see the client’s interaction within and between each subsystem. It also helps them to see subsystems as part of a highly complex life context (i.e. meta-system).

It is helpful to understand the complexity and utility of transdisciplinary thinking and practice when it is integrated into Bronfenbrenner’s Ecological Model (1977) (see Figure 2.4). The complementary relationship between Nicolescu’s and Bronfenbrenner’s ontological and epistemological stance provides a much more tangible way of understanding the concept of multiple realities and how transdisciplinary logic and ecological theory fit together.

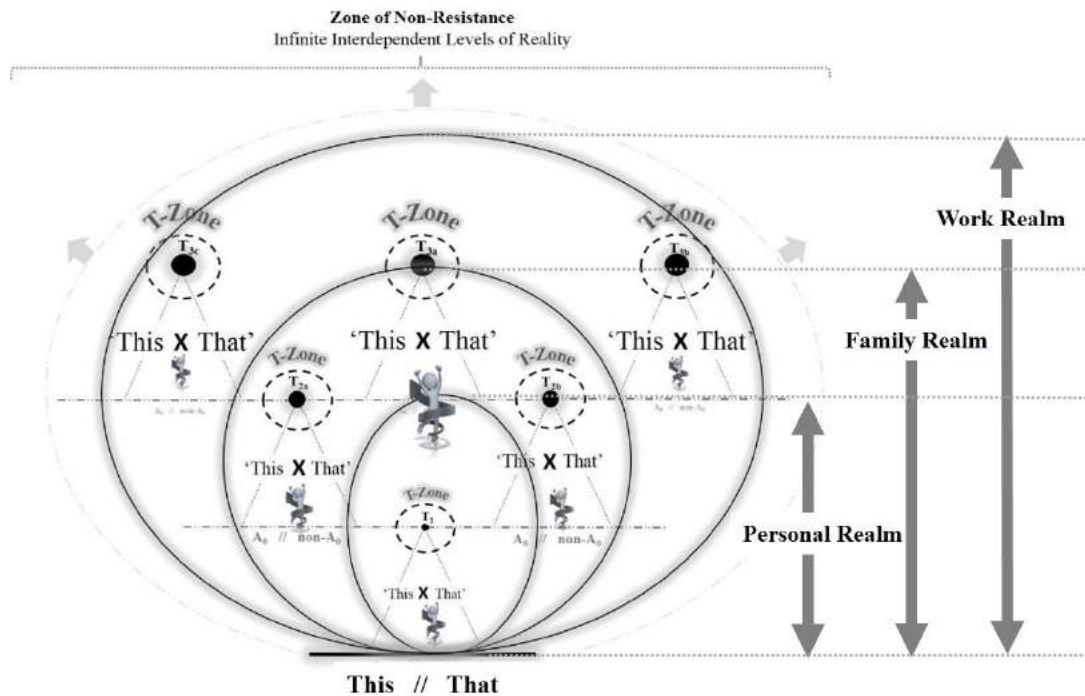


FIGURE 2.4. ECOLOGICAL PERSPECTIVE OF TRANSDISCIPLINARITY

For example, the team, client and family member may have been faced with the following ‘This or That’ challenge:

- 1) **Micro Level:** The client is having difficulty cooking breakfast. The team, family and client agree the challenge is either anxiety-related or a residual effect of a stroke. On further investigation, they determine it is a bit of both. The physician prescribes a new medication and the physiotherapist, occupational therapists and counsellor develop an innovative and integrated strategy to help the client master his or her cooking skills. For now, the therapists and spouse will coach the client at home until (s)he has the capacity to once again cook independently.
- 2) **Exo Level:** This strategy is not acceptable in the work environment. The client is a chef and the public health rules preclude the counsellor or wife from attending the workplace. The client has the option of work alone or quitting. This particular ‘This or That’ antagonistic pair appears hopelessly irreconcilable. However, the client, counsellor and employer discover the client is able to work confidently if a tape of the

counsellor is played in the background. Company and public health regulations to not restrict music in the workplace.

Transdisciplinarity liberates conventional disciplinary thinking and practices and sets them loose into a realm of infinite possibilities. To see reality as a complex multi-dimensional meta-system, healthcare providers must be willing to enter into the unfamiliar invisible realm of ‘the between’. Knowledge and perspectives must be allowed to come together equally as a dynamic, unified but imperfect whole. “*No level of Reality constitutes a privileged place from which...to understand all the other levels of Reality*” (Nicolescu, 2007, pp. 147).

Multiple disciplinary blindness: the empty ensemble.

A healthcare organization or multiple disciplinary team comprised of team members unwilling or unable to see beyond their own self-referential knowledge base and unidisciplinary perspective is an ‘empty ensemble’ (Bunt, 1979; Nicolescu, 2002). A single disciplinary paradigm might “*pretend to entirely contain all knowledge within its own field*” (Nicolescu, 2002, pp. 33) or, in some cases, all *relevant* human knowledge. None of the scientific disciplines have the capacity to integrate the totality of knowledge generated from the extensive fragmentation of specialties into subspecialties.

‘Disciplinary blindness’ (Morin, 2008) results from the paradigm of reductionist thought which “*suppress[es] disorder with order*” (pp. 5) and quells complexity-related anxiety. Researchers and healthcare providers oriented solely by the medical and scientific discourses are unable to consider the inherent complexity of socially embedded phenomena (i.e., health and illness). Instead, contextual noise is eliminated (i.e. controlled), isolating the object of study from its environment and eliminating the possibility of understanding multidimensional unification except in the abstract. Simple thought, reductionism and disjunction of subject from the environment lead to blindness. “*Key realities disintegrate...slip[ping] through the cracks between disciplines*” (pp. 4).

Gergen (2001) describes a concept similar to Morin’s ‘disciplinary blindness’ (Morin, 2008) and the ‘empty ensemble’ (Bunt, 1979) in which disciplinary paradigms and hierarchies engage in “*paradigmatic posturing*” (McNamee & Gergen, 1992, pp. 32). McNamee and Gergen suggest posturing protects consensus views of a singular objective reality and

standardized therapeutic interventions. Meaning becomes frozen and decontextualized and provide healthcare providers a picture of reality akin to fiction.

Gergen (2001) advocates for an open and unbounded reframing of self and one's 'social multi-verse' co-constructed through narrative multiplicity that is all at once locally, historically and culturally situated. The co-construction of new knowledge and broader shared understandings of the totality of a client's world can never be completely understood. However, a transdisciplinary paradigm might bring them closer to the impossible truth.

Healthcare Team Research

Persons with chronic illnesses and acquired brain injury face a multitude of challenges during the recovery period. These include fear of death, financial uncertainty and fatigue, psychological distress, and unexpected changes in social activities, roles and relationships (Devins, 1994; Fiske, Coyne, & Smith, 1991; Nelson, Baer, & Cleveland, 1998; Thompson, Ersser, & Webster, 1995). Traditional disciplinary training may not provide healthcare professionals with the breadth of knowledge to fully understand how the complex interplay of health determinants influences each client's multidimensional health and recovery circumstances. Even multiple disciplinary teams struggle to embrace holistic bigger picture understandings.

WHO (1985) acknowledges the complex nature of recovery in chronic illness, as well as the challenges of doing so in the context of multiple disciplinary perspectives. For example, it was hypothesized that factors impacting psychological and social well-being had been largely overlooked during the early to mid-1980s because of difficulties in communication between healthcare providers. During this period, empirical research on team functioning focused primarily on the appropriateness of a particular discipline's participation on rehabilitation teams, team member roles (Cohen, 1979; Dydzuk, Weeks, Meldrum, & Pineo, 1980; Errey, 1980; Lyons & Coren, 1984; Pomrenze, Tepper, & Somberg, 1985), team building (Fried, Edgerton, Lewis, & Frederick, 1983) and conflict resolution strategies (Margolis, Fiorelli, & Leonard, 1984).

While the empirical research shifted in the mid-1990s from team building and conflict resolution to the impact of team structure and functioning on patient outcomes, this body of

research is not without controversy. For example, in a review of outcome studies in cardiovascular rehabilitation, Seneviratne, Stone & King (2009) found considerable inconsistency in the use of the terms such as multidisciplinary, interprofessional and transdisciplinary to describe rehabilitation teams (see Table 1.1). Few of the published articles provide operational definitions for the terms, use the terms interchangeably or failed to describe the roles, communication patterns and collaborative practices to justify their use (Costa e Silva et al., 2008; Grimm et al., 2009; Mazanec et al., 2002). In spite of almost two decades of research, there still remains a lack of evidence that different types of healthcare teams improve patient outcomes.

Table 1.1. Operational definitions of multiple disciplinary teams (Adapted from Albrecht, Freeman, & Higginbotham, 1998)

Multidisciplinary Practice Teams	Several disciplines address distinct facets of clients' health issues independently. Fixed disciplinary boundaries/roles. Mutually exclusive understandings & explanations. Interventions are isolated & discipline specific.
Interdisciplinary Practice Teams	Several disciplines agree on health issues collaboratively. Facets of client's health issues may be ignored depending on disciplinary team structure. Distinct but softer boundaries. Independent applications of theoretical frameworks. Interventions informed by multiple disciplinary insights and understandings.
Transdisciplinary Practice Teams	Several disciplines conceptualize health issues as functioning on multiple levels in a complex, dynamic system. Open collaboration. All disciplines, patients and families contribute to understandings. Common conceptual framework. Creative interventions developed from a blending of insights from all parties involved.

The American Stroke Association (ASA) calls for the establishment of transdisciplinary teams to help clients manage the complex multifactorial challenges they face in the aftermath of an acquired brain injury (Schwamm et al., 2005). However, Hachinski (2007) contends health

institutions have been slow to understand the nature and potential of transdisciplinary teams. He argues there are still *“too many guidelines but too few guides”* (pp. 1402) to restructure existing health services and establish transdisciplinary practice teams.

In the early stages of my research, I conducted a comprehensive review of multiple disciplinary team research to determine if Hachinski’s 2007 contention still holds. I focused on articles published since 1990 to investigate how recommendations for clinical practice in chronic illness and rehabilitation have evolved. In total, ninety-two peer reviewed journal articles were reviewed in cardiac rehabilitation (n=15) cancer symptom management (n=8), rehabilitation for a wide-range of illnesses (n=30) and stroke rehabilitation (n=39) literature. Studies related to academic team research were excluded since the focus of this research project is to study a transdisciplinary team that interacts directly with clients and family members in a clinical practice milieu. Only three research groups claim to have quantified transdisciplinary clinical practice teams and their impact on recovery outcome in chronic illness. However, the operational definitions and study findings suggest researchers do not understand the philosophical foundations of transdisciplinary structures, reasoning and practices.

For example, transdisciplinary team practice is described as *“involve[ing] multidisciplinary across specialties and settings”* (Costa e Silva et al., 2008, pp. 40), *“incorporating ongoing cross-disciplinary education and regulated overlapping roles”* (Ruddy & Rhee, 2005, pp. 248) and as *“nurturing consensus...professional synergy, and...a learning culture”* (Shaw, Walker, & Hogue, 2008, pp. 301). These definitions and team descriptions do not provide a theoretically coherent representation of transdisciplinarity ‘thinking’, ‘doing’ or ‘being’ in relationships with cross-disciplinary colleagues, clients or families even if all three are combined. The teams appear to be more aligned with multidisciplinary (Costa e Silva et al., 2008) and interdisciplinary (Ruddy & Rhee, 2005; Shaw, Walker, & Hogue, 2008) team practices. Therefore, I believe that the mechanisms through which a theoretically sound transdisciplinary clinic practice team might be best suited to address complex health issues during recovery and rehabilitation in chronic illness (Schwamm et al., 2005; Seneviratne, Stone, & King, 2009) are still unknown.

Effectiveness of transdisciplinary teams.

Stokols, Misra, Moser, Hall and Taylor (2008) conducted an exhaustive review of the literature to determine common themes in studies that investigate the processes and effectiveness inherent in academic transdisciplinary team collaboration. The review draws on studies from four distinct areas of empirical research, including social psychology (organizational effectiveness), cyber-infrastructure research (computers), community-based health promotion, and studies focusing specifically transdisciplinary team collaboration. None of the transdisciplinary team research reviewed involved healthcare teams working in clinical practice settings. Although the authors contend that the effectiveness of teams is variable and context specific, they were able to identify contextual aspects of collaborative practice that influenced team effectiveness and/or outcomes. Themes that emerged included team member's familiarity and social cohesiveness; team size and physical environmental conditions; leadership traits and behaviours; participatory goal setting and communication patterns; and task and outcome interdependence.

The authors report that community-based transdisciplinary teams involved in research translation and program development are more prone to poor performance because of the complex nature of their work. The diverse educational and disciplinary backgrounds as well as the client/community groups they work with add to this vulnerability. Many of these teams are hybrids, having a combination of highly structured interdependent relationships, team coordination and independence (Stokols, Misra, Moser, Hall, & Taylor, 2008). Intrapersonal factors (i.e., collaboration, power sharing), open, multi-level communication, establishment of trust, shared notion of identity and goals, uptake of the philosophical underpinning of transdisciplinarity (i.e., flexible/open stance to alternative perspectives), and a non-hierarchical organization that supports transdisciplinary collaboration support the success of multiple disciplinary teams.

Given the diversity of transdisciplinary team composition, goals, research interests, practice areas/setting and the variety of ways in which team effectiveness are defined and measured, definitive conclusions and recommendations are not feasible. A more pragmatic approach to transdisciplinary team success is to target specific contextual factors that are most

likely to support the research/practice goals given the available fiscal and organizational resources. While the authors do allude to the structural, technological and environmental factors necessary for transdisciplinary team success, elements associated with human interaction (i.e., communication, collaboration, power sharing) are clearly at the forefront. However, even after such an extensive and in-depth review of the transdisciplinary team research, it is not possible to provide a one-size-fits-all map given the complex, multi-level and multidimensional nature of transdisciplinary teams themselves.

Transdisciplinary team leadership.

Transdisciplinary team collaboration is significantly enhanced by leadership that is empowering, democratic, supportive and encourages cooperation and knowledge sharing (Stokols et al., 2008). Conversely, power imbalances and disciplinary hierarchies within teams undermine the collaborative process and the attainment of mutually defined goals. Disciplinary or leadership power need not always dictate the actions or thoughts of others (Doolin, 2002); disciplinary power can be used to open up opportunities for alternative perspectives and knowledge by empowering members of the transdisciplinary team (Bloomfield & Coombs, 1992).

Power sharing and dismantling of the disciplinary hierarchy can be a daunting, if not monumental task in healthcare settings where power structures, personal and professional identities are built around traditional notions of expert knowledge (Reed, 1995). A challenge to the existing knowledge/power hierarchy may be inadvertently perceived as a more of personal threat to one's sense of self rather than an opportunity to invite a broader understanding of multilevel, multidimensional concepts in health. Transdisciplinarity not only requires communication and collaboration but must be located within an entire organization or healthcare system that supports disciplinary equality (Piaget, 1972). Broader organizational structures, policies and processes and culture may have a considerable influence on transdisciplinary teams in the healthcare milieu.

While there is a considerable body of literature related to the negotiation of power and status in healthcare settings and teams (Apker, Propp, & Ford, 2005; Lingard, Reznick, Espin, Regehr, & DeVito, 2002), research designed to understand the impact of power sharing or the

mechanism through which patients are empowered in the context of a transdisciplinary clinical practices teams was not located. From a transdisciplinary perspective, the knowledge and understandings that patients and family members contribute to a comprehensive understanding of their unique circumstances is otherwise inaccessible to members of the healthcare team unless they are invited onto the team as equally contributing members. However, the processes through which transdisciplinary teams evolve and maintain non-hierarchical, egalitarian relationships with each other, and with patients and family members has not previously been studied within health teams.

Critical Summary

Professional identities and practices (re)constituted in a healthcare milieu constituted by biomedical discourses constrains who we are as healthcare providers, our practices as well as the way in which healthcare is conceived of and transformed. The discourses of medicine sustains the clinical gaze on pathology and the population health promotion gaze at the level of the community. Even more concerning is the way in which the historically entrenched de jour knowledge/power governance models (i.e. hierarchies) sustain and reproduce standardized inflexible treatments, team structures and functioning and disciplinary boundaries. Healthcare may have the capacity to re-orient itself, but is transformation even a remote possibility?

In the chronic illness literature, the focus of recovery has also been historically directed towards symptom management and restoration of physical capacity. Quantitative research studies (e.g., randomized control trials) in recovery and behavioural change are not designed to facilitate a broader understanding of the underlying mechanisms through which complex, multi-factorial human recovery and transformation occurs. The dominant disciplinary ideologies, frameworks and discourse(s) in chronic care and rehabilitation may limit the way in which chronic illness is conceived and researched by privileging some aspects of recovery and excluding others. A group-based research approach cannot take into account the personal and context-specific factors that cultivate a client's or family's capacity to redefine themselves and to take up life's challenges.

Perhaps, herein lies the challenges in statistically modeling group behavior; the individual participants are complex, indeterminate entities whose day-to-day context is, itself, evolving.

While understanding group behavior in chronic illness programs may have fiscal and programmatic benefits, the 30 year history of research guided by theoretical models has yield consistently conflicting results and little progress towards increasing participation in at home or community-based chronic illness programs. In other words, it appears we are not further ahead in terms of engaging let alone activating the patient.

All theoretical frameworks and research paradigms are limited in their breath and scope, particularly in the study of complex human behaviour. Thus far, quantitative research studies designed to better understand recovery and behavioural change have not facilitated our understanding of the underlying mechanisms through which complex, multi-factoral human recovery and transformation occurs. The ontological and epistemological underpinnings of the positivist paradigm may be ill-suited to the study of complex phenomenon such as recovery in chronic illness (Bryman et al., 2009). The decidedly personal and uniquely situated process of recovery cannot be fully understood by objectively measuring broadly defined, generic attributes (Mhurchu et al., 1997) or their smaller constituent parts.

Empirical evidence has help to elucidate factors predictive of productive and efficient healthcare team functioning (Cashman, Reidy, Cody, & Lemay, 2004; Gage, 1998; Oandasan et al., 2006). However, the mechanisms through which multidisciplinary, interdisciplinary or transdisciplinary teams might differentially increase the capacity of an individual and his/her family are still unknown. Given the multifaceted nature of chronic illness and recovery, perhaps the approach taken thus far has been too simplistic in assuming that short-term education and intervention can produce long-term results (Carmody, Senner, Malinow, & Matarazzo, 1980; Yates, Anderson, Hertzog, Ott, & Williams, 2005). A group-based approach in cardiac rehabilitation and chronic illness recovery programs has fiscal and programmatic benefits. However, the 30 year history of research in this area has yielded consistently conflicting results. A standardized, effective one-size-fits-all approach remains elusive regardless of the theoretical stance (Millen & Bray, 2009; Fernandez et al., 2009; Luszczynska, 2006).

The processes through which a transdisciplinary healthcare team supports clients and their family members during recovery and rehabilitation has not previously been studied and will remain speculative unless the dynamics of the client-provider and healthcare team interactions

become the object of inquiry. The key to understanding what a transdisciplinary or salutogenic approach is and how they are enacted requires us to refocus attention from distal outcomes (e.g., measures of team effectiveness) to the team's reflexive and representational practices (Opie, 1997).

An interpretivist approach may be better suited to develop an understanding of how health care teams increase the capacity of an individual and his/her family take up their own life challenges and to foster independence and health. By studying the ways in which client-provider and healthcare team relationships are talked about, understood and enacted (i.e., discursive strategies), it may be possible to illuminate the mechanisms through which a transdisciplinary approach is taken up and enacted by transdisciplinary team members to help clients and family members move forward in their recovery journey.

Research questions

The research questions for this project are as follows:

- 1) How do the members of a transdisciplinary rehabilitation team discursively construct themselves, their practices and their clients?
- 2) How do the ways in which the team members describe themselves, their practices and their clients represent a unified, shared understanding of their values, beliefs, and practices?
- 3) How are the shared values, beliefs, and theoretical perspectives of a transdisciplinary team enacted in their social and professional interactions and practices?

Chapter 3

Research Methods

There are multiple different qualitative methods I could have chosen for this case study. For example, narrative inquiry studies personal stories to understand how participants make sense of their experiences. Phenomenology could have been used to study how the stories of multiple participants reveals the core essence of their shared experiences. However, transdisciplinarity is an unconventional approach to healthcare that is only possible when providers are not limited to or by the discourse of medicine. A purely narrative or phenomenological approach would not allow me to capture the ‘how to’ aspects of transdisciplinarity located in the day-to-day language used by participants to describe what their transdisciplinary team actually does. For this I required a discourse analytic approach with a twist.

Discourse analysis is the study of how language, and patterns of language use, convey and create meaning in social interactions and in text (Taylor, 2001). The ways in which language is used (i.e., speech acts) are not passive. Whether consciously chosen or brought to bear in a more reflexive manner, the use of language, in talk or in text, is performative by nature. Speech acts can, for example, relay compliments or insult, persuade or deny (Taylor, 2001) “*confer legitimacy....change opinion, incite war [or] inspire romance*” (Smith, 2005, pp. 33). Interpretation may require the listener to decipher clues as to the intended meaning, specific to the social context in which the speech act occurs.

Discourse is assembled from systems of words, metaphors and common understandings of broader social and cultural concepts (e.g., gender). As people converse in any given social context, they draw on these systems of language (i.e., linguistic resources) to construct an account suitable for the situation and their intended purpose (Potter, Wetherell, Gill, & Edwards, 1990). Therefore, a discourse analytic approach focuses on the numerous ways language can be used to construct, legitimize, contest or re-create a particular version of reality. Some forms of discourse analysis focus on the vocabulary, content and structure of talk or the sequencing of language use during a social encounter. Others investigate the ways in which discourse is used to categorize or classify aspects of their world and how larger societal concepts or institutions

(e.g. medicine, legal system) evolved. These latter approaches are concerned with the power of monolithic discourses, to which one is made subject (Taylor, 2001).

Wetherell and Potter (1988) approach discourse analysis from a perspective of human agency rather than subjugation. Individuals actively choose how to position themselves and their particular perspective using the wide array of terms and descriptive options available to them at the time. It hones in on the more fragmented way in which people draw on linguistic resources in everyday talk and text to position a 'something' as a particular version of 'X'. Researchers focus on the range and recurring patterns of words, ideas and images used to explain, characterize and make sense of certain topics and activities (Edley, 1997; Wetherell & Potter, 1988).

Wetherell and Potter's methodological technique is called interpretive repertoire analysis. This approach does not directly address the broader societal discourses such as medicine or masculinity (e.g., what it means to be a man in our society). Instead, it focuses on the ways individuals choose to (or avoid) talking about a topic or activity to unearth analytic clues about the purpose of the speech act itself. By honing in on the interpretive repertoires and the way in which individuals frame descriptions about themselves, their lives or their professional practices, it becomes possible to better understand *what* the discursive act is achieving as well as the strategies used in doing so (Wetherell & Potter, 1988).

The term 'interpretative repertoire' was introduced into the discourse analytic literature by Gilbert and Mulkay (1982). They were interested in settling a theoretical debate in the scientific community about how scientists view and justify their professional belief systems (Mulkay & Gilbert, 1984). Interviews with scientists provided the researchers with such richly diverse data, a literal (i.e., face value) interpretation could not make sense of the multiple, competing and oftentimes internally inconsistent rationales provided by scientists to justify theoretical preferences. At that time, contemporary choice theory (Zucherman, 1978) provided little guidance. More traditional approaches to understanding belief systems conceptualized departure from professional norms or second-guessing of scientific laws as either deviance or irrationality.

Mulkay and Gilbert (1984) found a seemingly more plausible explanation for the variation in accounts in the work of Thomas Kuhn (Kuhn, 1977). Kuhn suggests that the professional rules of scientific theory may influence individual choice but are not deterministic. Individual scientists use a consistent thinking process (i.e., algorithm) to develop theoretical preferences, but interpret concepts such as accuracy, consistency, and scope differently. Definitions vary depending on personal characteristics and cultural context. A “*common vocabulary does not imply...a shared basis for choice*” (Mulkay & Gilbert, 1984, pp. 113) because consistent application of basic concepts does not exist between scientists even in the same field.

Mulkay and Gilbert concluded it was not possible to determine the specific issues driving scientists’ beliefs or the theoretical debate in the scientific community from interview data alone. They also deduced that the variability within individual accounts provided sufficient grounds to reject the assumption that, in isolation, participant statements are representative of essential values, beliefs or the development process for theoretical preferences. The meanings ascribed to past events and an individual’s beliefs are most likely in a continuous state of flux, “*constantly [being] revised and reconstituted...as[participants] reformulate their interpretative accounts*” (Gilbert & Mulkay, 1982, pp. 383).

Mulkay and Gilbert (1982) refocused analytic attention to the variability within and between accounts. They were then able to demonstrate how scientists differentially drew on either formal/scientific or casual/personal categories of talk to describe scientific theory and practice, refuting the notion of one consistent thinking algorithm proposed by Kuhn (Kuhn, 1977). Within each category, scientists strategically deployed a specific limited range of linguistic resources (e.g., terms, metaphors, figures of speech) to revise and re-formulate the professional rules governing theory choice. These systems of terms or interpretative repertoires both characterize and comprise the multiple fragmented ways people draw on linguistic resources in everyday talk and text to accomplish specific activities (e.g. justify, criticize, blame) tailored for the specific social (i.e., discursive) context. The focus of analysis is on the identification of these differing patterns of words, ideas and images used to explain, describe and make sense of certain topics and activities.

Potter and Wetherell (1989) take up and elaborate on the analytic method proposed by Mulkey and Gilbert (Mulkey & Gilbert, 1984). In doing so, they provide the essential theoretical grounding and justification for the inclusion of interpretative repertoire analysis as a valid methodological option for discourse analysts. A number of researchers now use this method to explore a variety of areas. For example, some researchers have used repertoire analysis to explore the social construction of teacher identity (Moore & Rae, 2009), the different ways in which high-tech learning environments are represented in talk and text (Hannon & Bretag, 2010) and the range of possible identity constructions available in the context of patient-provider encounters (Laitinen-Väänänen, Talvitie, & Luukka, 2008). Examples of how interpretative repertoire analysis provide a more in-depth understanding of how this approach can be used for empirical research.

To investigate the ways that medical professionals understand and characterize their male patients, Seymour-Smith, Wetherell and Phoenix (2002) interviewed nine male and female health professionals in the UK. Participants were asked if men access their practice, placed importance on their health and brought support persons to their health encounter. Their analysis revealed three interpretive repertoires: 1) Women are health conscious and responsible 2) Men do not talk about health issues and 3) Men are serious users of healthcare. Health providers described women as being more health conscious, responsible and comfortable accessing healthcare. Men, on the other hand, were viewed as being childlike, secretive, passive, incompetent and ignorant about their health. Since women access healthcare for non-illness related health issues (e.g., pap smears, pregnancies), health seeking behaviours were constructed as a normal aspect of a woman's experience. When men did seek medical services it was interpreted by health provider participants as a signal of a serious, legitimate health concern. However, while delayed health-seeking behaviours in male patients may pose a serious danger to their health, humor was used to construct these potentially detrimental choices as "*entertaining foibles*" (p.262) that are "*indulged and protected*" (pp. 253) but not acted upon. By typifying men's lack of attendance to health concerns as expected and acceptable, health providers position themselves as helpless and relieved of responsibility to intervene.

In another study, Bower and Tuffin (2006) explored if and how people with disabilities might contribute as equal members of society through their internet practices. The authors identified an interpretive repertoire of ‘transcendence’ to characterize their online experiences. Participants framed their internet access as enhancing their capacity to function in society in ways that might otherwise not be possible. As linguistic resources, life-altering, overcoming and disconnecting disability were recurring constructs of empowerment used by participants to position themselves as significantly transformed into equally contributing members of society. These terms were also used to provide justification for internet use.

Taken together, these two studies demonstrate the power and applicability of this form of discourse analysis for understanding *what* a discursive act is accomplishing as well as the strategies used in doing so. Rather than focusing on the literal meaning of talk, this method taps into “*the local and broader discursive systems in which [the discourse] is embedded*” (Wetherell & Potter, 1988, pp. 169). These local, broader discourses not only give shape to local reality, but provide clues about values and beliefs as well as the reasoning behind professional or client behaviours (Opie, 1997). By honing in on the various the ways in which clients and health providers characterize themselves and their practices (i.e., their interpretive repertoires), it becomes possible to study the mechanisms through which a transdisciplinary team may increase the capacity of patients and families to understand and manage their health issues.

However, the legitimacy of this methodological approach remains contested by some, who question the use and connotations of the term ‘interpretative repertoire’. I have heeded Parker (1990) warning that a sole focus on interpretative repertoires risks an overemphasis on the words and grammatical formulations in speech to the detriment of content and substance. In this thesis, I have also included an analysis of how participants deploy broader societal discourses to construct themselves, social events and interactions and societal institutions. The impact of the discourses in participant accounts is so profound that any attempt to investigate how the team operates is dependent on an understanding of how they use the medical, institutional discourses to name but a few.

Anderson and Prelli (2001) emphasize the importance of using linguistic resources together (i.e. broader societal discourses and interpretative repertoires) to analyze equally

legitimate but alternative perspectives. This ensures discourses are not permanently bound up by one particular view or interpretation. Edley (1997) also invites a more dialogically oriented analysis that includes societal discourses and interpretative repertoires. The analysis is dialogic in the sense that the researcher seeks to understand the way in which a number of interpretative repertoires are drawn on and interwoven in talk and text to imbue meaning to the topic and accomplish particular social functions (Bakhtin, 2009; Potter & Wetherell, 1987).

The purpose of this project is to uncover the mechanisms through which a transdisciplinary team meets the population health goal of increasing personal and family self-care capacity. Using interpretative repertoire analysis, this study explores how transdisciplinary philosophy is taken up and enacted in community-based neurorehabilitation. To understand these complex multidimensional and socially embedded aspects of transdisciplinary team practice the study design brings together elements of case study research, discourse analysis, and health ecology theory.

A case study approach in social science research is the preferred method of inquiry when a) ‘how’ or ‘why’ questions are posed b) the researcher has little control over the research circumstances, and c) the focus of inquiry is a contemporary phenomenon within a real-life context. In such circumstances, the *“richness of the phenomenon and the extensiveness of the real-life context”* (Yin, 2009, pp. 2) require multiple sources of evidence and a mechanism for data to converge/triangulate in a meaningful way. The case study methodology proposed by Yin (2009) is appropriate for studying complex social situations in groups and organizations and to understand social and/or political phenomenon. This method should not be confused with case-study methodology used in epidemiology to study unique and rare disease.

Transdisciplinary Team as ‘Case’

In studying organizations, the boundaries between the phenomenon of interest and the context in which it occurs may not be clearly evident (Yin, 2009), since the phenomenon and the context are inherently intertwined on a number of levels. However, the boundaries around the case must be clear (Cutler, 2004; van Dijk, 1991). Once the case has been defined and a comprehensive study of case (i.e., transdisciplinary team) and the social context (i.e., clinical

milieu) has been undertaken, it is possible to tease out and understand the features/functions of the phenomenon of interest (Marshall, Mannion, Nelson, & Davies, 2003).

Description of the transdisciplinary team.

At the inception of this project I searched throughout North America for a transdisciplinary clinical practice team that specialized in chronic illness. Since I was unable to locate a team during the course of my literature review, I spoke directly with clinical coordinators and physician representatives from the Canadian Cardiac Rehabilitation Network, the American Heart Association and the Alberta Cancer Board, as well as an internationally renowned neurologist. I followed up on several possible leads, but none of the programs contacted believed they were a transdisciplinary team.

An internet search located what I believe to be the only two well-established transdisciplinary clinical practice teams in North America at this time. One is a hospital-based outpatient cancer symptom management program, the other a privately owned comprehensive community-based neurorehabilitation therapy facility. Neither of these programs have been the focus of investigation to better understand what a transdisciplinary approach is or how it is enacted. I chose to study the neurorehabilitation clinic because it is not affiliated with a major hospital system. I believed that there was a stronger possibility a program not affiliated with a hospital governance model could align with transdisciplinary philosophy. Transdisciplinary practice requires an egalitarian practice model (Piaget, 1972; Nicolescu, 2002) which might not be available to a cancer symptom management program connected to a tertiary facility. Broader organizational structures and policies may constrain the team's capacity to function completely outside a traditional hierarchical biomedical practice model.

In September 2010, I visited the community-based neurorehabilitation center to determine their interest in participating in this project. The team expressed interest in participating for three reasons. First, they felt they did not fit the traditional models of multi- or interdisciplinary team practice. Second, the team believed they most likely represented transdisciplinary team practice, but they were not precisely sure why. Finally, they felt this project might provide them the words to describe their team and therapy practices to others who did not understand why the Clinic was different from traditional rehabilitation models.

The clinic director was initially hesitant to agree. She was concerned that they ‘might let me down’ or ‘not meet my expectations’ if they did not fully meet the criteria of a transdisciplinary team. It took approximately five months of discussions for the group to come to consensus and agree to take part in the study as an organization. We agreed we would all work together to compare and contrast the team’s practices with the philosophical tenants of transdisciplinarity. The study would provide them with a point of reference from which to learn and continue to evolve and align their practices more closely with transdisciplinary philosophy.

The chosen clinic, hereafter referred to as the ‘Clinic’, has transformed over the past 30 years from a private neuropsychology practice, to a certified comprehensive transdisciplinary facility serving approximately 500 new clients annually. The aims of the program are to help clients with acquired brain injuries (e.g. stroke and head injuries) to begin the process of reintegration into their homes, families and communities during the rehabilitation process. .

The Clinic is not part of the regional hospital system. It is a privately owned rehabilitation facility situated several city blocks from the closest tertiary hospital. The medical team is comprised of multiple family therapists, occupational therapists (OT), speech and physiotherapists (PT), physicians, neuropsychologists, neuropsychometrists and one social worker. Administrative support includes receptionists, transcriptionists and billing clerks. The leadership team includes the clinical director, financial manager and the Clinic’s founder. Fifteen of the 28 employees have been employed at the facility for at least 10 years.

It is my contention this facility satisfies a case study approach given the considerable length of time the organization has been in operation, the longevity of employment of almost half of the providers, the geographically isolated location and the private nature of the business support.

Recruitment

I was invited to attend the team’s annual retreat in October 2011 to begin the recruitment processes. A copy of the Letter of Information and Informed Consent and Frequently asked Question (FAQ) sheet (see Appendix A and B) were provided to all attendees. I reviewed both documents and answered any questions. Participants were invited to contact me by email or telephone if they had any follow-up inquiries. Team members who wished to participate were

asked to leave their signed consent form in a sealed envelope in a designated study mailbox in the locked chart room. The clinical director informed non-attendees additional copies were available in the staff room and provided them with my contact information.

Five team members initially agreed to participate after the team retreat. The remainder volunteered after speaking with participant colleagues (i.e. snowball effect).

Data Collection Strategies (August 2011-July 2012).

The Clinic is a complex multifaceted social environment. Bronfenbrenner's (1977) ecological framework for understanding complex, multilevel systems is used to pictorially demonstrate the location of data collection used in this project (see Figure 3.1). Multiple data sources allowed me to cross verify (i.e. triangulate) data from multiple sources. Data collection

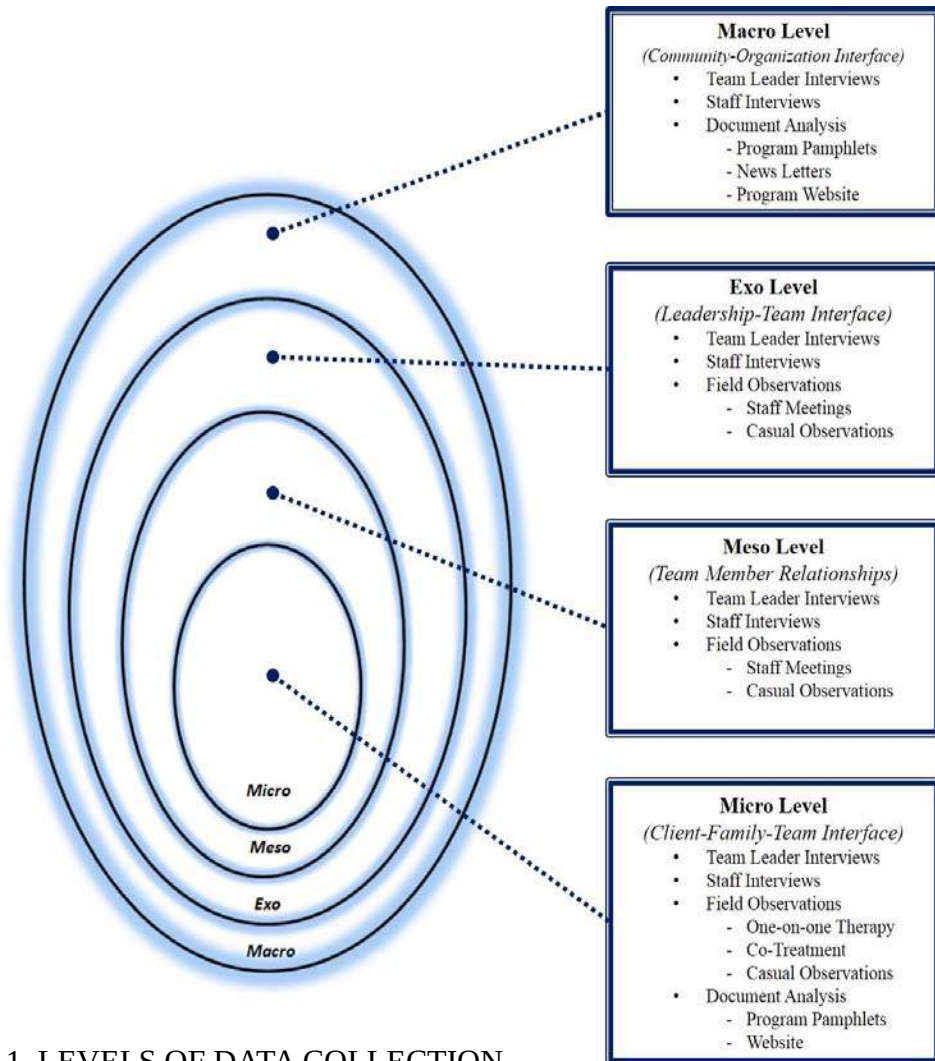


FIGURE 3.1. LEVELS OF DATA COLLECTION

strategies included: 1) Semi-structured interviews 2) Participant observation and 3) Document analysis. A detailed timeline for data collection is located in Appendix C.

Team member interviews.

Audio taped semi-structured interviews were conducted with 15 team members between September 2011 and June 2012. To protect the anonymity of study participants outside of the organization, I have elected not to disclose the number of participants from each department. With the exception of neuropsychometry, interviews were conducted with representatives from each discipline, and administrative department. Interviews lasted between 1-2 hours. Follow-up interviews were conducted either in person, via telephone or email and at the discretion of the participant. In-person and telephone follow-up interviews lasted between 15 and 30 minutes.

Twelve team member interviews were conducted at the Clinic. Three team members were interviewed at their homes during after work hours and only for convenience sake. All interviews held at the Clinic were conducted in swing offices or the conference room to ensure confidentiality. None of the team member participants wished to have their anonymity protected within the organization and were publically vocal about their participation.

An interview guide was developed specifically for this project based on recommendations of van Dijk (1991) (see Appendix D). According to van Dijk, creative interview questions are required when trying to elucidate the nuances of a common system of beliefs. For example, questioning participants about the differences between their team's beliefs and practices helped to provide rich detailed descriptions of both.

Direct field observations.

I kept detailed field notes during all encounters at the Clinic. Field notes include both broad and more detailed observations of events, interactions and the different clinical settings. I also noted any observations I wanted to discuss more in-depth with study participants. Personal reflections on and expansion of my field notes were completed as soon as possible after each encounter. Field note observations are not made explicit in the analytic chapters. Instead, my observations are integrated into the narrative to provide a comprehensive and seamless description of the team and their environment.

Transdisciplinary team observations.

Direct observation of transdisciplinary team members in their public (patient interactions, staff meetings) and private (staff room) contexts facilitated a description and understanding of the clinic setting and social interactions. Observation of team member interactions allowed me to corroborate team members' verbal accounts of their interpersonal relationships and professional discourse and practices. An unstructured participant observation schedule was used to collect rich and detailed field notes describing the setting, the participants and their interactions.

Four one to two hour follow-up meetings were conducted with the clinical director to review and further discuss my observations and her understandings of the team's interpersonal dynamics. I was able to explore these areas with participant team members in subsequent interviews to further corroborate and confirm my observations, interpretations and the director's perspective. Participants' perspectives about team functioning and interpersonal relationships only deviated in terms of how they characterized their affinity for colleagues and personal/professional boundaries between themselves and clients. These differences are highlighted in the interpretative repertoire analysis when applicable.

One-on-one therapy sessions.

I observed seven one-on-one therapy and co-treatment sessions. Sessions included four of the six client participants within two weeks of their initial interviews. Three sessions involved clients who declined to participate in patient interviews but were comfortable having me present during therapy. I observed client-therapy interactions with the clinical director (an occupational therapist) (2), a physiotherapist (1) a speech therapist (1), a family counselor (1) and a neuropsychologist (2).

Focus groups.

Three focus groups were conducted. Data from each focus group is incorporated into the four analytic chapters. The first three hour focus group was conducted in December 2011 (n=8). The purpose was to generate a list of topics the team wished to explore during the course of this study. This session was not audio-taped at the request of two team members who did not wish to participate in the interviews.

The second three hour audio-taped focus group was conducted in April 2012 after all team member interviews and field observations were complete but prior to beginning the detailed discourse analysis (n=24). A signed consent form was obtained from each participant. Many team members were anxious to receive feedback about my initial broad brush stroke understandings about their practice. I prepared an animated power point presentation (see Appendix C) for this meeting. Each team member took turns reading the slide notes and engaged colleagues in a discussion about a) the appropriateness of the language used and b) the accuracy of the description. One minor change was requested to simplify a complex sentence.

During the second focus group, participants identified we had all been using the terms client and patient interchangeably. The team was unable to come to consensus about whether they should adopt one term or continue to use the terms interchangeably. This discussion was deferred to a later date.

The last three hour audio-taped focus group was conducted in June 2012 (n=26). Team members were randomly divided into three groups:

- 1) Group 1 discussed the pros and cons of the term patient
- 2) Group 2 discussed the pros and cons of using the term client
- 3) Group 3 explored alternative terms to patient and client and discussed the pros and cons of each.

Groups were given 30 minutes of discussion time and documented key points on a flip chart. It was not possible to audiotape small group discussions. A spokesperson for each group presented discussion points and engaged the entire team in dialogue. The team were not able to agree to the use of one term nor could they reach consensus about a unified approach to the application of either (i.e. more or less dependent on the team or family members. The team's flip chart presentations were posted in the Clinic so they could continue to ponder the topic and write down any additional thoughts over a 30 day period.

The team was unable to come to consensus about how or when to use the terms client or patient. As a result, the team has decided to continue discussions on their own after the conclusion of this study. Data obtained during this focus group is not completely unrelated to

the research questions for this current study. However, since the team wishes to pursue this topic further, transcripts and flip chart presentations will be included in a subsequent research project.

Document analysis.

The clinical director provided a power point presentation used to educate community-based agencies and physicians about services and transdisciplinary practices at the Clinic. Program-specific pamphlets available to clients and families in the reception and waiting rooms were also collected. All website pages were downloaded for inclusion in the analysis.

Sample Size

Sample size for discourse analytic studies are generally small in number, and usual include 5-10 participants (Potter & Wetherell, 1987; Wood & Kroger, 2000). According to Wood and Kroger (2000), *“the question about number comes down to having sufficient number of arguments of sufficient quality and having sufficient data for those arguments to be well grounded ”* (2000).

A total of 26 team members participated in this study. Fifteen participated in interview and an additional 11 participated in focus groups two and three. I spent approximately 140 hours collecting data for this project including 72 hours were spent conducting direct observations in the field. The remainder of the time was spent meeting with the clinical director to discuss the project and opportunities for field observation. I also spent 2 hours with the Founder and the clinical director to discuss analytic chapters (e.g. word use, metaphors, diagrams and accuracy of my descriptions). Taken together data collected provided diverse and contextually rich accounts of participants' experiences working at the Clinic and the clinical milieu.

Ethical Considerations

Informed consent.

Team member consent.

Prior to participation in the study, I reviewed the letter of information and informed consent and the FAQ with each volunteer. I answered any questions before written consent was obtained. No team member participants withdrew their consent to participate.

Consent for document analyses.

The Clinical Director provided written informed consent to use documents included in the analyses (see Appendix F).

Client consent.

Therapists who allowed me to observe one-on-one or co-treatment sessions contacted clients 24-48 hours prior to their scheduled appointment to obtain verbal consent. Therapists used a script specifically designed for this study to obtain consent (see Appendix G). I was introduced to clients before the therapy session began. Therapists ensured ongoing consent prior to initiating the session. At the conclusion of treatment, clients were encouraged to review and discuss my notes and given the opportunity to remove or edit my notes. Ongoing consent to participate was also verified after conclusion of our post-therapy review. No client participants withdrew consent.

Right to privacy.

To ensure anonymity, each participant was assigned a unique identifier, for use on interview transcripts and field notes. No names were recorded on audio tapes or interview transcriptions. A master list of participants' names and unique identification codes are in a locked filing cabinet in the office of Dr. Kirsten Broadfoot, Associate Professor, Department of Family Medicine, University of Denver, Anschutz Medical Campus. The master list of participants was kept separate from the research data. Two encrypted back-up drives study data were kept in a safety deposit box at First National Bank, Loveland Colorado. Access to the bank vault requires palm print verification. Back-up drives were transported back to Canada in person. They are currently stored in a locked file cabinet in Dr. Marlett's office. They will be kept for a period of five years, after which time they will be physically destroyed and all paper documents shredded. No data files were saved on my laptop computer.

Participants were informed that data from interviews, in the form of excerpts, may be used in presentation of findings, but their anonymity will be protected. Without exception, all participants stated they had no desire to have their anonymity protected. Interviews conducted away from the Clinic were done so for the participants' convenience only.

Computer files containing data were secured with a password known only by myself, Dr. Nancy Marlett (PhD supervisor) and Dr. Kirsten Broadfoot (supervisory committee member). All members of my supervisory committee were provided with anonymized paper copies of my level one data analysis to familiarize themselves with the individual participant transcripts before second and third level analysis. All audio-recordings have been erased.

Protection from harm.

Because of anonymity and the unobtrusive nature of the interview questions, it was not anticipated that participation in this study would result in any harm to the participants. Participants were provided with full control over the degree of information they wished to discuss and a choice to withdraw from the research at any time. Participants were also provided with the opportunity to discuss issues of a private or more personal nature separately from their family member/significant others if required. None of the team member, clients or significant other participants became distressed during the interviews or requested help from outside sources to relieve anxiety caused by interview questions.

Analytic Journey

I had not expected so many team members to participate in the study or that the size and data collected would be so complex and diverse. Data analyses progressed in stages and levels of analysis, beginning with reading and rereading interview transcripts and text documents. This in-depth process of familiarization and review facilitated my appreciation for the diversity of the data and the initial identification and coding of topical markers (e.g., topics, activities, events, places, people, organizations, policies) (Rubin & Rubin, 1995).

The following is a summary of analytic decisions and processes that occurred between September 2012 and August 2013:

Analytic step 1: data familiarization and level one topical markers.

PROCESS: I spent four months listening to audio-taped recordings, reading, and re-reading the 15 interview transcripts and reviewing text documents (i.e. power point, pamphlets and the Clinic's website). I created multiple copies of each text document to keep track of my evolving analytical thoughts. Familiarization with the data was a time of deep reflection

FIGURE 3.2. ANALYTIC STEP 1 EXCEL® SPREADSHEET

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I came to the realization that my interview strategy (see Appendix A) was one source of my analytical difficulties. I had purposely asked participants to contrast their current practices with work experiences in other healthcare settings. I had hoped this line of questioning might help uncover how transdisciplinary team practice was enacted. I had not anticipated the degree to which transdisciplinary practice narratives had become entangled with descriptions about traditional practice

ANALYTIC DECISION: I was still able to detect four very broad topics of conversation common to participants' descriptions about traditional and transdisciplinary practice: team interactions, professional practices, client-family interactions and the work environment. These subject areas (i.e. topical markers) would later guide the first step discourse analysis (Rubin & Rubin, 1995). However, I decided I could not proceed any further without separating the traditional and transdisciplinary narratives because the composites narratives were far too complex.

Analytic step 2: data fragmentation by practice context.

PROCESS: I used HyperRESEARCH®, a data analysis software package, to create two separate traditional and transdisciplinary sets for each participant. This software does not analyze textual data per se. It allowed me to create and apply a variety of different codes to fragments of raw data. At this stage, I only coded data as either traditional or transdisciplinary practice. Narratives that compared and contrasted traditional and transdisciplinary practice were coded as both. These fragments appear in both of the two larger data sets.

ANALYTIC DECISION: Once the traditional and transdisciplinary data sets were separated I felt confident I could fragment the data into smaller meaningful topic-specific units.

Analytic step 3: data fragmentation by level one topical markers.

PROCESS: I used HyperRESEARCH® to code the traditional and transdisciplinary data sets with the Level 1 topical markers identified earlier (see Table 3.1). I applied multiple codes datum fragments if they included more than one topic of conversation. I printed out hard copies of each participant's Level 1 data summaries and familiarized myself with the smaller data sets one participant at a time. I wrote analytic notes directly on the reports as I searched for the similar and different ways participants talked about each Level 1 topic.

Table 3.1. Level 1 topical markers

Participant 1001	
Level 1 Topical Marker Codes	Level 1 Topical Marker Codes
1a TRAD Team Interactions	1b TRANS Team Interactions
1a TRAD Professional Practice	1b TRANS Professional Practice
1a TRAD Client-Family Interactions	1b TRANS Client-Family Interactions
1a TRAD Work Environment	1b TRANS Work Environment

CHALLENGES: My one-participant-at-a-time approach posed another unanticipated challenge. Each data set provided a more detailed but limited perspective. In isolation, Level 1 data sets constrained my ability to evolve a bigger picture understanding about each topic.

ANALYTIC DECISION: I elected to merge Level 1 data sets by topic.

Analytic step 4: composite level 1 topical marker data sets.

PROCESS: I used HyperRESEARCH® to merge the data. This resulted in eight Level 1 data sets, one for each of the eight topical markers. The software allowed me to tag each data fragment with its corresponding study number. This feature facilitated within and between participant analyses. I printed hard copies of each composite Level 1 data set on 11x14” paper and left spaces on the right side of each page for analytic notes (see Table 3.2). I then began the processes of familiarization and analysis once again.

CHALLENGE: The analytic examples i-iv in Table 3.2 appear to represent isolated transdisciplinary-specific descriptions of team interaction. However, exemplar iv) provides an example of how sub-topics (i.e. Level 2 topical markers) further complicated the analysis. At first glance it seems participant 1005 is only describing cross-disciplinary knowledge exchange and learning. However, she also refers to the team’s shared philosophy. I had successfully isolated transdisciplinary narratives but had not yet isolated each topic.

ANALYTIC DECISION: Identify sub-topics and further fragment the data sets.

Table 3.2. Composite level 2 topical marker analysis

1a – TRANS Team Interactions			
Page #1		Page #2	
Data Chunk	Notes	Data Chunk	Notes
i) <i>I almost get spoiled working here because the therapists are so good</i> (source 1001)	-Respect for colleagues -expertise is a resource for efficiency and job satisfaction	iii) <i>[the team] helps you grow in ways that you wouldn't anywhere else. I don't think it would have developed to the extent that it is if I had just stayed in a traditional setting</i> (source 1001)	-supportive learning environment at the Clinic promotes professional growth -Traditional roles stunt professional growth
ii) <i>the director can be directive if need be but they are really very good at sharing leadership and decision-making</i> (source 1005)	-shared leadership is discretionary	iv) <i>there is that philosophical understanding and sharing of our information across our therapy specialties</i> (source 1005)	-team interactions provide opportunities to share disciplinary knowledge and evolve cross-disciplinary understandings

Analytic step 5: transdisciplinary data fragmentation by level 2 topical markers

PROCESS: I identified 11 Level 2 topical markers (see Table 3.3), coded the data printed and hard copies. As a starting point, I reviewed the data sets containing descriptions of transdisciplinary team practice.

CHALLENGES: After many weeks of analysis I realized I had fragmented and de-contextualized the transdisciplinary data to the point that nothing concrete or interpretable could emerge. I had created pages and pages of disconnected sound bites that, together, made little if any sense to me at the time. I could not see the emergence of interpretative repertoires from such a vast array of tiny splinters.

ANALYTICAL DECISION: I realized I needed to step away from the transdisciplinary data set and my frustrations. I turned to the data set containing the transdisciplinary team members' experiences of working in other healthcare settings.

Table 3.3. Level 1 and level 2 topical markers

Traditional Data Set	Transdisciplinary Data Set
1a – TRAD Team Interactions -Organizational structure & leadership -Knowledge sharing and integration - Organizational Philosophy	1b – TRANS Team Interactions -Organizational structure & leadership -Knowledge sharing and Integration - Shared team philosophy
1a – TRAD Professional Practice -Roles & tasks -Therapeutic interventions -Clinical gaze	1b – TRANS Professional Practice -Roles & tasks -Therapeutic interventions -Clinical gaze
1a – TRAD Client-Family Interactions -Client roles -Family roles -Professional relationships	1b – TRANS Client-Family Interactions -Client roles -Family roles -Professional relationships
1a – TRAD Work Environment -Personal & professional safety -Interpersonal relationships	1b – TRANS Work Environment -Personal & professional safety -Interpersonal relationships

Analytic step 6: traditional data fragmentation by level 2 topical markers.

PROCESS: It was during this second attempt at Level 2 analysis I realized the formulation of repertoires to describe team members' work in traditional practice settings were well-developed, clearly defined and unmistakably informed by the medical discourse. However, this analysis also yielded a surprising and unanticipated finding. Embedded within the repertoires of the 'other' (e.g. former workplaces, colleagues and practices) were the subtle reflections of transdisciplinary practices. The repertoires and discourses of transdisciplinary team practice did not exist in isolation; their emergence was only possible by viewing the

dissonance created by their co-existence with the medical discourse. It seemed as though I was bearing witness to transdisciplinary discourse and practices as emerging discursive entities.

ANALYTIC DECISION: I decided to take time to reflect on how best to proceed. I needed a way to analyze the traditional and transdisciplinary data sets simultaneously but my analytic software would not accommodate this approach.

Analytic step 7: concurrent traditional and transdisciplinary data analysis.

PROCESS: I returned to each participant's raw interview data interview transcript and applied the Level 1 topical markers (i.e. team interactions, therapeutic practices, client-family interactions and work environment) to the entire document. I did not apply more than one Level 1 topical marker to any datum and I did not separate the composite traditional-transdisciplinary narratives.

I printed out each of the 60 data sets (i.e. 15 participants x 4 Level 1 topical markers) and began to analyze them one participant and one topical marker at a time. I cut out and taped each Level 1 data fragment to the center of 11x17" sheets of paper (see Figure 3.3). This step allowed me to disentangle and yet simultaneously analyze the traditional and transdisciplinary narratives.

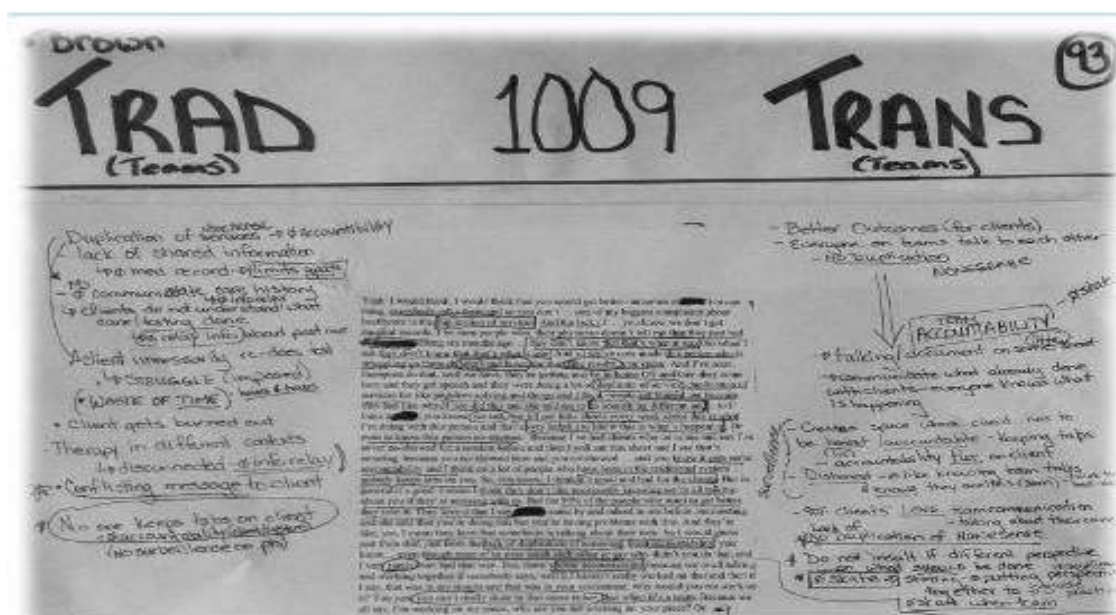


FIGURE 3.3. CONCURRENT LEVEL 1 TRADITIONAL/TRANSDISCIPLINARY DATA ANALYSIS

I had to create a sophisticated way to organize the data because this entire stage of analysis had to be conducted by hand due to software limitations. First, I colour-coded each of the four Level 1 topical markers to keep the data organized (see Table 3.4). I then colour-matched my analytic notes to keep track of the multiple topic areas contained within each data fragment.

The colour-coding system created an efficient way to cross-reference topic-specific notations within and between participants' data sets (see Figure 3.4). Study numbers at the top of each page provided a simple way to trace datum back the original interview transcripts and ensure my analytical interpretations were contextually relevant and valid. The new approach not only visually exposed the discursive dissonance between the traditional discourse of medicine and the emerging It also allowed me to systematically fragment and reorganize the data depending on my analytical needs.

ANALYTIC DECISION: I was now so intimately acquainted with the data I was able to identify narrative fragment by participant without seeing the study number. This level of familiarity, colour-coded topical markers and colour-matched analytic notes provided a solid foundation and point of reference to proceed with the identification of Level 2 topical markers.

Table 3.4. Colour-coded level 1 topical markers

Participant 1001	
Level 1 Topical Marker Codes	Level 1 Topical Marker Codes
1a TRAD Team Interactions (brown)	1b TRANS Team Interactions (brown)
1a TRAD Professional Practice (orange)	1b TRANS Professional Practice (orange)
1a TRAD Client-Family Interactions (green)	1b TRANS Client-Family Interactions (green)
1a TRAD Work Environment (blue)	1b TRANS Work Environment (blue)

Analytic step 8: (re)fragmentation of data by level 2 topical markers.

PROCESS: I identified a total of 13 Level 2 topical markers (see Table 3.5), coded the data, printed each data set and familiarized myself with each. These topical markers provided a more meaning framework to organize the data fragments and build more comprehensive description of each aspect of transdisciplinary practice and 'other'.

ANALYTIC DECISION: With the Level 1 data set and analysis as a backup, I decided I had finally arrived at the stage where I could separate the traditional and transdisciplinary narrative without losing track of the underdeveloped transdisciplinary interpretative repertoires.

Table 3.5. Level 2 topical markers

Level 2 Topical Marker Codes	
1. Administrative Structures	7. Clients
2. Work Environment	8. Families
3. Leadership	9. Client and Family Transitions
4. Physicians	11. Regionalization
5. Team member Interactions	12. Healthcare Provider Education
6. Therapies	13. Organizational History

Analytic step 9: level 1 data integration and fragmentation by practice context.

PROCESS: My previous analytic decision to fragment the data at this level had taught me that isolated disconnected sound bites could not yield the comprehensive descriptions I was looking for. I elected to first combine the Level 1 data set by topical marker prior to separating the aggregated data by practice context. I also created Level 2 codes that included study numbers so I could sort the data by practice context and by participant (see Table 3.6).

CHALLENGES: Even though I had sorted topical markers by study number, I had no way of tracing data fragments back to the original interview transcripts. The purpose of interpretative repertoire analysis is to understand the similar and different ways participants described each topic (Wetherell & Potter, 1988). I could easily identify the language (e.g. words and metaphors) each participant used to constitute each aspect of traditional and transdisciplinary practice. However, I could not consider participants discursive accomplishments without tracing each one back to the part of the interview narrative in which language was deployed.

ANALYTIC DECISION: The only way to cross-reference data fragments was to document the line numbers from the original transcripts by hand. I was able to accomplish this

more efficiently by copying a portion of each datum into the ‘search’ function in Word® to find the location in its original transcript.

Table 3.6. Level 2 topical markers by topic and participant

TRAD Data Set		TRANS Data Set	
TRAD_Administrative Structures		TRANS_AdministrativeStructures	
-	TRAD_Administrative Structures_1001	-	TRANS_AdministrativeStructures_1001
-	TRAD Administrative Structures_1002	-	TRANS_AdministrativeStructures_1002
TRAD_WorkEnvironment		TRANS_WorkEnvironment	
-	TRAD_WorkEnvironment_1005	-	TRANS_WorkEnvironment_1005
-	TRAD_WorkEnvironment_1006	-	TRANS_WorkEnvironment_1006

Analytic step 9: identifying themes and the construction of demi-narratives.

PROCESS: I encountered the same challenge at this step as I had in all of the previous stages. Each Level 2 data fragment refer to more than one topic of conversation. On reflection, I realized these were not really separate topics of conversations they are themes: threads that connect some data fragments together and send others into a slightly different narrative direction (Frank, 2009). These are the strings that would eventually tie the data together into a comprehensive description of transdisciplinary practice (see Table 3.7).

I recorded single or multiple themes on their respective data fragments. Each fragment now seemed to me like one-, two- or three-sided domino. I decided to reconnect the fragments in a bric-a-brac fashion. What emerged was a meaningful, understandable and cohesive whole that I refer to as ‘demi-narratives’ (see Figure 3.4).

Table 3.7. Level 2 topical markers and themes

Level 2 Topical Marker and Themes	
1. Administrative Structures a) Support structures b) Clinical support roles c) Organizational Philosophy	7. Clients a) Roles b) Client/Provider relationships
2. Work Environment a) Orientation and socialization b) Interpersonal relationships c) Organizational Culture d) Satisfaction and meaning	8. Families a) Role b) Family/Provider relationships
3. Leadership a) Accessibility b) Communication patterns c) Administrative gaze d) Roles and tasks e) Interpersonal relationships (Power) f) Leadership style g) Personal Qualities	9. Client and Family Transitions a) Hospital to home b) Home to clinic c) Clinic to society d) Dependence to independence e) Role transitions
4. Physicians a) Accessibility b) Communication patterns c) Clinical gaze d) Roles and tasks e) Interpersonal relationships (Power) f) Personal Qualities	10. Overlapping Practices a) Traditional Practices at the Clinic b) Transdisciplinary practices in the traditional setting
5. Team members a) Roles and tasks b) Communication Patterns c) Professional relationships	11. Regionalization a) Purpose b) Perceived benefits c) Perceived detriments
6. Therapies and Treatments a) Clinical gaze b) Practices c) Outcomes	12. Healthcare Provider Education
	13. Organizational History

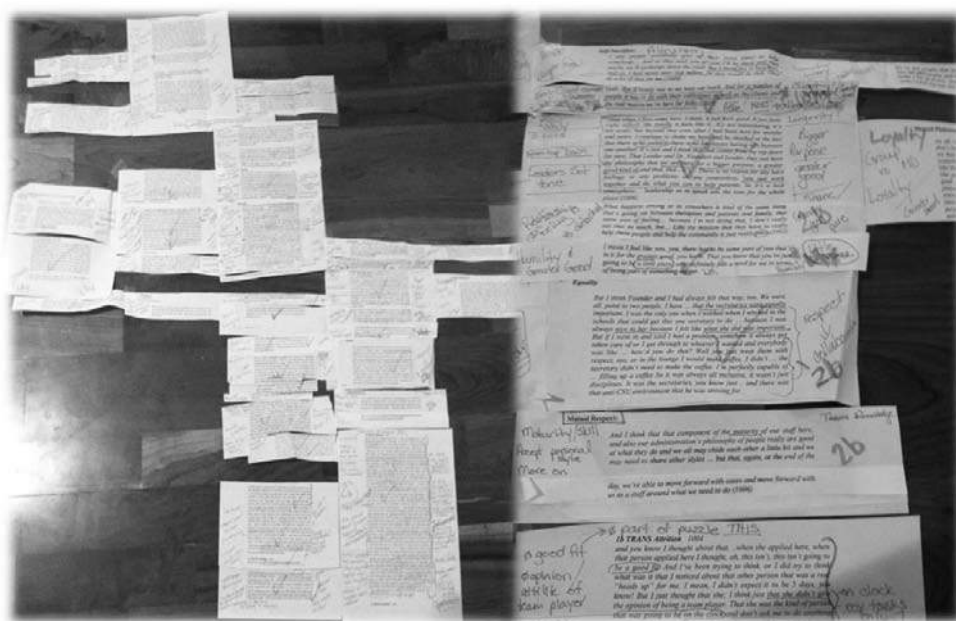


FIGURE 3.4. LEVEL 2 DEMI-NARRATIVES

Analytic step 10: traditional and transdisciplinary meta-narrative construction.

PROCESS: The last step before beginning the interpretative repertoire analysis was to link the demi-narratives together into two separate traditional and transdisciplinary meta-narratives. Not all data fragments were included in the final version of the narratives. I tried to avoid redundancies by excluding narratives that overlapped. However, I made sure all of the language is accounted for in the narratives themselves or my interpretations that follow. All of similar and different ways participants portrayed each topic of conversation are represented in the meta-narratives and participants discursive accomplishments discussed throughout each analytic chapter (i.e. Chapters 4-8). This was a long and exhausting process but there are no adjectives, metaphors, subject positions or discursive accomplishment left behind.

The transdisciplinary meta-narrative.

The transdisciplinary meta-narrative describes a historical journey from the creation of the Clinic creation to present day. It fuses the voices of each participant together in a polyphone and offers a profound level of insight into their shared history and a comprehensive description of this particular transdisciplinary organization and team practices. The entire transdisciplinary meta-narrative is located in Appendix G.

The traditional meta-narrative.

During my initial readings of the separate traditional and transdisciplinary meta-narratives a very striking difference was immediately apparent. The transdisciplinary meta-narrative was constructed by factual and value-neutral or highly positive descriptions of the Clinic. In fact, there was a very conspicuous absence of negativity that points to participants' efforts to position their transdisciplinary rehabilitation practice as superior to the medical model for therapies aimed at home, life, and school or community reintegration. In doing so, participants cast specific aspects of the traditional the work environment and former colleagues in a disparaging light.

As my analysis continued, an even more illuminating consequence of disconnecting the traditional and transdisciplinary narratives emerged. Initially, a particularly negative and/or positive depiction of self and other in the individual interviews seemed relatively innocuous. However, the aggregation and isolation of the interpretative repertoires used collectively by participants to differentially characterize themselves and others amplified both the positive characterization of themselves and the negative portrayal of other. In-and-of-themselves, the positive positioning of transdisciplinary is not particularly problematic in terms of how the results of this study might be received. However, the aggregation, isolation and amplification of negativity in the traditional meta-story required consultation with participants to reach consensus on how best to proceed.

We elected not to include the transcript of the traditional meta-story in its entirety. While illuminating, the intent of this project was not to present an exposé on the traditional healthcare system. The team and I agreed the possibility members of the healthcare community might find the narrative offensive out-weighed any perceived benefit that might result from its telling. We did agree the analysis of the traditional meta-narrative should be included in the dissertation (see Chapter 4).

Analytic step 11: interpretative repertoire analysis.

PROCESS: Wetherell and Potter's (1988) approach to discourse analysis focuses on the analysis of textual and conversational data. Each section of the traditional and transdisciplinary meta-stories were read and re-read. This was a more deeply iterative, complex and reflexive process than I had originally anticipated. After a 2-3 month period I was able to see the emergence of clear but distinctly different repertoires in each of the data sets.

This methodology involved a detailed analysis of the linguistic resources used to construct/frame each of the interpretive repertoires (i.e., words, metaphors, concepts and images). Broader societal discourses (D) and discourses used to frame portrayals of, for example, team relationships etc., were coded and tracked by repertoire to facilitate the analysis (see Table 3.8).

Table 3.8 Discourses by interpretative repertoires

Interpretative Repertoire	Constituent Discourses		Related/Constituent Repertoires
Chapter 4: Traditional Neurorehabilitation			
The Excluded Middle	<ul style="list-style-type: none">• Fragmentation• Reductionism• Medicine (D)	<ul style="list-style-type: none">• Inequality (D)• Subjugation (D)• Containment	
Economy of Scale	<ul style="list-style-type: none">• Cost Containment• Efficiency• Regionalization• Assimilation• Resource Scarcity	<ul style="list-style-type: none">• Replication• Standardization• Subjugation (D)• Containment	
Disciplinary Boundaries	<ul style="list-style-type: none">• Unification-Segregation (D)• Inequality (D)• Constraint• Health Sciences Education (D)	<ul style="list-style-type: none">• Specialization• Militarization (D)• Medicine (D)• Subjugation (D)• Exclusionism (D)• Protectionism (D)	
Disciplinary Blinders	<ul style="list-style-type: none">• Containment• Myopia• Isolationism	<ul style="list-style-type: none">• Apathy• Complacency• Self-preservation	<ul style="list-style-type: none">• Disciplinary Boundaries

Table 3.8 (Cont'd)

Every Man for Himself	<ul style="list-style-type: none"> • Self-preservation • Isolationism • Inequality (D) • Toxic Workplace 	<ul style="list-style-type: none"> • Egocentrism • Incivility • Militarization (D) • Subjugation (D) 	
Burnout	<ul style="list-style-type: none"> • Apathy • Burnout • Self-sacrifice 		<ul style="list-style-type: none"> • Every Man for Himself • Economy of Scale
Chapter 5: The Creation Story			
The Included Middle	<ul style="list-style-type: none"> • Inclusivity • (Re)integration • Unification • Holism • Inclusivity 	<ul style="list-style-type: none"> • Complexity management • Freedom (D) • Population Health (D) 	
Moral High Ground	<ul style="list-style-type: none"> • Humility • Altruism • Inclusivity • Equality (D) • Personal Safety • Collectivism • Accountability • Reciprocity 	<ul style="list-style-type: none"> • Empathy • Mutuality • Intersubjectivity • Humanism • Social Harmony • Solidarity (D) • Empowerment (D) • Human Rights (D) 	
By Invitation Only	<ul style="list-style-type: none"> • Resistance • Secrecy • Exclusionism (D) 	<ul style="list-style-type: none"> • Protectionism (D) • Medicine (D) 	
T-Zones	<ul style="list-style-type: none"> • Mentorship • Transparency 	<ul style="list-style-type: none"> • Scientific Inquiry (D) 	<ul style="list-style-type: none"> • Moral High Ground • Included Middle
Open Complex Communication Network	<ul style="list-style-type: none"> • Chaos • Complexity Management 	<ul style="list-style-type: none"> • (Re)integration • Freedom • Flexibility 	
Chapter 6: Transdisciplinary Leadership			
Leadership from Below	<ul style="list-style-type: none"> • Organizational Equality • Propulsion • Mentorship • Moral Stewardship (D) • Moral Custodianship (D) 	<ul style="list-style-type: none"> • Freedom (D) • Liberation (D) • Democracy (D) 	<ul style="list-style-type: none"> • Moral High Ground

Table 3.8 (Cont'd)

Professional Intimates (Leadership)	<ul style="list-style-type: none"> • Kinship • Unity • Mutuality 	<ul style="list-style-type: none"> • Interdependency • Personal Boundaries 	
Serving the Greater Good (Leadership)	<ul style="list-style-type: none"> • Humanitarianism 		<ul style="list-style-type: none"> • Moral High Ground
Safe Haven (Leadership)	<ul style="list-style-type: none"> • Personal Safety • Liberation (D) 	<ul style="list-style-type: none"> • Freedom (D) 	<ul style="list-style-type: none"> • Moral High Ground
Preserving the Moral High	<ul style="list-style-type: none"> • Exclusionism (D) • Protectionism (D) 		<ul style="list-style-type: none"> • Moral High Ground • Safe Haven
Keeping Ego in Check	<ul style="list-style-type: none"> • Reflexivity 		<ul style="list-style-type: none"> • Moral High Ground
Chapter 7: Transdisciplinary Team Membership			
One for All and All for One			<ul style="list-style-type: none"> • Moral High Ground
Professional Safe Haven (Team)	<ul style="list-style-type: none"> • Personal Safety • Professional Transformation • Integration • Harmonization 	<ul style="list-style-type: none"> • Liberation (D) • Freedom (D) 	<ul style="list-style-type: none"> • Moral High Ground • All for One and One for All
Conflict-Free Zone	<ul style="list-style-type: none"> • Negotiation • Compromise • Atonement 	<ul style="list-style-type: none"> • Purity • Peace (D) 	<ul style="list-style-type: none"> • Moral High Ground • Professional Safe Haven
Fami-we	<ul style="list-style-type: none"> • Kinship • Personal Boundaries 		<ul style="list-style-type: none"> • Moral High Ground
Therapeutic Self	<ul style="list-style-type: none"> • Humanism • Compassion/Caring 	<ul style="list-style-type: none"> • Empathy • Vulnerability 	
Professional Intimates	<ul style="list-style-type: none"> • Professional/Personal Boundaries • Equality • Personal Safety 	<ul style="list-style-type: none"> • Mutuality • Compatibility • Trust 	<ul style="list-style-type: none"> • Therapeutic Self
Maximum Power Transfer	<ul style="list-style-type: none"> • Negotiation • Propulsion • Ownership 	<ul style="list-style-type: none"> • Accountability • Capacity Building • Empowerment (D) 	<ul style="list-style-type: none"> • Therapeutic Self • Professional Intimates

Table 3.8 (Cont'd)

Context-Embedded Practice	<ul style="list-style-type: none"> • Health Ecology • Husbandry • Liberation • Freedom • Flexibility • Translocation • Adaptability 	<ul style="list-style-type: none"> • Client-Centeredness • Holism • Humanism • Intersectoral Collaboration • Health Promotion (D) 	<ul style="list-style-type: none"> • Maximum Power Transfer
Chapter 8: Transdisciplinary Therapy			
Embodied Knowledge	<ul style="list-style-type: none"> • Embodiment/Disembodiment • Intersubjectivity • Transparency • Mentorship • Cross-Training • (Re)integration 	<ul style="list-style-type: none"> • Mentorship • Professional Development/Learning (D) • Freedom (D) • Liberation (D) 	<ul style="list-style-type: none"> • Professional Safe Haven
Customized Evidence-Based Practices	<ul style="list-style-type: none"> • Heterogeneity • Flexibility • Adaptability • Client-Centeredness • Integration 	<ul style="list-style-type: none"> • Innovation • Freedom (D) • Liberation (D) • Medicine (D) 	<ul style="list-style-type: none"> • Maximum Power Transfer • Context-Embedded Practice
Context-Embedded Therapy Homework	<ul style="list-style-type: none"> • Peer-to-peer Learning/Mentorship (clients) 		<ul style="list-style-type: none"> • Maximum Power Transfer • Context-Embedded Practice • Customized Evidence-Based Practice
Chapter 9: Transdisciplinary Physicians			
De Facto Transdisciplinary Governance	<ul style="list-style-type: none"> • Resistance • Efficiency • Flexibility • Disciplinary Equality • Organizational Equality 	<ul style="list-style-type: none"> • Freedom (D) • Liberation (D) • Medicine (D) 	<ul style="list-style-type: none"> • Moral High Ground • Fami-we
Regionalization by Assimilation	<ul style="list-style-type: none"> • Assimilation • Homogeneity • Rigidity • Protocolization • Resource Scarcity 	<ul style="list-style-type: none"> • Inequality • Conformity • Annihilation • Medicine (D) 	

At the interpretive level, each of the interpretive repertoires was analyzed to understand the performative possibilities for each. For example, what possibilities for action are made possible, what subject positions are constructed, what actions and/or identities are constrained and with what consequences? Data from field notes (i.e., direct observation, document analysis) were introduced as a point of reference during this stage of data analysis. The process of confirming and disconfirming evidence from interviews, field notes and relevant documents ensured that my understandings and interpretations were corroborated by using more than one data source (Yin, 2009). In the final stage of analysis, the interpretive repertoires and discursive strategies used within and between transdisciplinary team members were compared and contrasted. This allowed me to develop a bigger picture understanding of the similar and different way team members reified traditional and transdisciplinary practices.

According to Stokols (email communication, December 25, 2013) there are multiple ways to ascertain if a multiple disciplinary team is transdisciplinary or not. However, there is no consensus view amongst transdisciplinary scholars how evaluation of a team's transdisciplinary characteristics should be conducted. Since transdisciplinary philosophy speaks to processes related to transdisciplinary 'thinking', 'doing' and 'being' in addition to personal attributes of team members and leaders, I felt that transdisciplinary philosophy would provide the best frame of reference with which to determine how transdisciplinarity is enacted.

Analytic step 12: a salutogenic interpretation of study data.

PROCESS: To investigate if/how the transdisciplinary team works to increase the *capacity* of patients and their families to anticipate health challenges, amplify strengths, and engage resources with which to mitigate vulnerabilities, and foster independence and health, Antonovsky's Salutogenic model was used as a framework to inform the discourse analysis (Antonovsky, 1979; Antonovsky, 1987). The intent, however, is not to limit the identification of interpretive repertoires to the constructs prescribed within the Salutogenic model (i.e., comprehensible, manageable, meaningful); rather, the analysis will explore these concepts as embedded within the interpretive repertoires that emerge from the data collected.

Rigor

I applied Creswell's (2007) criteria for evaluating the quality of qualitative research. This framework helped to guide the development of research strategies and demonstrate rigor in this study. The criteria applied included:

- 1) Multiple forms of data collection:
 - (a) Data was collected from participant interviews, focus groups, textual documents and field observations to provide a comprehensive, multifaceted and more broadly inclusive data set.
- 2) Representative sampling:
 - (a) Team member participants represent all healthcare professions and administrative staff positions at the Clinic. The sample included representatives from: reception, transcription, accounting, occupational and physiotherapy, speech language pathology, family counselling, neuropsychology as well as the clinical director. The founding members of the Clinic provided a comprehensive description of the creation and evolution of the Clinic.
- 3) Sufficient time in the field:
 - (a) Field observation was conducted over a period of 11 months for a total of 72 hours, not including participant interviews.
- 4) Data and congruence
 - (a) Considerable time was spent reading and re-reading interview and focus group transcripts and textual data. This allowed me to become intimately familiar with raw data, a key step in moving forward with each level of data analysis. Transcript data were compared with audio tapes to ensure accuracy and corrections made as necessary. A copy of audio tapes and corrected transcripts were provided to Dr. Nancy Marlett to ensure accuracy of the final transcripts.

- (b) A well-organized data system allowed me to trace my analytic interpretations and analytic congruency within and between participants, level one, two and three topical markers and demi-narratives
 - (c) Each Level 2 data fragment was tagged with a participant's unique study and line number from their interview transcript. This allowed me to trace each and every data fragment back to the participant's interview data to ensure fragments retained contextual congruency.
 - (d) Analytic notes were color coded so that multiple topical markers could be easily identified at each stage of the analytic process.
- 5) Methodological Congruence:
- (a) I checked for methodological congruence at each level of analysis before beginning the next. This step ensured congruence between my research questions, the theoretical underpinnings of the method and the analytical strategies I was using.
- 6) Analytical Coherence
- (a) Analytical chapters provide readers with direct quotations from participants as well as a theoretical explanation of how and why the narratives of each participant and/or the collective support how I attached labels to each interpretative repertoire as well as the discursive accomplishments of team members.
- 7) Peer review:
- (a) The 154 page stack of level one topical markers was provided to each member of my supervisory committee. Copies were color coded so committee members familiarize themselves with the raw data and first step of data analysis.
 - (b) Dr. Nancy Marlett and Dr. Kirsten Broadfoot provided support and feedback throughout the entire analytic process. Both were provided examples of how my analytical decisions lead me to the

next level of analysis. This allowed two members of my supervisory committee to personally bear witness to the entire analysis as it unfolded and provide constructive support and feedback as the analysis was translated into written chapters.

8) Participant feedback:

- (a) The participant feedback process began after all participant interviews and field observations had been complete. Multiple participant and non-participant team members were eager to know if I had ‘figured them out yet’. They understood one of the aims of this project was to uncover the language used by their discourse community. They wanted me to provide them a summary of ‘initial findings’ using theoretical language in a simple and easily understandable way (see Appendix F). I lifted and simplified the theoretical language (i.e., the discourses of transdisciplinary philosophy and Salutogenesis) used in my research proposal to prepare the slides and slide notes. I also integrated the language the team used to describe themselves on their website and in their program pamphlets.

Team member participants took turns reading the note that accompanied each slide. They engaged each other in a dialogue to discuss whether or not the words accurately describe their practice or needed to be changed. The team only requested one change to slide three. “*What is ‘affordable versus extended health insurance coverage? Could you say, ‘Affordability and coverage of health insurance benefits?’ Let’s keep it less wordy*” (Focus group 3002). One of the Clinic’s founding members returned his copy of the presentation to me. He provided some grammatical edits and added a notation that read, “*Great job*” (Participant13). The slide

presentation, anecdotal comments from team members and the focus group transcripts were used to inform the analytic chapters.

- (b) The transdisciplinary and traditional meta-stories were provided to study participant for review. Participant identifiers were removed to protect anonymity. Direct quotes from the leadership team were reworded to protect the anonymity of the leaders and conceal the way leaders described their practices and characterized themselves. Leadership quotes have been presented in their original form in the analytic chapters.

The following is an excerpt from an email sent to me by the clinical director after participants agreed to share and discuss the meta-stories with the entire team: *“Hi Donna, I made time this weekend to read the transcript and WOW! I am very impressed with your work and diligence....Thanks, Donna for being a catalyst to help us learn from ourselves”* (Participant 5, email communication, April 29th, 2013).

Team members did not request changes to the meta-narratives. All participants affirmed their individual contributions were represented in a contextually relevant manner and stayed true to the way in which they personally characterized topics discussed in their interviews.

- (c) Twenty team members volunteered to read and critique the five analytic sections (i.e. chapters 4-8). The chapters were bound and a copy provided to each volunteer. Volunteer were given 21 day to review the chapters beginning in late October 2013. Five volunteers chose to remain anonymous. All volunteers provided positive feedback. No one requested any changes to the language or my analytic interpretations. Four volunteers requested a bound copy of my dissertation for future reference.

I chose to share the meta-narratives and analytic chapters the team to ensure that I had accurately represented their practices, no alternative perspectives were omitted and participant's felt their quotes had not been taken out of context. I also believed their review would ensure that I had neither over- nor under-interpreted their narratives (Creswell, 2007).

‘Member check’ is a hallmark of participatory action research. It is used to promote co-learning and enhance participants’ confidence in the researcher. Emphasizing the knowledge of participants and developing trusting collaborative relationships heightened participants’ interest in and ownership for the research process and knowledge generated during this study (Green et al., 2003).

Introduction to the Analytic Chapters

Chapters 4 to 9 are analytic chapters. They are informed by field observations, participant interviews, document analysis, focus groups and participant interviews. The analyses of talk and text provide insight into how participant members of the team portray themselves, their practices, colleagues, clients and the work environment. Field observations are intermingled into the analytic narratives to illuminate how I witnessed the discourse of transdisciplinary philosophy taken up and enacted in everyday circumstances. While the majority of the data presented in chapters four to nine are either direct quotes or paraphrased directly from participants’ narratives, I have also interwoven my analytical interpretations throughout to help the reader link empirical data to theoretical concepts. However, all of the language used in the analytic chapters was negotiated with team member participants and volunteer readers. Any words, concepts or portrayals contested by team members were replaced with language or descriptions suitable to the team as a whole (e.g. ‘moral space’ was changed to ‘the moral high ground’).

It may seem an unusual choice to begin the analytic section of a dissertation about transdisciplinary practice with the participants’ portrayal of the biomedical model. My decision to do this is threefold. First, the Clinic’s founders left their traditional practices and created a new world for neurorehabilitation because of challenges they faced working in a biomedically driven approach. The creation story (i.e. chapter five) seems incomplete without fully understanding the founders’ experiences in and journey away from traditional healthcare settings. Second, each and

every member of the team began their professional careers in a traditional training program and worked in a traditional rehabilitation environment for at least five years prior to working at the Clinic. It is their starting point and their point of reference from which to compare the similarities and differences between a traditional and transdisciplinary approach.

I believe the co-location of the ‘other’ and ‘selves’ in the analytical chapters is essential for the reader to fully appreciate how the team’s portrayals of themselves and their practices is, at times, inextricably tied to what and who they are not. The importance of juxtaposing these two very different healthcare modes at the outset is underscored by the antithetical repertoire running throughout nine of the 15 participant interviews. Transdisciplinarity practice and the healthcare providers who work at the Clinic are portrayed as different from the medical model in many ways. They focus on life reintegration versus physical recovery. The work environment is different. Therapeutic treatments are more diverse. They see and interact with clients and family differently. The team works together, sees and treats each other in very different ways. In fact, transdisciplinarity practice is so very different from traditional practice it is the “*anti-medical model*” (Participant 14).

According to Merriam (2001):

Narratives are disjointed, but tend to focus on the negative and the positive, and to a striking extent they rely on comparison and are therefore relational. While a strong normative component is found, ambiguity and contradiction are central elements of all narrations...Collecting such narrations, in tandem with investigating social practices, organizational frameworks and public discourses, we can begin to dismantle the category of identity itself. (pp. 512)

Therefore, I will refer to the differences throughout analytic chapters to keep these distinctions at the fore.

However, it will become apparent that some, but not all, portrayals of the traditional model seem pejorative. Some negative portrayals can be taken at face value while others are simply used by participants to position the Clinic’s version of healthcare as a better or more

legitimate model for community-based neurorehabilitation. However, I do not believe negativity detracts from the transdisciplinary meta-narrative if it helps to better elucidate the constructions of identity and practice. Varying degrees of negativity served as an important discursive resource to define and delineate who participants are as individuals, team members and team. Taken together, the positive, negative and value neutral portrayals provide a balanced perspective that is more representative of all views.

As a critical scholar, I do not shy away from including sometimes harsh criticisms of ‘other’ in my work. Neither do I believe the majority of the healthcare community is unaccustomed to or outraged by the unfavorable opinions of others. That said, positive or negative, participant’s descriptions of the traditional model do not necessarily reflect my personal opinions or observations. My role in this project is threefold: I am the researcher, the narrator and the translator. However, some of my personal experiences working in traditional healthcare settings do align with some participants’ narratives. They also differ significantly from others. My opinions and personal biases have been largely bracketed to allow the participants’ versions of the story to take center stage. Therefore, while it may appear that I am fully co-located as a participant in each of the chapters, my role is inform the analysis with theory and my personal observations in the field. I take ownership and identify my personal reflections when and where required. Most often, you will find my voice in the traditional discourse to which I have been aligned and aligned by for most of my career.

Chapter 4

The Discourse of Traditional Neurorehabilitation

I saw many of my former selves reflected in the medical narrative. I have assumed many traditional roles over the course of my career and invoked the medical discourse to wholly constitute myself, colleagues and patients based on their assigned position in the institutional hierarchy. I have worked as a critical care nurse, a clinical manager and a clinical research coordinator. I have gazed upon patients in the clinical setting and peered deep within body cavities in the operating room. I recall being mesmerized at the miracle of the beating human heart but not knowing the person whose life and livelihood was contingent on the skill of the surgeon or maybe the grace of God. I saw body parts but not people engaged in a life outside of the clinic setting. I was rewarded for staying under budget and worked hard to enforce policies, standards of practice and to streamline the business of medicine. At least one half of my 27 years of practice was spent completely unaware that my clinical gaze, nursing practice and administrative duties were oriented to the traditional medical model.

For these reasons, I have written parts of this first analytic chapter in the first person because I could hear my own story and my own voice in the stories of the study participants. I have also positioned myself as part of a much larger collective than my own disciplinary training may have defined. From this new perspective, I believe that some of these stories may be in ‘our’ stories in the sense that ‘you’ and ‘I’ and the study participants are all members of the healthcare community.

Participants invoked four distinct interpretative repertoires to characterize themselves, their colleagues, patients, practices and the workplace: ‘The Excluded middle’, ‘The Economy of Scale’, ‘Every Man for Himself’ and ‘Burnout’. My hope is that this first chapter will provide you with a point of comparison, a touchstone, with which to explore the similarities and differences between traditional healthcare practice and the illusive concept of transdisciplinarity.

Interpretative Repertoires

The excluded middle.

Looking at the history of some fields in medicine, I think most healthcare providers differentiate between the normal brain and

the injured brain because the injured brain couldn't attend or remember or conceptualize, whereas the normal brain could. So it's a diagnostic thing. (Participant 13)

In the world of traditional neurorehabilitation there are “*normal brains*” and there are “*injured brains*” (Participant 13): There are “*inpatients*” and there are “*outpatients*” (Participants 1, 2, 7 14): There is “*sickness*” and varying definitions of “*health*” (Focus group 3): There is ‘A’ and there is ‘not A’. Healthcare is a world of binary opposition, mutual exclusivity, “*differentiation*” and final finite “*diagnoses*” (Participants 9, 13). It is a world in which healthcare providers, patients, and treatments are bound up by the historically entrenched practices of medicine. It is a space in which knowledge and understandings are constrained by the excluded middle (see figure 4.1)



FIGURE 4.1 THE EXCLUDED MIDDLE

We choose “*standardized treatment*” ‘A’ for disease ‘X’ and “*standardized treatment*” ‘B’ for disease ‘Y’ (Participants 6, 9: Focus group 2). “*In a traditional medical model it is very much black and white*” (Participant 9). ‘A’ and ‘B’ are completely different and irreconcilable differences require an ‘either or’ decision. The ‘or’ in ‘either or’ is a line of demarcation between what we believe to be two very different things. It is a non-entity. It is neither a place nor a placeholder. It appears to be a nothingness that I have dubbed ‘the between’.

A final finite diagnosis requires “*hard working dedicated physicians*” (Participant 6) rationality and deductive reasoning. Medicine is not for the faint of heart, particularly with the advances in technology. “*It’s so sophisticated now to determine if it’s this or that diagnosis.*” (Participant 13). Over time technology has sharpened an already well-honed medical gaze. As the human body becomes increasingly reduced to its most basic molecular parts, new fields of study have opened up (see Figure 4.2)

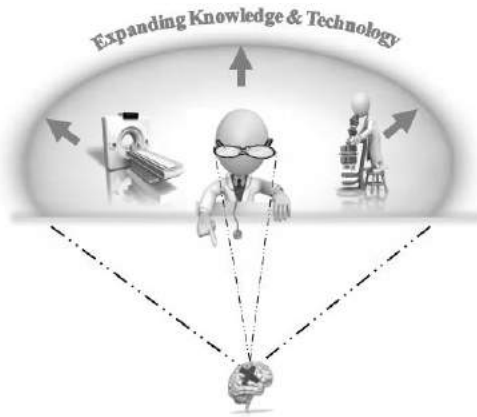


FIGURE 4.2. INCREASING KNOWLEDGE AND TECHNOLOGY

Such is the paradox of medicine: All at once expanding in knowledge and practice while the clinical gaze becomes increasingly myopic. ‘A’ and ‘not A’ can now be reduced to complexities visible only through the lens of the microscope. Brains, rather than human beings, conceptualize and remember. People are such as “*wrists and shoulders and knees,*” (Participant 2) “*cases*” (Participants 5, 7, 9, 15) and “*caseloads*” (Participant 6), “*pieces*” (Participant 1, 3, 5, 9, 14 and 15) and parts. They are our subjects and objects, passive recipients of “*direct patient care*” or body parts we are “*doing*” (Participant 1) while personhood fades away into the shadows beyond a gaze confined to the clinical context (see Figure 4.3)

I think life kind of goes on hold when they are in inpatient rehab because they are so sick that they can't think about anything else but their illness that they are currently experiencing. They are not at home and they are kind of isolated from their family, so their life kind of stops while they are rehabbing. I think they feel like they have to look to the professionals to say what the say is. They don't feel like they have as much of a say. (Participant 1)

Some of us locate illnesses in isolate body parts consumed *by* disease. We may locate patients in hospital beds alone, isolated and fully consumed *with* their disease. Perhaps it is no wonder that the differentiating gaze cannot differentiate the disease from the diseased. The disease is in the process of active treatments while the dehumanized and decontextualized

diseased lay powerless in silent, silenced stasis under our watchful eye. Health and illness are viewed in the biological domain.

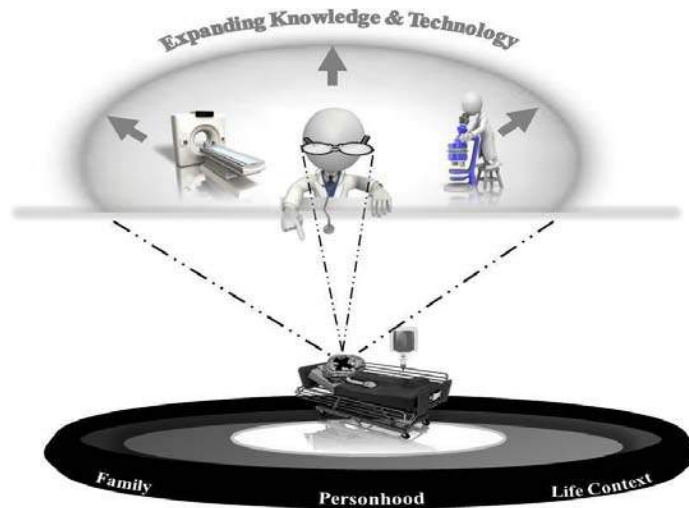


FIGURE 4.3. THE MEDICAL GAZE IN THE CLINICAL CONTEXT

I believe it is highly unlikely that we have lost our way, sold our souls or traded our morality for crisper vision. From a scientific perspective all of this makes perfect sense. In the hospital setting, the disease/diseased in their silent, silenced stasis is the isolated and fixed dependent variable. Doctors assess and diagnose so the disease/diseased can be treated with a variety of medicines and therapies (i.e., independent variables). Ultimately, we wait to see how the disease/diseased responds and (re)act accordingly. The health/illness continuum is viewed only within the space between hospital admission and discharge (see Figure 4.4).

Acute care medicine was not designed to differentiate, diagnose and treat while simultaneously conceptualizing the implications of the disease for the diseased in terms of their



FIGURE 4.4. TRADITIONAL HEALTH ILLNESS CONTINUUM

uniquely situated day-to-day life circumstances before and after discharge. It is not that a living, breathing human being with a partner and family has been lost because of our ‘this or that way of thinking’. In the excluded middle there is no such space in which to become lost. In the world of dependent and independent variables, diagnosis, treatment and discharge, a reality outside of the hospital setting is simply not part of the equation. Effective treatment within an efficient system of healthcare delivery seems to be our primary focus.

The economy of scale.

As the population grows and ages, healthcare systems strain to keep up with the evolving demands of the populations they serve. It is no wonder that the system is so focused on only two of the key principles of primary healthcare. I believe we are in a continuous feedback loop reorienting healthcare services and improving access while containing costs. Healthcare systems work to maintain their economy of scale:

Each entity or program within that system is given relative autonomy. And then in each program, like neurosciences, would have a joint operating committee that consists of administrative people and physicians and support people who decide on how things are going to be done within the group.

Outpatient rehabilitation facilities can become integrated into the system, especially if the overall financial responsibility is in a region for people getting better from traumatic brain injuries from the time they arrive on the trauma service to when they are discharged from the system. If all of that is under one purview then having one program that is effective at a certain stage in the process becomes useful. And it would solve some of the funding issues associated with smaller private clinics in the region.

(Participant 15)

Hospital systems expand geographically through the acquisition and assimilation of tertiary and community-based healthcare facilities. In some cases, I believe organizational

differences create chaos and noise that an under-resourced system cannot deal with or manage. Seamless transitions from inpatient to outpatient services when we're doing more with less, "running around trying to take care of things" (Participant 6) when the patient is ready for discharge. Regionalization to sustain an economy of scale is characterized by most participants as a reasonable and rational approach to cost-containment. Participants position traditional healthcare provider roles, practices, system-wide integration of services of smaller healthcare organizations as a legitimate, natural, common sense way of doing business. Streamlining the system and maintaining the economy of scale works through the division of labor, protocolization and standardization to enhance the system's capacity to provide more comprehensive, cost-effective care to the most number of people. Time constraints, communication barriers, and staffing cutbacks are frustrating but a manageable part of our reality.

For some participants, the agency and power bestowed on us by the traditional system are just an illusion. In-patient and outpatient units are functionally decentralized but ultimately ruled by an all-powerful centralized governing body. We believe ourselves to be autonomous, self-governed and self-scrutinizing when we may actually be pawns manipulated by an invisible hand. We may all be slaves to commerce:

The goal of the healthcare institution isn't the right goal. It's all about the money. When you go to work in a big hospital you, I mean, it's numbers driven. You can have your salaries where you need to, but all comes down to money. If you work somewhere where you get a big salary for doing a good job, they own you!
(Participants 9, 10)

Physicians are no exception to the rule. Doctors are loyal and dutiful, they are "very busy" (Participant 6) and are "there 24/7" (Participant 15). However, their power and position may be contingent on their capacity to generate sufficient revenue for the system and to contain costs at the front line. One participant characterized doctors as obligatory instruments of financial sustenance:

For things that get authorized, physicians can control the expenditures and say, you know, "We don't know about that

procedure for that thing. That's costing too much." The physician is where the buck stops. That's just the way the system works. And when the doctors get over there all of a sudden 'boom', they've got to show a certain amount of revenue or they're in trouble. (Participants 10, 15)

Participants who resisted the traditional model characterized the hospital system as inflexible and archaic. Allied healthcare professionals are now being trained to see beyond the medical gaze but attempts to break out of historically defined disciplinary roles and binary thinking are trumped by the power of physicians and invisible agents of the hospital system. Physicians were by no means demonized. Their role as financial gatekeepers may very well keep our gaze focused on illness, expediting physical recovery (i.e., health) and discharge but this form of power is fundamental to sustain an already strained and under-resourced healthcare system.

Most participants positioned themselves as conforming selves resigned to the limitations imposed on them. Developing more intimate relationships with the diseased/diseased, *"meeting them as persons where they need to be met"* (Participant 1) rather than body parts is a necessary trade off to get our jobs done. *"The therapist goes, stuff happens and you're done. That's just what people do, right or wrong. I mean we did quality care. We did what we needed to do"* (Participant 5).

Traditional health-care and educational institutions were universally characterized as closed systems. They fragment themselves to measure the performance and conformance of the component parts and aggregate the pieces to evaluate the functioning of the whole. Serving the greater good is about serving the immediate clinical needs of the patients and meeting our obligations to the bottom line. We act and react to the changing needs of the populous by acting and reacting in the same predicable way. It has been my own observation that successful metamorphosis is the purposeful attainment of organizational morphostasis.

Healthcare for the masses requires system stability and routinized sameness to function optimally. Maintaining an economy of scale seems to work in healthcare as long as: a) the people at the top are working to match the supply with the demand and b) the people on the

bottom focus on getting their assigned tasks done in a timely manner and c) patients are discharged from the institution as soon as possible. We stick together by sticking to business (see Figure 4.5)

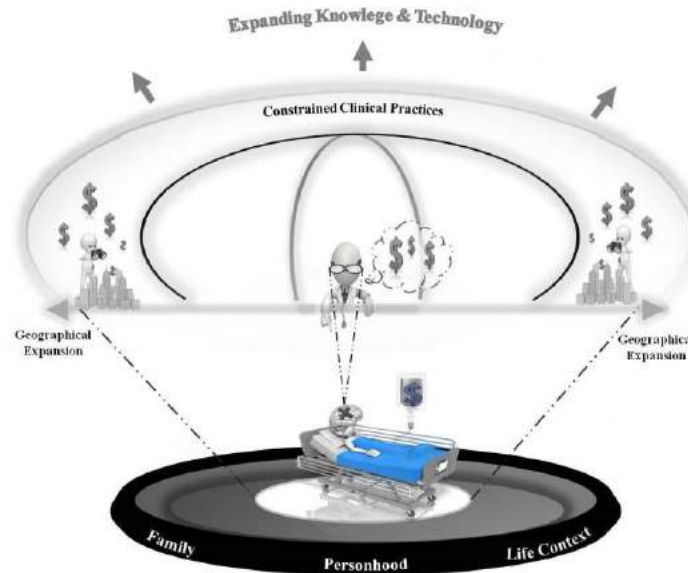


FIGURE 4.5. ECONOMY OF SCALE

Disciplinary boundaries.

By-and-large, healthcare providers are also united in our desire to heal the sick:

I think that most, a lot of healthcare providers are trained to be more client-centered as a philosophy or beginning point for sure. And I do think that you have to be client-centered. That has to be the number one. Getting your client better has to be number one. That's critical. Once you approach it with that viewpoint how else could you do it, you know? (Participant 13)

And yet as a collective we have become divided by the disciplinary memberships we “declare” (Participant 1) in our undergraduate training and the roles and tasks we take up in our hospital-based practices:

Many of us have spent time learning about brain anatomy brain chemistry and physiology, hearing sciences, language

pathophysiology and so on. That's your underpinning. But everyone has unique training and a very unique skill set, whether you're an OT, a PT, a neuropsychologist, a counselor or a speech. Each of them has a unique view of the person and each of them is certainly more qualitative than quantitative. Especially, you know, OT versus speech. There is a big qualitative/quantitative difference in their assessment. (Participant 13)

In undergraduate training aspiring healthcare providers are on equal footing. We are all grounded in a foundation of scientific knowledge with which to build our professional careers. However, declaration of membership into a particular disciplinary group has created lines of demarcation between 'us' and 'them'. Doctors diagnose, nurses "*pill pass*," (Participant 1) different kinds of therapists do different kinds of therapies and social workers organize patient discharge. On the surface it seems like a very simple and practical approach. What problems could possibly exist when highly skilled specialists, experts in their disciplinary field, focus on doing the jobs they were trained to do?

When we orient ourselves to the institutional discourses of efficiency, diagnosis, treatment and discharge and we may become rigid in our practices. We may become "*loyal to our positions*," (Participant 14) our disciplinary collective and the roles and tasks into which we were indoctrinated. We may even identify ourselves, our disciplinary peers, our practice and our gaze as special or "*unique*" (Participant 13)

Everyone has a unique training and a very unique skill set. We have our own areas we can get certified in. There are big qualitative and quantitative differences in our assessments. We don't step on each other's toes because we all do different things, but we have a common goal. So for example, therapists don't really delve into the biological pieces of what brings people to where they are at, or the cognitive or emotional status. (Participants 9, 13)

Some participants felt confined but resigned to the limits imposed on themselves and their practices. *“I think there’s so much specific skills in some of the domains that like I couldn’t do anything with physical therapy or speech things.”* (Participant 9)

Some of us in healthcare might find ourselves routinely using terms such as areas and fields to delineate the patch of ground claimed by our disciplinary clan and to which others are denied access. Some of us might present ourselves to others as professional custodians with the power to rule over and protect the boundaries of the practices that define us as a certain type of healthcare provider. The narratives of some participants included stories about extra-disciplinary peers dismissing attempts to participate in discussions that traditionally excluded input from other members of the multidisciplinary team. They had tried and failed to breach knowledge/practice boundaries despite educational credentials that should have given them the right to have their input acknowledged and taken into consideration. They were ousted from the group and sent back to practice on their own disciplinary turf.

The powers above that require us to perform prescribed disciplinary tasks in a safe, efficient and competent manner may also constrain our ability to work together. We may strive to create interdisciplinary learning and interdisciplinary or transdisciplinary team practice but segregation and self-segregation in the context of a bio-medically driven healthcare system may only serve to reinforce and reproduce multidisciplinary (see Figure 4.6):

In some inpatient units physicians have dual positions as program directors and unit medical directors. And when they are in charge of the unit they manage the rules about how the team functions together. For example, the medical director attends all the family conferences and is, you know, the big decision maker and the physician would be the spokesperson for the team. But it’s not very team-based like it is here. I think that a lot of healthcare providers are concerned about the client but they just aren’t willing or don’t know how to work together. Maybe somebody at the top is not allowing that. (Participants 13 and 15)

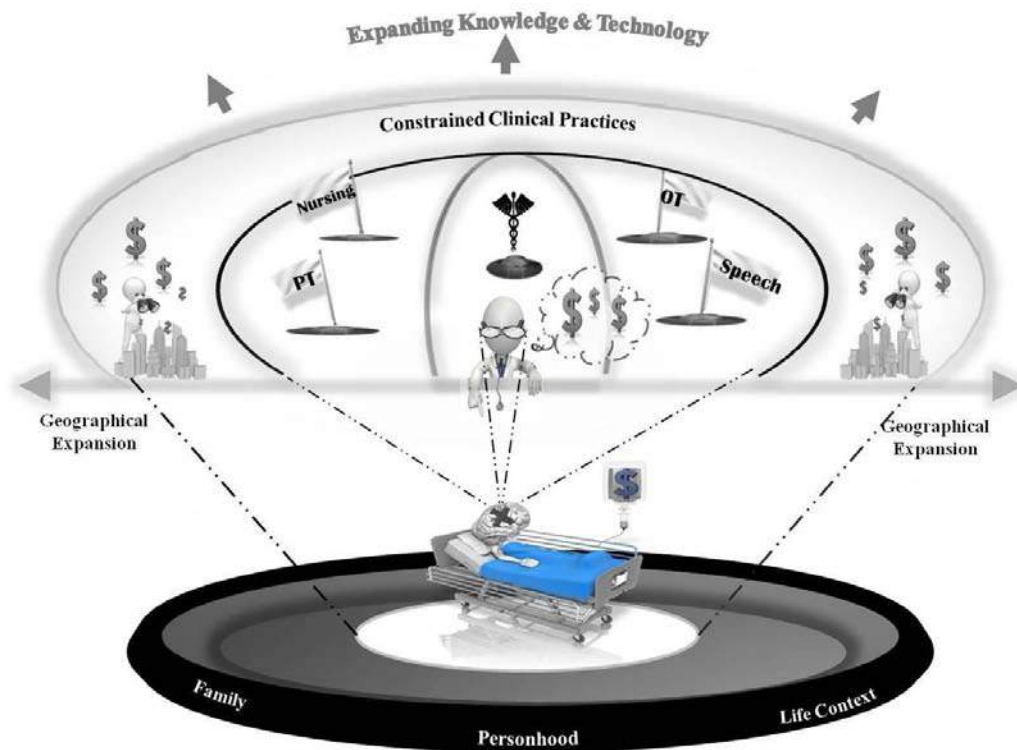


FIGURE 4.6. THE MEDICAL GAZE AND TRADITIONAL DISCIPLINARY BOUNDARIES

Disciplinary boundaries and self-segregation can also be deployed as a mechanism to protect some of us from our fallible colleagues in case something goes terribly wrong:

And I also know lots of people who, they're good people, but they don't want input. They say, "This is what I want to do and I want to have, sort of, rule over my piece." Or "We own this part and another discipline owns this. That's your piece of it." And that works in some settings, you know? I think it probably works in forensic settings and other stuff where everything has to be meticulous and you have to defend every move you make.

(Participant 9)

Those who resisted biomedical thinking and disciplinary divisiveness implicated the power of the medical academy for molding allied healthcare education into a less skilled and less knowledgeable image of itself. "Our schooling is so focused on the different disorders and what you do to treat those disorders and all the different pieces" (Participant1). And yet, in another

turn, participants deploy the discourse of medical education to legitimize themselves and each other as competent and highly skilled. They had moved up their disciplinary ranks “*doing an internship or a residency or a clinical fellowship*” (Participant 1).

Why is it that some of us in allied health use the language of the very same power structure that we claim constrains who we are and who we are capable of becoming? Has allied health aligned *itself* with medicine in a seemingly futile attempt to gain equal footing in the medical knowledge/power hierarchy? Why is it that physicians, nurses, or therapists cannot see the possibilities made possible by “*loosening our disciplinary boundaries,*” (Participant 9) sharing and collaborating? I wonder if our traditional academic upbringing, our drive for legitimacy, power and status along with the seemingly insurmountable healthcare needs of our growing population have unwittingly trapped us *all* in a biomedical knowledge/practice bubble.

Disciplinary blinders.

One of the problems with disciplinary boundaries seems to be the disciplinary *blinders* that some of us wear. Some of us can spend countless years in our educational institutions on a seemingly endless pursuit of knowledge in our chosen area of expertise while others can hit a virtual brick wall:

I'd kind of answered the questions I wanted to and I kind of got to the point where I couldn't go any farther. I had sort of met the limits of what I was studying. I looked at variety of different populations but I wanted to go in a different direction. (Participant 13)

This particular participant characterized herself as a professional student. She worked hard and studied hard. She lived to learn. In this case, seeing the blatantly obvious brick wall as an obstacle to furthering her knowledge was not the issue. The problem was not seeing any pathways with which to access knowledge beyond the scope of her disciplinary silo. She had arrived at the dreaded excluded middle. Medicine is medicine, social work is social work. ‘The between’, the potential space between disciplinary silos was hidden from view.

Fortunately, a former mentor removed her blinders to reveal the illusion of the excluded middle. A new field of science was emerging that combined the knowledge and practice of two

seemingly disparate disciplinary fields. They had not simply built a bridge across ‘the between’, ‘A’ and ‘not A’ had been combined to create an innovative and integrated whole. The medicalized gaze had been enhanced by ‘zooming out’ rather than ‘zooming in’. This gaze could not only see the body part, it could also see the patient as a person in the context of their everyday reality. Her new holistic gaze was much bigger, broader and more inclusive than could merely be accounted for by the sum of its two disciplinary parts.

As with many things in life, I believe this is a good news, bad news story. A new way of seeing the patient had emerged by creating a whole new field in medicine. Housed within the same closed system of academic healthcare the new and unique field came equipped with its own set of blinders. Another disciplinary silo had staked its claim on a separate patch of ground to be “owned,” (Participant 13, 14) protected and “ruled over” (Participant 9).

Study participants did not draw on the repertoire of disciplinary ‘blindness’ found in publications by other transdisciplinary scholars. Rather, a repertoire of disciplinary ‘blinders’ was invoked to characterize their colleagues as simply not seeing beyond their own self-referential disciplinary field. It is not that they are so gravely myopic that they cannot see. Their capacity to see is merely an untapped resource. Some of us may see ourselves as just one of the many doing our jobs, relaying information to colleagues or up and down the chain of command. We may be so completely aligned with the traditional model, rules and conventions that we are oblivious to what we do not know and cannot see. We may be happy being a small cog in the large wheel finding fulfillment in a job well done.

The more troubling difficulty with disciplinary blinders occurs when we choose not to see (i.e. I know what I don’t know and I don’t really want to know). Information outside of our disciplinary knowledge base is visible but the meaning and relevance to our practice seems completely irrelevant.

I do think there are efforts to try to get to a bigger picture understanding in healthcare, but it doesn’t always work. So like nursing will do a BIMS or a PHQ-9 assessment when the patient comes in checking their cognitive status. But therapists are not trained in that assessment and they don’t really always know what

those scores mean. They could look into that and stuff, but then nursing doesn't really know what those mean either.

And some of the therapists on the therapy team, you know, you have to see the client is what they say. You can't confront them if you think their thinking is wrong. If you confront them you'll cause problems in your work relationships so it's better just to go see for yourself. So some therapists will end up co-treating just to see why the other therapists think the person is crazy. (Participant 1)

I have observed complacency wearing many faces in the healthcare milieu. It has no preferences as to age, sex or disciplinary membership. It is not limited to the nurses or therapists we see in the above exemplar. We may not all be guilty, but we are all susceptible, particularly when complacency is a deeply engrained cultural norm in the organizational environment.

When we choose to be complacent we make a conscious decisions to avoid going down the rabbit hole. The rabbit hole may seem like a place of darkness with unforeseen dangers lurking around every corner. According to Participant 1, some of her traditional colleagues may believe from 'my' disciplinary vantage point on the surface, 'I' am safe and don't have to see the gaps in my own knowledge. I don't have to question my own expertise and I can successfully fend off any attacks on my sense of self. I can keep my expert professional identity intact.

If it is not safe to be vulnerable in the workplace or we are unwilling to take personal risks we could lose the unseen treasures located in the depths and the darkness. We may tighten up our disciplinary blinders and don a virtual suit of armor to protect our ego integrity. At least if we are purposefully avoiding the rabbit hole it is a signal that we really do have the capacity to see a visible road to 'the between'. It is the road marked by those clinical breadcrumbs.

However, if we are fully oriented to the discourse and practices of the biomedical approach or engaged in acts of self-preservation we might not see the rabbit hole as the metaphorical illusion it really is. Going down the rabbit hole may actually leads us to a higher vantage point where we can 'zoom out' and see the "*bigger picture*" (Participants 1, 6, 8, 15). It can take us to a space of knowledge integration where we can combine my knowledge with

“*your stuff*” (Participants 2, 3, 5). It might even provide me the opportunity to see your ‘stuff’ as legitimate and valuable knowledge neither of us had not previously understood nor appreciated.

There may be very real dangers in revealing an imperfect professional self in the workplace but with courage and willingness and our focus squarely on our *patients*’ best interests, the treasures we find in the darkness may be life saving for those in our care. The more rabbit holes we explore the more chances we might have to constructively collaborate with colleagues, build on our knowledge base, see our patients from a new perspective, and embrace the opportunities to be innovative and creative in our practices. The rabbit holes that lead you to ‘the between’ are the pathways to a space of enlightenment (see Figure 4.7).

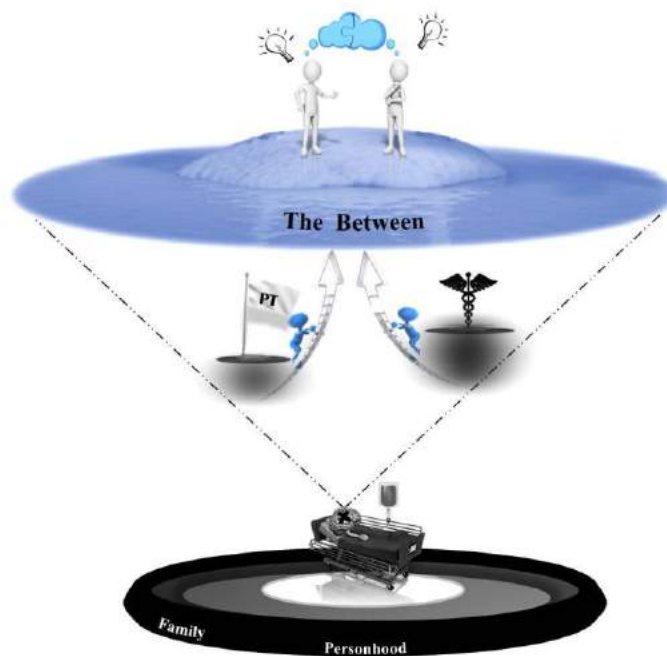


FIGURE 4.7. PATHWAYS TO ‘THE BETWEEN’

Every man for himself.

In the fight for intellectual superiority in the workplace personal attacks on self can confront us with another set of irreconcilable antagonistic choices. We can flee, conform or we can fight. Some of us might choose to run away from threats and “*hide behind closed doors*” (Participant 1) to shield ourselves from the very real dangers to our credibility and our sense of self. On the battlefield, sometimes your defense is retreating into the safety afforded by the

darkness of your office. I believe that there are times when you need a fox hole if chasing rabbits could lead you directly into a trap.

The surveillance system in the traditional work environment does not enforce its own clearly delineated rules of engagement. *“In larger settings, the philosophy is set. You will look at the team concept. You will keep the client and family as a priority. You will be respectful of your colleagues”* (Participant 6). In reality, it’s every man for himself. We may be loyal to our disciplinary clan, but on the battlefield collectivism loses out. It can be an unmitigated struggle for intellectual superiority, power and status.

For some, the traditional workplace can be a space of interpersonal incivility, *“competition and little support”* (Participant 13) because we work in a system fueled by society’s orientation to individualism. Good people can become unwittingly caught up in a cultural norm where intellectual prowess and personal accomplishments are privileged over the greater good of the collective. *“Your degrees and your accomplishments, that’s really the most important thing before you are the person”* (Participant 14).

To be battle-ready, the more sensitive vulnerable human self might need to take shelter or become subsumed within an idealized self wholly constituted and legitimized by the *“character role”* (Participant 13) afforded by one’s educational credentials and disciplinary rank in the system. Credentials and accomplishments have become the yard stick by which professionals are deemed more or less worthy, defining and constraining who ‘I’ am, who ‘you’ are and who ‘we’ are as a collective. When we occupy a space where we are not free to express our authentic selves, to grow or to become a new and better self, we can begin to stagnate:

Personally, I guess I didn’t ever feel that it was hugely connected to other disciplines in the larger hospital systems. I think I really felt emotionally detached from my work and from my colleagues because it was just devoid of sharing and co-creating and collaboration with other like-minded like-mind. (Participant 5)

A toxic workplace may seem similar to a workplace characterized by disciplinary divisiveness. In both environments we may find ourselves trapped within the silent, silenced stasis alongside our patients. Whether we segregate and isolate ourselves within our disciplines

or dehumanize and objectify our competitors, we risk becoming disconnected from our inner selves and from the human beings we work with.

4.1.6 **Burnout.**

The momentum required to expand and maintain an economy of scale means doing more with less. In healthcare, there seems to be more and more technology but fewer healthcare providers spread out over a larger geographical plane. Over time, the energy required to run the system can deplete the energy of the workforce, the cogs in the wheel, to the point of physical and emotional burnout:

I think that burnout in the traditional model is about those people where that whole sort of social harmony is like a big piece of their life. And when there are missteps at I think people turn against the system and then everything is, “Well, this place sucks!” instead of looking at other things. (Participant 9)

Irrespective of your job or your status in the knowledge/power hierarchy, doctors, therapists, social workers, transcriptionist and receptionists are on equal footing when we reach this point in our careers. Some of us exchange our personal well-being to meet our obligations and duties owed to our patients, families and our organization. We can run ourselves ragged in the name of our moral imperatives but not have the capacity to meet the ever increasing demands of jobs or our personal needs. The candle that once burned at both ends can become fully extinguished.

When an organization dictates that “*You will come to the table on staffing and you will push yourself,*” (Participant 6) but fails keeps us feeling safe in the workplace, we can lose our spark and our spunk. Participants did not identify particular individuals who might have failed to survey the work environment and intervene if necessary. They were not able to name persons or positions of authority who might be preventing disciplinary collaboration. A transdisciplinary physician who also held a leadership position in a regional hospital could not direct me to someone higher up who could discuss if or how transdisciplinary practice would fit into a bio-medically oriented healthcare system.

Some participants portray the system's gaze as being similar to the medical gaze. It is both myopic and unidirectional. Not only does the system's gaze not see and survey the culture of the workplace, those below cannot see or name those gazing (or not gazing) down. The system may seem like a virtual black box. Professional roles in the power/status hierarchy that position providers below the level of the system's gaze may relegate human needs, humanity itself, into the shadows where irrelevance resides. We may even see and characterize our inner selves as being located in the shadows and our professional selves completely in the dark

We can resign ourselves to our plight, become complacent, and fight the system if we have sufficient energy or we can flee. Some team members left intuitional positions to relocate while others characterized themselves as bored, burned out and emotionally detached from patients and co-workers. A few participants characterized themselves as wounded warriors who had gradually become battle wary. They did not take up this identity to position themselves as victims of the system, they chose not to engage in or tolerate social disharmony and workplace incivility. They are the survivors who could have chosen to become tired alone and isolated in the darkness, but chose to walk, not run, into the light.

Figure 4.8 is a pictorial representation of participants' descriptions of the traditional work environment.

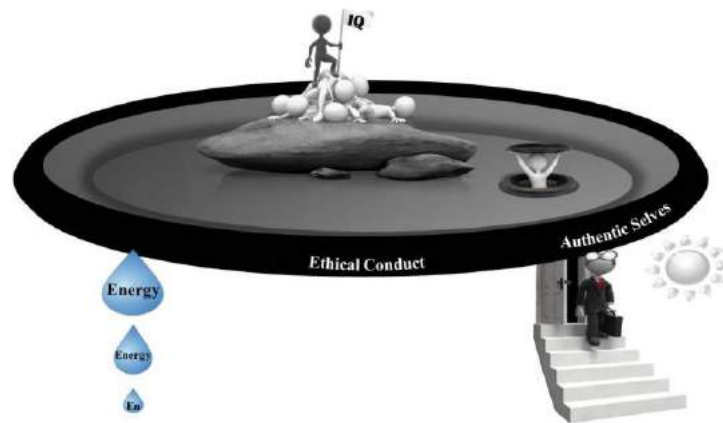


FIGURE 4.8. TRADITION WORK ENVIRONMENT

4.2 Summary

Figure 4.9 represents the traditional model of healthcare as portrayed by participants. It depicts how the broader more inclusive meta-narrative provides a more complete picture of how they characterize the medical model. In other words, participants talked about their education, practices, gaze and the work environment in such a cohesive way that I was able to create a visual representation of their collective descriptions.

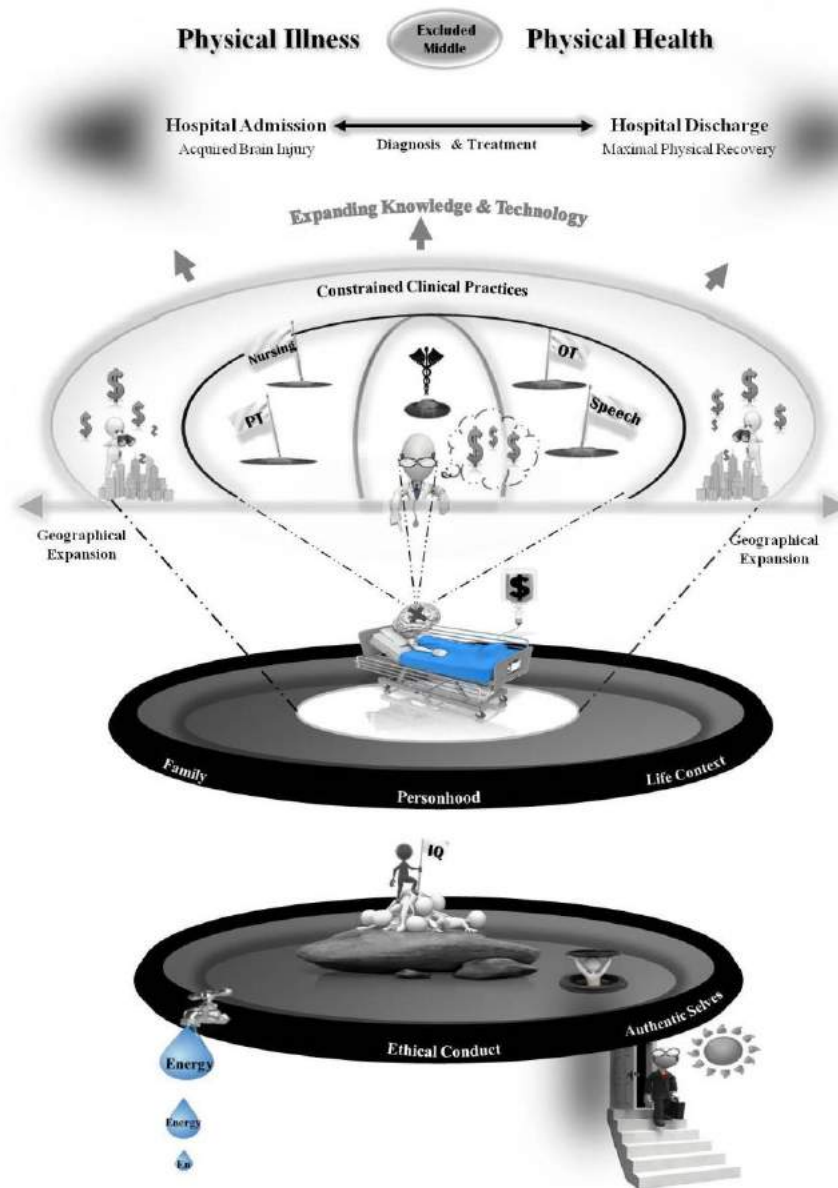


FIGURE 4.9. TRADITIONAL PRACTICE MODEL

I have purposefully placed the health/illness dichotomy at the top of the model to represent how the power behind the discourses of traditional medical practice, efficiency and cost containment orients and maintains our practices and gaze towards diagnosis, treatment physical recovery and discharge. The health/illness continuum we have traditionally used to visually locate a patient's progression towards health or illness is now depicted as a health/illness dichotomy. If there is a journey between health and illness, is it a journey between hospital admission and discharge. Life before illness and life after discharge is as invisible to the gaze as it is absent from the model.

Participants characterize the topography of our academic and clinical institutions as flat. The knowledge/power/status hierarchy is an illusion co-created by ourselves, the values imposed on us as a society and the valorization of some disciplinary institutions over others. The knowledge/practice bubble we have created is a closed system that expands laterally (i.e., geographically) and vertically (i.e., knowledge and technological advancements). It contains and constrains our clinical practice, the construction of our identities and the possibilities for meaningful collaboration with each other. I cannot see a person situated in the complexity of their real life circumstances. We are under resourced, doing more with less and burning the candle at both ends. We have such precious little time to do our jobs is it any wonder why we have lost sight of our patients?

A lack of social support in the workplace or too few resources to bolster the emotional and psychological well-being of the workforce can drain the energy of our healthcare providers. The administrative gaze does not survey the socio-cultural context of the workplace or enforce the prescribed rules of conduct. We may thrive, survive or simply co-exist with our colleagues. We may win the battle for intellectual superiority but at the expense of the success and well-being of others.

The Clinic's founders recognized they had outgrown the traditional biomedical practice model and they no longer wished to work in competitive and sometime negative workplace. If they old world wouldn't change, they would have to set out on their own to create a new one. Chapter 5 is the story of that journey and the realization of their dream.

Chapter 5

The Creation Story

I think it emerged initially because we wanted our work to include the whole picture of neuro rehab. We wanted to create a world where the focus became the client, that's gotta be number one and you don't worry about what you're doing in this or that.

There is this common nurturing thread here and shared a common vision in terms of trying to come up with, first of all, strategies that really helped the people function better in their day-to-day activities. (Participants 13 and 14)

Interpretative Repertoires

The included middle.

The neurorehabilitation Clinic was created so that neurorehabilitation providers could focus on enhancing the capacity of clients, family members, and their support persons to maintain an orientation towards independence, improved quality of life and well-being. In community-based rehabilitation, the transdisciplinary gaze needed to see far beyond the clinical setting and gaze upon the multiple complex factors that contribute to a particular client's health/illness orientation. Traditional medical practice is not designed to support clients as they reintegrate into their families, leisure activities, work environments and communities both during and after physical rehabilitation.

The Clinic's founders recognized that life, health, illness and recovery from acquired brain injury are dynamic processes that cannot be understood from a traditional 'either or' perspective. Recovery is a complex and multi-faceted journey through which clients may be **simultaneously** moving toward health in some areas of their lives and moving toward illness or disease in others (see Figure 5.1). Illness is real. It does include physical injury, cognitive impairment and increasing physiological decline. Illness is also a reality. It is a life journey oriented towards dependence on family or healthcare providers, decreased quality of life and an overall decline in feelings of personal well-being. At the same time, there is a reality that is an orientation towards health, to more independence from family members and healthcare services, improved quality of

life and feelings of personal well-being. An orientation towards health does not have to be limited to physical and cognitive recovery. An overall orientation towards health could include physical and cognitive stasis or a lifelong decline.



FIGURE 5.1. TRANSDISCIPLINARY/SALUTOGENIC HEALTH/ILLNESS CONTINUUM

When a person's existence is viewed through a biomedical lens or focuses on the economics of medical treatment we, as a community of healthcare providers, may be blind to factors outside of the physical domain that contributed to the client's illness and hospital admission in the first place, to the reality of the client and family. Perhaps we work in a clinical setting where we do not have the time or the resources to see, let alone assist, clients and families to face real life challenges outside of our institutional walls. Some of us may not have the capability or sufficient cross-disciplinary training to "*see the whole rehab piece*" (Participant 13) or "*get the big picture very well*" (Participant 14).

In some institutions, the constrained and constraining biomedical gaze could not and, at times, would not bend to accommodate a more holistic and integrative approach to neurorehabilitation:

This is what I can add to that. And that's my piece of it as far as what happens afterwards. That's not necessarily what I'm supposed to be doing. I'm supposed to be providing [physicians] information. So a lot of them don't look at the whole rehab piece and ...they still go on that model (Participant 14).

Transdisciplinary healthcare requires a different way of working together and a gaze that is all at once panoptic and multifocal. Healthcare providers and healthcare teams still need to see the biological, but the biological has to be viewed within "*the bigger picture*," (Participant 3, 6) the "*whole picture*" (Participant 1, 8) and include the "*whole person*" (Participant 2). The

pieces and parts of the client and their “*fragmented families*” (Participant 5) need to be put back together to see the big picture, even if seeing the bigger picture means asking clients to “*bring me pictures*” (Participant 12) to see into their world. The founders created a space where team members could free themselves from their disciplinary blinders and excluded middle thinking so they are free to venture outside of the (self)imposed confines of their disciplinary boxes and delve fearlessly into the darkness of ‘the between’. They wanted a space to “*meet the client or the patient where they need to be met*” (Participant 1), in all of their personhood and the messiness of their real lives.

Understanding the factors that impact a person’s life circumstances and their orientation on the health/illness continuum requires a broader more inclusive framework. The transdisciplinary team needed to consider all of the factors that impact health when they ‘zoomed in’ and ‘zoomed out’. They needed to re-conceptualize the client, their families, community and broader social systems as a multi-level, multidimensional and interactive whole (see Figure 5.2).

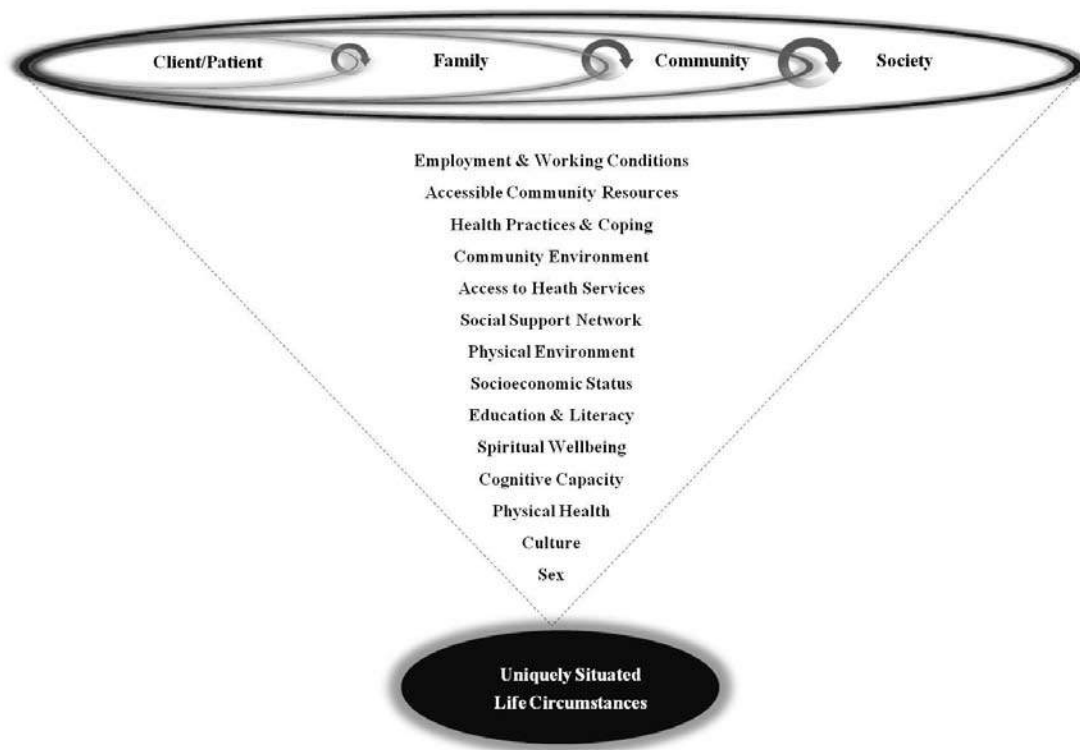


FIGURE 5.2. TRANSDISCIPLINARY DETERMINANTS OF HEALTH FRAMEWORK

At the level of the individual and family, the newly created team was now able to consider all of the determinants of health rather than viewing them in isolation or from their own disciplinary perspective. Together they created a transdisciplinary/salutogenic gaze that included aspects of health such as physical functioning and cognition, the client's health practices, spiritual beliefs, coping strategies, level of education and reading ability, cultural beliefs and practices, family dynamics and financial circumstances.

The transdisciplinary gaze was now free to move past the individual level of reality into the community so the team could begin to understand social support networks, access to health services, working conditions and the resources available during recovery. They could now see the characteristics of the social and physical environments influencing each individual client's position on the health/illness continuum. They could gaze into the broader social systems, structures and institutions to understand how clients and families are being impacted by health and social policy and the ever-changing political climate. The transdisciplinary gaze sees complex interactive meta-systems.

The transdisciplinary gaze was also allowing them to consider the dynamic interplay between health determinants, *"tease things out"* (Participant 13) and co-create individualized solutions. *"I see [the determinants of health] as clouds that come together and then dissipate as we work with clients and their families. And just when we think that we've gotten through one situation, another set of clouds appears"* (Participant 5).

For example, factors such as physical illness, reduced cognitive capacity, a home ill-equipped for wheelchair access and barriers to community resources may represent a cluster of factors orientating a client towards dependence, disability, decreased quality of life and a decreased feeling of personal well-being. At the same time, healthy coping mechanisms, strong social and community support networks, their culture beliefs and financial stability may provide sufficient support to maintain their orientation towards health. While dealing with priority issues for the client and family, the founders knew they had to simultaneously bolster the client and family's capacity to manage their life and health circumstances even in the face of potentially overwhelming burdens (see Figure 5.3)

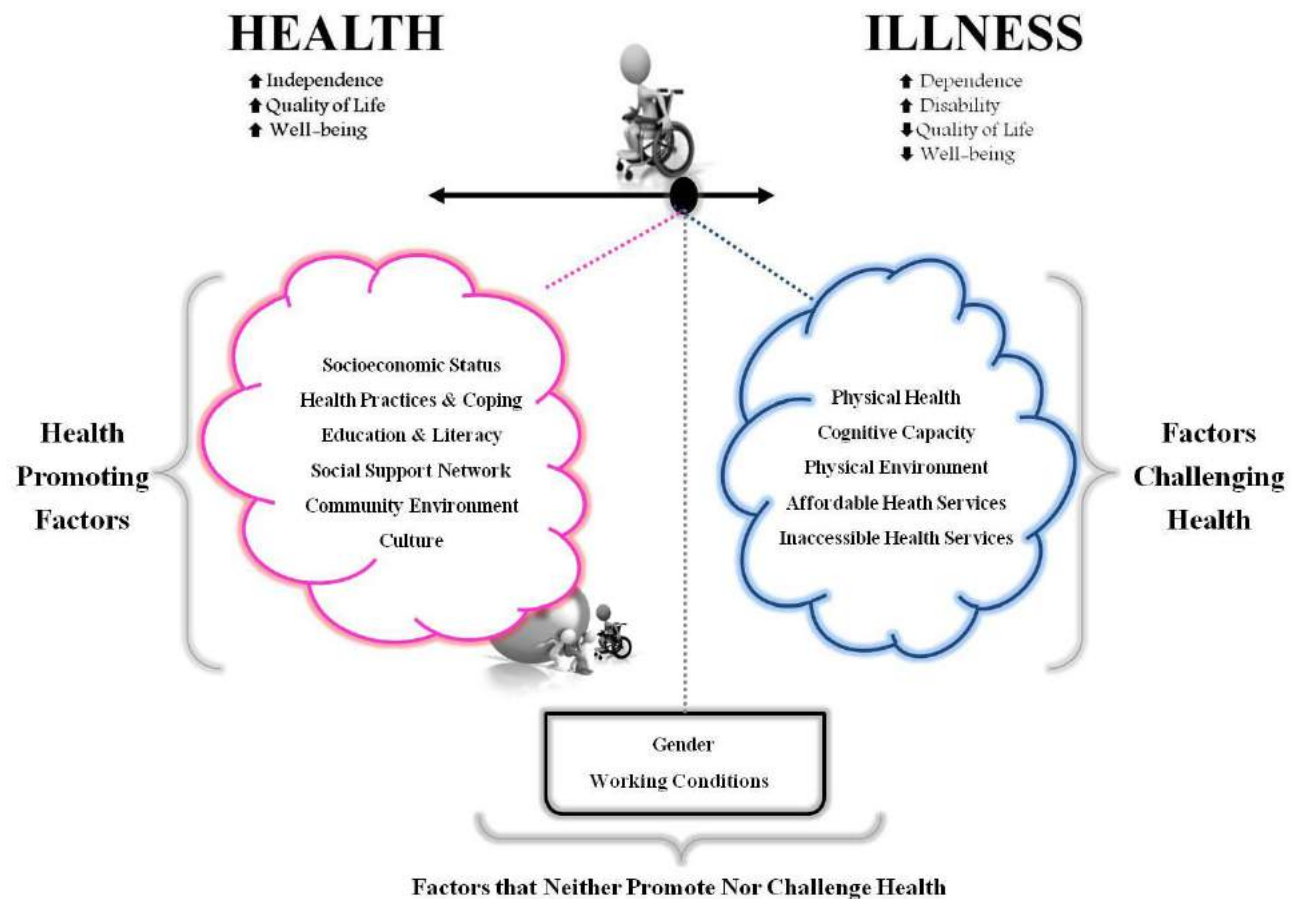


FIGURE 5.3. DOH INTERPLAY AND HEALTH/ILLNESS ORIENTATION

Such complex and rapidly changing circumstances require complex multidimensional perspectives and reactive responsive healthcare teams. What has changed? What is working or not working? How can healthcare providers work together and evolve new understandings and new interventions? The founders and their new transdisciplinary team created a gaze that could ‘zoom out’ to see the big picture, ‘zoom in’ to see the details, modify interventions and ‘zoom out’ again to evaluate the physical effectiveness of therapies and the overall impact on real life circumstances. *“For years our motto has been upwards and outwards”* (Anonymous Team Member Feedback, November 25, 2013)

The subject of the transdisciplinary team’s gaze is not the same as the silent, silenced decontextualized subject of biomedical gaze (i.e., the diseased). The subject of the transdisciplinary gaze is the client’s, family’s and/or team’s perceptions about the each client’s uniquely situated complex realities. The object of the gaze is the client’s multiple real life

circumstance where he or she will recover and heal. The team's primary focus is how the client thinks about and interacts within his or her meta-system.

The founders knew the healthcare team had to work together in a much more interactive and collaborative way than they had worked in the traditional healthcare system. They needed a team that was united as a collective. The medicalized gaze requires a controlled environment and sees the disease/diseased in stasis. Traditional healthcare teams are made up of singularities, each with their own unique disciplinary perspectives. That approach would not work for community-based neurorehabilitation. Could a lone physician prescribe specific physiotherapy exercises to help a coach cross the uneven terrain of a football field and return to the job he loves? Could a lone occupational therapist develop and implement evidence-based client-specific anxiety reduction techniques while simultaneously helping a stroke survivor to drive his or her car? The founders recognized early on that the honest answer to these questions was 'no':

Everything you've learned that might happen doesn't always happen. Something else happens. So why do you say, "I have all the answers?" How could you possibly? How are you going to help this human whose behaviour is already altered by some, you know, intrusion into the brain, without utilizing everything that's out there? You couldn't possibly! (Participant 14)

No singular disciplinary perspective can conceive of, gaze upon, or understand the complex, interrelated and multifaceted interactions of the client in his or her evolving real world context. Further, the capacity to design individualized, contextually specific, culturally relevant, understandable, meaningful and novel interventions is well beyond the scope of any one discipline. There **are** times when a client only requires the help of a single occupational therapist to get them safely back on the road. Others might need a psychologist riding along in the back seat helping them to implement anxiety reduction techniques during rush hour. The combination and permutation of transdisciplinary healthcare providers needed to work collaboratively with clients and families is always already person-specific, contextually driven and changes on a regular basis depending on the evolving needs of the client.

The transdisciplinary team, as a whole, turned its gaze upward and outward to see the big picture together. They welcomed opportunities to delve into ‘the between’ and ponder the infinite possibilities made possible by linking my knowledge and your stuff. Exclusionary thinking could not see or understand messy, real life problems. Real life and real life solutions during rehabilitation required them to throw away any attachments to binary thinking. If it’s not A or ‘not A’, it must be something else we just can’t quite put our finger on. We need to find the answer and a solution somewhere in the included middle.

The moral high ground.

I think we wanted this to be the antithesis of the traditional model. The kind of model that was, you know, everybody should be treated equally. And the work that everyone does, each person’s contribution, everyone’s piece, deserves to be treated with respect. And when we first started out what was especially insisted upon was that people act in that way. And I mean, well of course we didn’t even know what a transdisciplinary program was. For us, transdisciplinarity was just about egoless people coming to share their knowledge and figure out how to help these people. We cared. And from day one we were that way. We were the antithesis of the traditional model. It has really become the anti-medical model and the egos and hierarchies that we were striving for from the beginning.

(Participants 3 and 13)

The moral high ground is a sacred place. It is hallowed ground. It is a space so unlike the traditional work environment, it is the “*anti-medical model*” (Participant 13). For the founders, the moral high ground represents everything the traditional workplace was not and could never be. It is “*a place where when people walked in, they left their egos at home and they didn’t flaunt their degrees*” (Participant 13). It is a safe haven where they are free to relinquish their traditional identities and expose their most vulnerable human selves. It is a place of

equality, peace and social harmony where each member of the team is treated with dignity and respect irrespective of their disciplinary identity or professional designations:

We never felt like we knew more than anybody else.

I never let people call me ‘doctor’ except when we were having a meeting because then it’d impress the outside world because sometimes people would say, “Oh you guys don’t really know what you’re talking about.” Why people get caught up in their egos is beyond me.

I was the same way as a grad student, you know, the secretaries, some would treat them kind of nasty. I’d always go out of my way to be nice because I didn’t like that. Yeah we were always that way. That it doesn’t matter what you do, you have a, you know, you’re making a contribution and you should be recognized for it. So, I think, you know, I think it just goes back to who we are as people in the beginning. (Participant 14)

The new world is a place to share knowledge and to support the growth and learning of transdisciplinary colleagues. You don’t have to “*play the games*,” (Participant 13) or worry about people who try to “*knock the props out from each other*” (Participant 13). You don’t have to hide behind closed doors or retreat into the darkness. Each and every member of the team sees themselves as normal, everyday “*folks*” (Participant 10). They are the salt of the earth type of people: humble and firmly grounded in the morals and values they have used to grow and nurture their creation for the past 25 years. The moral high ground is a place of mutuality, kindness and compassion where team members are on equal footing. It is an ethical foundation that envelopes the team and floods their space with light (see Figure 5.4)



FIGURE 5.4. THE MORAL HIGH GROUND

Open complex adaptive communication network.

Transdisciplinary ‘thinking’ and transdisciplinary ‘doing’ cannot exist without an open complex communication network. “*Communication leads the team*” (Participant 5). The founders needed to establish a communication network that would support documentation and communications in a simple and easily accessible medical record. It had to readily facilitate communication between team members, clients and family members and liberate them all from the formal, hierarchical, and oftentimes disconnected communication patterns of traditional healthcare systems. Team communication needed to simultaneously operate at the edge of chaos but somehow come together as an integrated whole. It had to include easily accessible and informal relay systems between, multiple team members, clients, families and external healthcare providers. It also needed to include more structured and inclusive modes of communication to bring all of the sound bites together in an integrated, holistic and meaningful way.

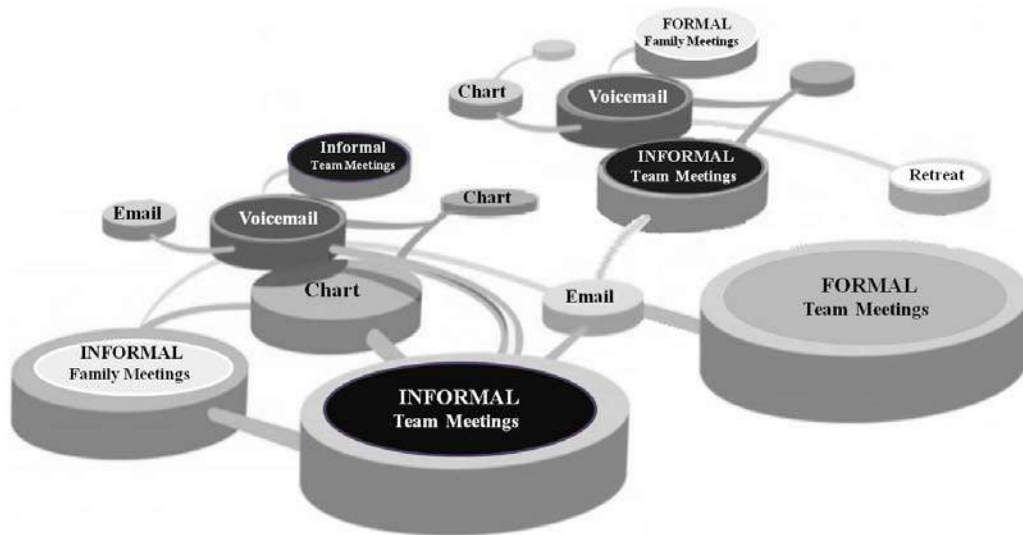


FIGURE 5.5. OPEN COMPLEX ADAPTIVE COMMUNICATION NETWORK

Figure 5.5 represents the primary methods of communication at the Clinic but does not provide an adequate representation of how the transdisciplinary team’s communication system actually functions. To understand the system in all of its complexity, you must envision it being much more organic, multidimensional and multimorphic. The connections between communication hubs are not static; they are continuously connecting, disconnecting and

reconnecting in an infinitive number of different ways. The communication network shape shifts.

“I think that, you know, a lot of the credit goes to the director too because we did share this common view” (Participant 13). The clinical director was entrusted with the lead role as systems architect during their initial period of growth, while the founders focused their attention and practices on building and nurturing team relationships. It was a challenging period of transition for the organizations. The director had a firm hold of their reins while she worked with the team and administrative staff to develop the physical structures and processes needed to support transdisciplinary team collaboration, knowledge integration and practice. However, this form of leadership seemed incongruent with the founders’ vision of equality in the workplace. It certainly did not come without consequences for the culture of the organization:

Of course, it used to be more hierarchical when we first started out and it was really tough for a lot of reasons. There was a lot more sense of control because we were creating system and the support staff and administration were trying to figure out what documentation they needed and so on. So they were running and they were learning. Looking back on it, I can understand why it felt more controlled. (Participant 11)

In retrospect, team members are able to see that the clinical director was building a system that would eventually support the founders’ vision:

There was always that sort of wanting to work within a system that we’re all on the same page. We didn’t want people all doing their own thing because it, that’s not what we do here. (Participant 9)

The director needed to build a system that was not entirely unlike the traditional model of healthcare in which *“services are all integrated into the same system”* (Participant 15). However, the system was not built to primarily support and maintain an economy of scale. They had to create a business platform that would support and coordinate service delivery but, more importantly, it needed to background the business and foreground team relationships, collaboration and communication. It had to provide them with unfettered access to each other,

facilitate and support their holistic gaze, transdisciplinary thinking and creativity. It needed to be a system that could integrate multi-minded thinking. The open complex communication network to support their transdisciplinary practice had been built on the moral high ground.

The zone of transdisciplinarity (The T-Zone).

What I found lacking in the field was the attempt to say, “Okay, well these are the problems, now how is this going to play out in the person’s day-to-day activities and what can be done by various disciplines to deal with that?” They’re all just as good. And I would see situations where people would tell me stuff that was going on and I might see a little bit of a hint of it in my practice but you know you can either say, “Oh, they’re a big crock of crap,” or you know, “Maybe some of their complaints are real and you should give them some strategies to deal with them”.

And I just ... I never, I never had the view that I was better than the other people and I think that that is how it has to grow. And if I had had the view that, “Okay, I’m the guru here and then I’ll make a decision and I don’t care what you say. If I don’t agree with it then you’re data aren’t any good.”

I tried to learn from the people that were the therapists such as speech and OT, to a lesser extend physical therapy just because what they’re doing is typically outside of my realm. But we hired some people to help with the counselling and I did, back then I did a lot of the counseling myself and tried to figure out what was going on.

Another learning environment for me was just kind of hanging out at the hospital and seeing people that were in in-patient rehabilitation with bad strokes or bad brain injuries and, in some cases, feeding them their breakfast just kind of observing what it

was like to have a severe brain injury and then trying to get to know what they needed and trying to understand them.

I like the kind of investigation of, “Okay, what’s going on? What do I see in this that I think is interfering with learning ability? I was used to a team approach like we developed here where we’d put all our data together: my piece, everybody else’s piece, and then we determined what the client needed and what kind of disability might be going on. I already came from a model where we shared our data. And we were trying to set up that model here. But we would have to do a lot of arguing a lot of times with outside professionals because if you test a brain injured person they don’t often look that injured. And then they’d say, “Well, they didn’t meet our criteria for our program,” and I said, “Put them in their real world with all the background noise, everything that’s going on in there and you see how they react. They’re going to fall on their face because they can’t process with all of that happening around them.” So they had to get used to the whole, this is what a brain injured person is like. It may not fit what you have for your patients.

I think we were certainly helpful in getting the some professional to recognize that there is that population out there and they are different than their typical learning disabled people, so you can’t do your standard testing and decide whether or not they qualify for your one and only program. They need further testing. They need the kinds of tests we can do in the clinic to pinpoint these problems that they have.

Here, we would have people would come to the table and say. “I’m doing speech-language but it’s so obvious that this person isn’t ready. They can’t do speech-language yet because emotionally

they're so wrapped up in what happened and how their life has changed that they can't, do we need counselling. We need you to help me with that or if they can't get in right now, what would you suggest I could do in my sessions to allow them, then, to be able to partake of the speech-language that's going on?" (Participants 13 and 14)

In the language of transdisciplinary theory, the founders serendipitously created an organization in which team members create 'zones of transdisciplinarity' (i.e. T-Zones). The T-Zones at the clinic are more than just physical spaces (i.e., a meeting room) or a virtual space created using email or voicemail. Creating a T-Zone requires each participant to enter into a different kind of head space: a moral and ethical headspace that protects the sacred nature of their collegial relationships.

Any healthcare team can create a space where they gaze on the bigger picture, consider the client's real life context, develop innovative solutions and reflect on the effectiveness of interventions and team functioning. Some might even say, "Well our gaze is at panoptic, multifocal and reflexive. What's the big deal?" What makes this team unique from others is that T-Zones are purposefully sustained by a "*shared philosophy*" (Participants 6, 10) aligned with the founders' vision for organizational equal rights, mutuality, collectivism and interdependency. T-zones are grounded in an ethos of humility and service (i.e. the moral high ground) (see Figure 5.6). T-Zones are safe places team members work as a collective to understand the transdisciplinary subject-object (i.e. how the client thinks about and interacts in their complex multi-dimensional meta-system). They do so using included middle thinking in these spaces between the disciplines.

The team invites, co-creates and actively engages clients, families and themselves in a continuous process of reflexivity in T-Zones. They seek out 'the between' to question their big picture thinking. Are solutions innovative, relevant, effective and acceptable to the client? They question what they see, what they understand and how they have individually and

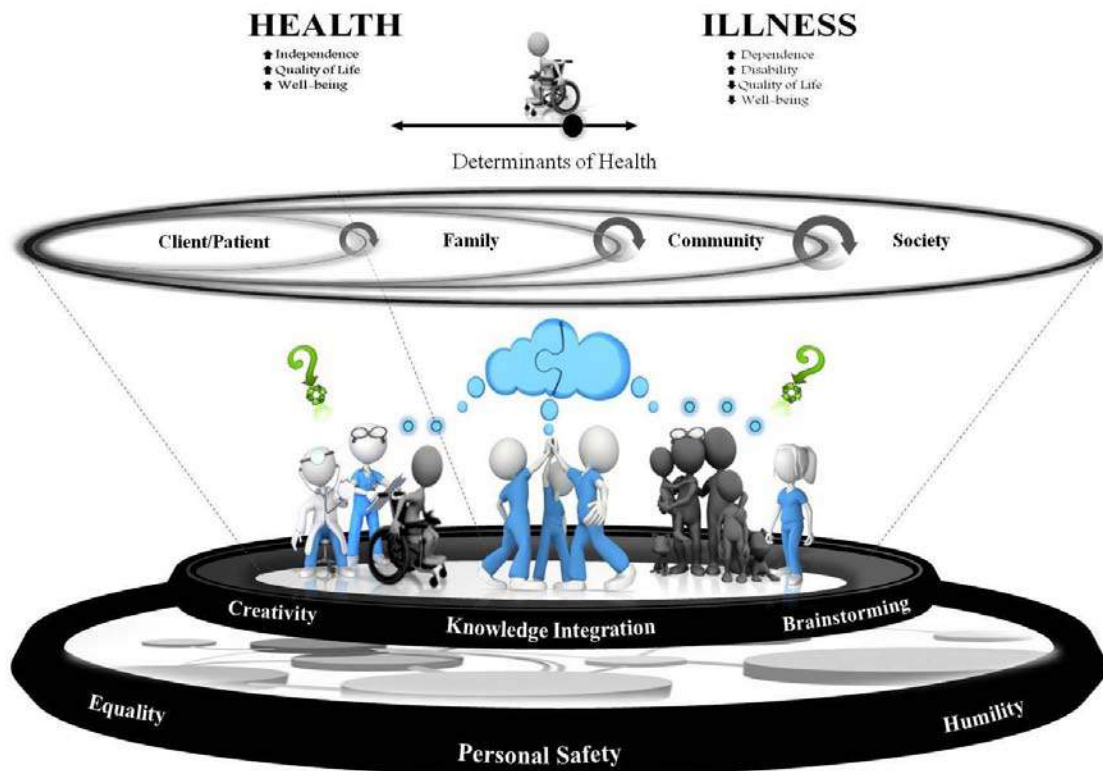


FIGURE 5.6. T-ZONE ON THE MORAL HIGH GROUND

collectively arrived at shared understandings. They invite other colleagues and outside healthcare professionals to participate in dialogue when they recognize their understandings are incomplete and their solutions are ineffective. They search for new sources to help them rethink and revise their perspectives and their practices.

T-Zones are also spaces where clients, families and all members of the healthcare team are awakened and liberated from their silent, silenced stasis. Each and every member of this collaborative team is willing to amplify and integrate the multitude of voices that can potentially expand their knowledge and understandings of complex clients, families and their real life circumstances. The founders empowered and encouraged the team to use any and all forms of communication however and whenever they needed to evolve their understandings and meet the needs of the client. Dialogue is not constrained by formal reporting structures or meetings. Dialogue needs to flow freeing to understand how the teams ‘thinking’ and ‘doing’ is influencing

the clients 'being' in the real world. T-Zones and the complex open adaptive communication network is essential to maintain this level of collaborative team practice.

By invitation only.

In the mid-1980s, thinking and working outside of the medicalized rehabilitation model was done on the down low. I told one of the founders it seemed like they were part of some secret society. "You know, it really was at that time" (Participant 13). They were meeting like-minded people "through the grapevine" in informal settings (Participant 13):

Around '83 or '84 one of my colleagues came in and spent the afternoon with us at someone's practice and we talked about win-win models for businesses. It was the kind of model that was, you know, everybody should be treated equally and, you know, that means the physician. There was kind of a bunch of counsellors and the psychiatrist was the head of the food chain. But he was never a guy with much ego. He never had any.

So my friends buddy, have you ever heard of win-win, you know? And he was giving national workshops because he was the big 'win-win' guy. But you know I think I was sitting there that day and saying, "God, this is great. This is the antithesis of the university! "And my friend was saying at the time, "This is the way a practice should be." And then when I set up my own practice I thought, "Yeah, that's the way a practice should be."

I think we met at somebody's house, though and it was an evening.

I think we did that once. (Participants 13 and 14)

The founders recognized that a win-win approach to multiple disciplinary team practice was far ahead of its time. Educational institutions were indoctrinating healthcare students into the biomedical approach and locating disciplines, disciplinary knowledge and practices within a knowledge/power hierarchy where physicians were "at the top of the food chain" (Participant 13). Building their new world for community-based rehabilitation meant they had to particularly selective in their hiring practices.

Initially, the founders actively recruited people with whom they had already established close personal relationships. They had known the first transdisciplinary physician for many years. He was a personal friend and his more humble personality fit their vision for disciplinary equality. The clinical director was one of their graduate students who had ventured outside her disciplinary institution to seek knowledge and understandings from another disciplinary perspective. She had the same vision for community-based neurorehabilitation.

Another graduate student required more convincing about the win-win benefits before she joined the Clinic. She was eventually convinced that she would find her work more meaningful and rewarding working with a very different type of team than working in isolation. Her experiences had taught her that there are “*very rare opportunities to really work in a place where people have each other’s backs and are helpful and enjoy each other*” (Participant 9):

I think he sort of brought it to me as, “It’s really comprehensive and you’re part of a team and so you get follow-up, you know?”

We are often doing evaluations. You write it and you have no idea whatever happened to that person. That’s just, that’s part of the way they like it is you sever connection after you write your report. And that’s probably how 90% of us work is in that capacity. And that’s what I had done prior to working with the team is I had been at settings where I would do it and I would give it to the person or give it to somebody else and then I had no idea.

The selling point to me was, you know? It’s special because you get to see if you were right. And you get to see if that panned out or if that was helpful and that is the big appeal is that I’ll write a report and then you’ll go back in six weeks and look at the OT report and the speech language and you’re seeing a lot of similarities and you’re seeing things that are sort of supporting what you do every day. So I think he presented it as being sort of comprehensive care because I hadn’t been in a place that had

comprehensive care, that everything could be done under one roof.

I thought that was fantastic. (Participant 9)

The founders were very careful in recruiting healthcare providers from the outside world. Membership on the transdisciplinary team required people who had the capacity and willingness to relinquish any preconceived notion of ownership over their traditional disciplinary roles and practices. They had to be willing to embrace and respect the overlap of knowledge and practices between the disciplines. *“We don’t want anybody in here that doesn’t buy into what we’re doing”* (Participant 10):

We interviewed this person that really looked like a great speech and language therapist and we started telling her, Oh yeah, well, you know, some of the cognitive rehab will be done by OT, some by speech, some by psychology even depending on the needs. And, or they might do it together or something like that.” And she called back later that afternoon and said, you know, “I don’t want to interview anymore because cognitive rehabilitation is owned by speech and language therapy and, you know, I just can’t believe that you guys would be letting other people do that,” basically. And that kind of, we felt that was good because someone was recognizing what we do. (Participant 13)

The new transdisciplinary team needed the founders to nurture their neophyte relationships and provide a welcoming and safe environment. Traditionally trained healthcare providers needed their support, guidance and mentorship to help them remove their disciplinary blinders and to expand their disciplinary gaze. They needed role models who could teach them how to share knowledge, embrace new perspectives and to create new understandings. Above all, they needed someone to cradle and protect the moral high ground (see Figure 5.7).



FIGURE 5.7. TRANSDISCIPLINARY LEADERSHIP

Raising the family.

Creating a new world for transdisciplinary practice is not unlike raising a family:

The Founder was like a father to me. So, him being there was very, it was very family-feeling because he sort of guided me and helped me and you know we have a special relationship that wasn't just a boss. (Participant 9)

The team needed a father-figure who could focus on instilling a philosophy of inclusivity, collectivism and ethical conduct. They needed to be nurtured and learn how to care for each other. “*There is a common nurturing thread here*” (Participant 13) that binds the team together. “*I think it's still expected here, but not in a shake your finger sort of expected here, but it's just the way it is you know*” (Participant 3).

Their other parent, the clinical director, was more of the task master in the beginning. It was clear to the team who was in charge during the early days. The founders and the director had focused their administrative gaze on what they knew to be the most crucial aspects of building a different kind of healthcare team: Relationship building, an open adaptive communication network and a safe haven.

Unlike the invisible power of the traditional administrative gaze, the transdisciplinary leaders were embedded in the team. They were not unnamed sources of invisible power, they

both maintained active clinical practices on top of their administrative positions. They work alongside other team members as professional equals in the T-Zone. Their clinical gaze is panoptic and multifocal. They looked upward and outward with the team to gaze on clients as situated beings interacting in their unique and complex meta-systems.

Over the years, administrative leadership styles have changed. The founders have semi-retired and now function more as consultants. The team looks to them for wisdom and guidance when they are at a clinical or philosophical impasse. They sometimes attend staff meetings, were present for the team retreat and they all participated in this project. The remaining study participants spoke about the founders with a sort of reverence. They all referred me to the father figure so that I would be sure to get the authentic version of the story

The history with this one founder I think is so significant because he was a pioneer in his field. And I don't know if you know much about his background, I'm not sure what has been shared with you. He's a very, very interesting gentleman to speak with. (Participant 6)

As the team grew and matured, the clinical director's leadership style also changed: *"Over the years, we've all kind of been evolving. The director has evolved and everyone has been allowed to evolve. And that's been the great thing,"* (Participant 11). Like parenthood, transdisciplinary team leadership is about taking control and then letting go when the team is able to spread their wings and fly as an independent collective. Relationships transform into mentorship roles or even friendships. *"I'm very close to the clinical director now. We're very good friends now"* (Participant 11). As the team expanded their knowledge and gaze, the hierarchy flattened and the spaces between leadership and team members contracted. Professional relationships became much more personal. They became professional intimates.

Transdisciplinary leadership does not simply fade into the shadows or evaporate over time. The administrative gaze still watches over team relationships, protects the moral high ground, co-creates and participates in T-Zones, and monitors business operations and the communications network. The transdisciplinary gaze is not administrative and budgetary

oversight, it is panoptic and multifocal under-sight and around-sight. Transdisciplinary leadership is leadership from beneath (see Figure 5.8).

Complex open adaptive system.

Over the past 30 years, the Clinic has continued to grow and evolve:

If you look back from where it started this you can see all the disciplines that have been added from the history to see how this place has evolved. And there's a reason it's evolved. And I think that is has grown is what seems to be important, you know?

I think the main reason the clinic has evolved over time is because it is meeting needs of the community. We have a very special niche that is very different from outpatient services. There are many wonderful outpatient services out there, but this is a very different environment: a different goals: different plans: different treatments in many ways. We developed a number of new interventions that nobody had quite figured out. So I think we were pretty successful there. We opened, I think, people's eyes, too, to what rehab could do for people.

The only problem with what happened was that it evolved to where every place that had the most difficult client they had to deal with, was sending them to us hoping we could tease things out. And some of those got very, very difficult. So the patients changed. The general thrust changed. They're sicker. They are more involved, more complicated and they're older. (Participants 3, 6, 8, 13, 14, Focus Group 2)

The Clinic is an open, complex adaptive system that does not expand geographically or technologically to maintain its economy of scale. Humility and social harmony (i.e., the moral high ground) combined with an open multimorphic communication network, broader disciplinary gaze and liberation of institutionalized disciplinary knowledge and practices (i.e., T-

Zones) are efficiency resources that sustain the system's capacity to meet the needs of the client, the community and itself:

It's the access for people to get to you and to be able to do as much as you needed to in a home setting, as long as you needed to without any restrictions. Those would be the key things that would make it work. It would not be the equipment. It would not be the computer programs and it would not be all the stuff that is there. But you don't have to have all of that to do this quality care. Those things help you meet the requirements of the outside world. Here it is the people; it is the staff. (Participant 5)

Systems that support transdisciplinarity are a paradox. Transdisciplinary teams do have the capacity to do more with less in terms of headcount, physical space and technology. However, they also do more with more: more access to colleagues and cross-disciplinary knowledge: more input from clients and family members: more and more practical integration of clinical findings into reality-based interventions: more programs that meet the specific needs of the clients and the community: more emphasis on ethical conduct and collaborative relationships and more of the right type of people, humble people, to get the job done. How this is accomplished by the team will be the focus of chapter 6.

Original Transdisciplinary Practice Model

Figure 5.8 depicts the original transdisciplinary practice model as portrayed by the study participants. The founders created a highly efficient and flexible organizational structure that allowed the team and business to grow and flourish. However, team relationships and practices continued to evolve in subsequent years. New team members brought different disciplinary perspectives and the evolving needs of the community provided opportunities to create innovative programs and solidify the Clinic's niche in the healthcare sector. Chapter 6 explores how the evolution of the clinical director and her leadership practices have had a profound and positive impact on the team and the organization over the past 20 years.

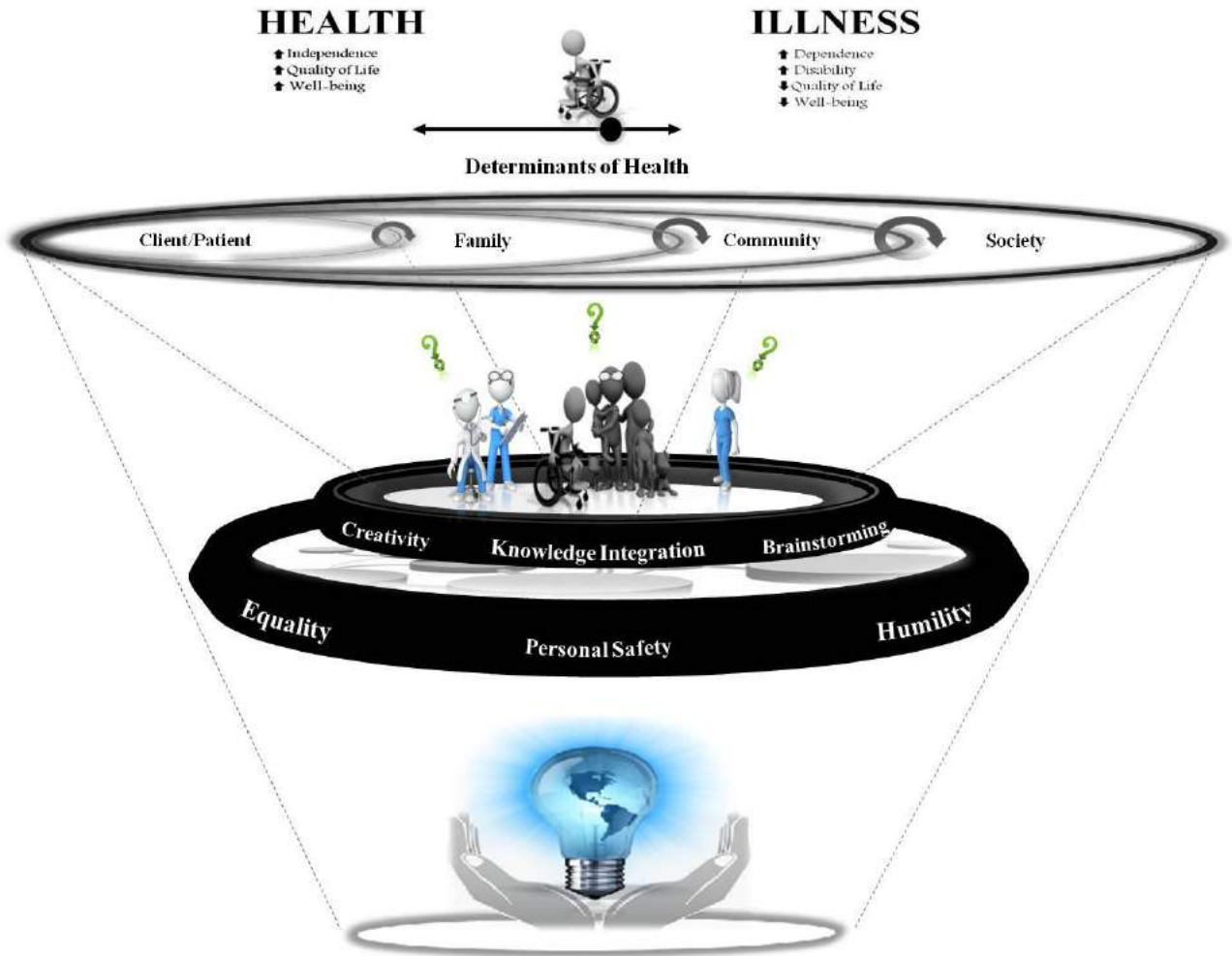


FIGURE 5.8. ORIGINAL TRANSDISCIPLINARY PRACTICE MODEL

Chapter 6

The Emerging Discourse of Transdisciplinary Leadership

The discourse of transdisciplinary leadership is by far the most challenging for me to articulate in an understandable and meaningful way. I spent many hours observing the clinical director and leadership team interact with each other and the team. However, writing this chapter in a way that would make this type of leadership accessible and replicable was more of a challenge than originally anticipated. It seemed to be a riddle with no possible solution. What form of leadership has 56 legs, is visible and invisible and isn't in it for the money? I could not see any one familiar traditional leadership repertoire that captured its essence.

To my surprise, the answer was hiding in plain sight. I could not articulate present day leadership because I had not taken into consideration the historically situated circumstances in which it had evolved. As the guardian of the moral high ground moved into semi-retirement, responsibility for watching under, nurturing and tending to the family was gradually taken up by the clinical director. The tension between the founder's orientation to relationships and social harmony and the clinical director's orientation to systems architecture and hierarchical leadership style had to be creatively blended to support their shared vision for a new world. Rather than labelling leadership style, the repertoires in this chapter will focus on how the founding members' philosophy has been taken up and enacted by the clinical director in unique and novel ways.

Interpretative Repertoires

Leadership from below.

The philosophy here comes from the top down, because leadership, so to speak, sets the tone for the whole place. I think that if you didn't know better, you wouldn't know who your boss was because the director leads in a way that makes you know that they are not above you and that also makes me feel like I am part of something bigger really. So I suppose while it is from the top down, you need to look what you have at the top. (Participants 2, 3, 8 and 10)

Leadership from below cannot be articulated using the traditional discourse of hierarchical hospital-based leadership. This form of leadership is all at once visible and invisible: hierarchical but not hierarchical: top down and bottom up: directive and indirect: ‘A’ but ‘not A’. It is ‘us’ and ‘them’ but somehow ‘them’ and ‘we’ at the very same time. Transdisciplinary leadership is a paradox. The almost unspeakable nature of the director and her leadership practices are related to the director’s gradual rise to a position of power below:

The clinical director here is a therapist, who is the primary decision-maker and the person who has really emerged as the power and the impetus over the years. (Participant 8)

The discourse of transdisciplinary leadership does not invoke a traditional discourses of subjugation or servitude. Over time, present day team leaders have come to see and actively resist the insidious effect that an orientation to individualism can have on the psyche of healthcare providers. Like the founders, the present day leaders no more wish to be “owned” (Participant 10) than to have absolute power over others. They are emancipated and purposefully work towards ensuring team members are and remain liberated.

The narratives of team members demonstrate the validity of the leaders’ characterizations of themselves. Participants do not portray transdisciplinary leaders as anonymous decision-makers or invisible hands of power that control their practices, sustain the lines of demarcation between the disciplines and protect the financial best interests of the institution or themselves. Some participants are acutely aware of the problems created by a traditional downward unidirectional gaze particularly when it comes to hierarchical communication practices. The traditional hierarchy is portrayed as virtual black box that looms over their heads. It blocks their bigger picture understandings, clinical and organizational gazes and constrains clinical practices:

In the traditional model, there are also administrative meeting that just the departmental directors go to. That meeting is just, “This is what’s happening. Do they have a urinary tract infection, a doctor’s appointment or a fall last night?” And then kind of checking to make sure that we did everything we needed to do to fix that problem.

I've never been to it and it's just my director of therapy who goes to that with my notes that I've written on patients that I see. And that might be more whole person, but I never hear what comes out of those meetings either. (Participant 1)

In contrast, the leadership team and practices at the clinic are nameable, visible and liberating. Participants cannot fully explain or contextually locate a leadership power below. Her power and leadership style is emergent and emerging, evolving and evolutionary. It's 'issness' and the words to describe it are elusive. Power from below elicits a feeling of liberation that speaks to the invisible nature of this leadership style. The absence of hierarchical powers from above frees them to connect with "*Something bigger*" (Participant 3). This ethereal entity is just mysterious as a proverbial black box but it does not serve to orient them solely to skills-based practices or to fixing things, pieces or parts. It does not keep them in the dark. 'Something bigger' is an invisible, benevolent, somewhat spiritual and almost inexplicable, for lack of a better word, something that guides their moral compass in a direction they choose to follow and choose to serve. It is a cause that unites them and a calling that sets them free.

The director has not abdicated decision-making authority. "*I can be direct if need be*" (Participant 5). It's that "*She is really very good at sharing leadership and decision-making*" (Participant 8). The director has adopted a more democratic leadership style over time. Her power to invoke finite final decision-making is a discretionary instrument of organizational efficiency:

I mean, if there is some protocol that we're looking at, or we can't come to consensus about a time-sensitive matter, the director will make a final decision. People will give input and defer to the director's judgment when it's called for. Otherwise, if it's not a time sensitive thing, we'll usually just keep talking about it until we come to consensus or majority rules. And even after all of that, people can certainly object to certain things as well. (Participants 5 and 8)

Leadership oversight and ‘around-sight brings new language and meaning to the traditional discourse of leadership support. The director’s leadership style, role and practices are similar to traditional leadership in that she strives to accommodate the needs of a complex growing evolving organization. The difference is that the director also strives to support, protect and fortify the sanctity of the moral high ground by building you up. Team leaders are invested in each and every team member’s feelings of personal fulfillment, inclusivity, confidence and professional success. The Clinic is an organization where team members do not and cannot “*knock the props out from each other*” (Participant 13).

The clinical director creates and empowers an entire team of professional, collaborative and competent leaders. Every team member is a strong, secure and empowered pillar of their transdisciplinary community. Each member of the team helps to carry the load:

The director is very open to new ideas when people do it in a constructive way! We love it! We call it ‘great thinking! If someone hates something and it’s small and changing it is going to be positive for everyone, all they have to do is change it! Change things around! Do what you have to do! The director just puts it back on us and tells us to just get it done the way we think it should be done. Leadership here is very different that way. (Participant 10)

The director’s energy is a renewable and sustainable resource. She works tirelessly to keep the team and the organization moving forward:

I think that my role is pretty much a facilitator and spending a lot of time facilitating communication amongst us. That role is about building and generating of a very positive environment where everybody is sharing and doing together. Communication leads the team. (Participant 5)

There is no drain on a system with a seemingly endless source of generative, regenerative, restorative and motivational power. Her power and empowerment practices are in co-creating organizational synergies sufficient to overcome inertia and stagnation. Sharing and

unification of power generates enthusiasm, creativity and the conscious desire to engage in creative complex thinking and problem solving:

It can be very invigorating here and it can be frustrating. But I think at the end of the day the staff has enough respect for themselves and the other staff members that we just carry on to the next case and the next and the next. But, I think the efforts from people are, there's still energy, there's still interest. In some work settings I have worked in, the people have dragged themselves to work and dragged themselves home. And I think that people are here because they want to be here. (Participant 6)

Team leaders take pride in their capacity to hire highly skilled and competent employees. They trust in their staff's professional skills and decision-making ability. They believe they have the capacity to make right decision for their clients and to “*fix the problems*” (Participant 1) on their own or in conjunction with colleagues:

We believe that if you hire professional people, they know what they need to do. They just need an environment that supports and facilitates them doing the very best they can. If I am a hard-assed it would not go over well at all. I mean, that would be bad. We are not that kind people as managers. We believe that if you're doing your job we just leave you alone. And, I don't know it's just, I think they just understand if she comes up with something it's probably going to be something we need to do. (Participant 10).

Trust and empowerment are instruments of efficiency and solidarity. Trust in their employees liberates the traditional administrative practices and downward financial and skills-oriented gaze. Transdisciplinary leaders are able to focus more time and attention on supporting the team, the culture of the organization and seeking out new and creative business opportunities. Trust in also creates and sustains trust within. The director trusts in competency of team

members who, in turn, trust the clinical director, her judgment and her intent to look after the best interests of the collective.

Transdisciplinary leadership is truly “*an interesting balance*” (Participant 3) and a complex balancing act accomplished in a space of unity, equality, trust and mutuality. Power under is the power that supports and protects the moral high ground. It is a power that generates the synergies essential to the co-creation of T-Zones. Power under is the power of a team empowered with the capacity to support, protect, nurture and sustain. Power under is the power and energy of a strong, visible and united whole (see Figure 6.1).



FIGURE 6.1. LEADERSHIP FROM BELOW

Professional intimates.

Traditional hierarchical structures, disciplinary boundaries and the orientation to skill-based practices and large scale economic sustainability create social distancing and personal feelings of “*disconnection*” (Participant 5). At the Clinic, employee-employer relationships have transformed over time to the point that the staff no longer feels “*controlled*” (Participant 11). They do not characterize themselves as subordinates. Some team members now characterize themselves as feeling “*very close...[and] very good friends*” (Participants 11).

Today, you can still hear echoes of the founder’s philosophy in team members’ narratives, “*We are people first, right from the beginning*” (Participant 14). “*People here are not their own entity that you can’t possibly really touch. People here are real. I think everyone here comes from that kind of humanity perspective*” (Participant 12). The preservation and enactment of a shared ethos of humility, equality, collectivism and unity has all but obliterated the illusory

lines of demarcation that separate people, human beings, because of assigned power and status in the traditional hierarchy. The relationships between the leaders and most team members are more than just professional. They are personal relationships that hold personal value and meaning. Team leaders create a space into which they invite team members to engage with each other as professional intimates.

Team members are not characterized by leaders as subject-objects of financial gain. Leaders are not simply departmental directors who only serve to monitor their practices and “*make sure that we did everything we needed to do to fix that problem*” (Participant 1). Professional intimacy transcends hierarchical status, disciplinary roles, disciplinary tasks, ego and externalized ego-based selves. There is a felt sense of “*cohesion*” (Participants 8 and 9) that, for many team members, feels more like a family. The founder is still a father figure, the director now mother earth.

Professional intimacy draws on discourses of mutuality and reciprocity. The leaders, team members and employer-employee relationships are constructed using a discourse of intersubjectivity. Team members are others to team leaders only in the sense that they are physically separate human beings. However, personhood is present and accessible. Decisions that might impact the entire team are largely based on the consciousness of the collective. The leaders, themselves, no longer feel “*emotionally detached from my work and from my colleagues...because it was just devoid of sharing and co-creating and collaboration with other like-minded people*” (Participant 5). The team is all at once single minds, multi-minded and of one collective mind. The clinical director has stayed true to the founders’ vision for a world of oneness, collectivism and unity in stark contrast to the traditional world of oneness, singularities and solipsism.

The degree to which team members engage in more personal relationships is contingent on each team members’ personal and professional comfort level and ethical stance. For one participant team member, professional intimacy is a line that should not and would not be crossed. That person prefers to keep personal relationships with professional colleagues outside of the workplace and at arm’s length. “*Work is work. Family is family*” (Participant 6). Team

leaders are tuned into and honor the personal and professional boundaries of each and every team member.

The conscious preservation of the sacred, the moral high ground, allows team members to transcend the conventional and redefine what is right, moral and professional in the workplace. One leader participant tried to use my own personal perspective to gauge the level of unconventionality and professional acceptability of their interpersonal relationships. *“We all really actually like each other, I think. Is that weird”* (Participant 10). Unfortunately, I could not provide him with an accurate barometer of how people from the outside world might judge them. Their world of professional intimacy is far too aligned with ethical principles and personal values that similarly orient my leadership practices. *“No,”* I said smiling. *“I don’t think that’s weird at all.”*

Serving the greater good.

The clinical director and other members of the leadership team are oriented to and their practices oriented by a discourse of service to the greater good:

The leadership here have the philosophy that we are here for a bigger purpose, a greater good. And that’s what drives this place is what’s in the best interests of the clients and the mission to really help these people and to help the community is just really pure. (Participants 2, 3, 10)

Team leaders do not see themselves as martyrs. They are not choosing to suffer personally or financially. They have comfortable lives, nice homes and enough money to enjoy family vacations and favorite past times. They simply do not see the need to accumulate excess personal wealth. Instead, they find joy and fulfillment in selflessly caring for others and serving the community:

Taking care of people is the bottom line here. If it was for making money we sure wouldn’t be doing this, we’d be doing something else. We’d rather be here for the people that we can be here for than not be here at all. And, again, it’s not a matter of getting rich. It’s a matter of just keeping the doors open. It’s very

expensive to run this program. I took a 45 thousand dollar per year pay cut to work here. None of us make a lot of money. We will if there's profits at the end of the year, you know? We just love what we do (Participant 10).

The clinical leaders characterized themselves and are portrayed by others as altruistic. Leaders are devoted to providing healthcare services that place the needs of clients, families and communities (i.e., the collective) ahead of monetary gain. *"We always tell people here, "Don't worry about the cost of care as clinicians. Do what you need to do. We will let you know if there are restrictions and things that you need to be aware of""* (Participant 5). Serving the greater good orients leaders to practices that liberate and sustain the transdisciplinary gaze on the bigger picture clinical practices that meet the needs of the people and communities they serve.

The entire leadership team is portrayed as kind-hearted. Their leaders make emotionally-based decisions when it is the morally right thing to do. The Clinic is built around a paradoxical business model. It is a minimally profitable, for profit not-for profit:

Taking care of people is the bottom line here. They make a lot of decisions from their hearts more than if someone else was in charge. Someone else might be making decisions from the bottom line or only the financial picture. I mean that's really the mission, not to make money. (Participant 2)

Participant leaders make visible another traditionally invisible aspect of the organization. *"We've got people that understand and buy into the philosophy and the situation we have. They know we don't make a lot of money and so they buy into it"* (Participant 10). The organization and leaders are fiscally transparent. Leaders believe their visible orientation to altruism, humanism and fiscal transparency inspires team members to purposefully align with and adopt a shared philosophy of service to the greater good as their own. Participant team members' narratives demonstrate their own orientation to the greater good and validated the leaders' understanding of the shared reasons why they choose to work at the Clinic:

I think that people are here because they want to be here. We don't all make the income here. Most of us could make money

elsewhere, make much more money elsewhere. I mean, the money is adequate. But it really has to do with the work. And for a number of people it has to do with their colleagues as well as the clients and the real reason we're here for folks. We are all here because we care passionately about the work that we do. There has to be some a part of you that's in it for the greater good.

(Participants 6, 9, 10 and 12)

Serving the greater good is a discourse of unification. The shared decision of the collective to resist the outside world's orientation to materialism is portrayed as another source of team cohesion.

Safe haven.

We don't just put minors in the minors and majors in the majors just because certain, there's certain things about your personality that's going to make you different than somebody else. If it doesn't affect your job, we're like, "Just go with it." (Participant 10)

The present day leaders have preserved the founders' vision of a world where healthcare providers are safe to expose their vulnerable authentic selves. Their narratives demonstrate how they purposefully resist a traditional social hierarchy that stratifies, divides and disconnects human beings based on personal attributes. They accept individual differences, encourage diversity and diverse thinking. The leaders' portray themselves as accepting and non-judgmental.

Team members' narratives demonstrate the congruence between the leadership's perception of themselves and the perceptions of the team. Team members articulate how transdisciplinary leadership style creates a noticeable difference between the environment at the Clinic and the traditional workplace. The Clinic is a safe haven where team members feel safe to expose their vulnerable authentic and imperfect selves without fear of judgment or reprisal:

This is a very safe place, a really safe place. I think that safety is a really important piece. And I think that everyone on the staff would say that they feel safe here. It's not intimidating, it's not

scary. So we're not very, I don't know what the right word is... guarded...we're not very guarded about our shortcomings, not like it is elsewhere.

Here I can say, like, "Oh my god! I can't believe that I just said that! I'm really sorry! I'm such a dork!" because we're all just human beings. I think that we all feel safe because we all trust that we're all here for the same reason.

I think that what is different here is that in any another setting they would fire people over and over again because they are having personal challenges But the director has such compassion, foresight and creativity. As all of our supervisor, the director will totally have our back and be very accepting if we screw something up. So there is also that element of feeling safe here that also comes from there.

It's an interesting balance because I feel very independent here in terms of like, I don't feel like anybody is looking over my shoulder or like I have to be careful that I do things right all the time so to speak. (Participants 3, 6, 9, 11 and 12)

Team members do not feel they are under constant surveillance. They do not feel the uneasy sense of paranoia generated by the threatening and unpredictable traditional administrative gaze. There is no visible director or invisible hierarchical gaze looking down on them to catch slacking on the job or slipping up in their practice. In the biomedical model, someone in power might surreptitiously peer over their shoulder anywhere and at any time. That is not the case at the Clinic.

Transdisciplinary team members do not feel pressured to expend time and energy being vigilant over their own practices. Their gaze is free to look upwards and outwards because team members feel safe, secure and protected. Their leaders work alongside them as allies, comrades and equals and bolster their confidence because of the unconditional support from below. Trust between the leaders and team members is unquestionable and reciprocal and feelings of personal

and professional safety are valuable resources for organizational efficiency. Team members are free to focus on the needs of their clients and team leaders to focus on the current and future needs of the team and the organization as a whole.

In a sense, the safe haven repertoire portrays the organizational structure as a nested hierarchy. However, the laterally situated administrative layer (i.e. around sight) is not used as an instrument of power within. It serves as an invisible but palpable layer of protection from any and all threats from the outside world. Behind the scenes, away from the purview of the team, the clinical director also works to protect the team from potential threats from within.

Preserving the moral high ground.

The founders actively recruited team members who they knew to be aligned with their personal and professional ethos and shared their vision for a new world. Team members were hired because the founders had come to know who they were as human beings before they were invited into the practice. Present day leaders do not have this luxury. It is challenging for them to hire professionals raised in the traditional biomedical power/knowledge hierarchy and a society that values individualism and professional success over personal virtues. *“I don’t really know that you can learn to leave your ego behind. I mean, I don’t know though. Maybe you could if you work with the team for a while”* (Participant 14).

Basically, if someone comes here with a different agenda, or if it looks like a one-man show, it just doesn’t work. And you can tell pretty quickly, within a couple of months. If you’ve got an ego it shows you know? We don’t want people here with a different agenda and whose egos overrun what you’re trying to do as a program.

People just don’t fit in if they just think that they know how to run things better. They think, “We need to do it this way. You people aren’t doing it right! I know better, blah, blah, blah....”. It’s horrible! You can’t have that in any business, especially not in a team-based rehab environment. We just don’t have time for that!

If somebody doesn't fit in with what we want to do, or they don't have the same mindset, it's 'bye-bye' when you quit. And they either quit themselves you know? Kind of weed themselves out. It's pretty natural attrition when that happens. Or we get rid of them. Either way, they don't stay very long, because we don't want anybody in here that doesn't buy into what we're doing. So if you're coming in here pretty impressed with yourself, you don't want to interact with other disciplines or you give off an attitude that you're your own entity or not a team player, it's not going to be a part of the puzzle that's going to work. But if you're coming in with an attitude more like, "I've got a lot of knowledge I can share with you guys and learn more as I go along", then you're going to be successful. (Participants 10 and 13)

In the academic environment, an orientation to individualism creates and sustains the battle for intellectual superiority. At the Clinic, the orientation to collectivism and power sharing makes individuals who seek power over others stick out like a sore thumb. These people, these others, are characterized as self-absorbed, power hungry weeds in the moral high ground. Their own egocentricity and unwillingness to collaborate on equal footing with team members, the essential ingredients for creativity and complex problem solving, sets them up for failure.

Transdisciplinary thinking and transdisciplinary doing cannot be accomplished if individual members are not inherently capable of functioning from a place of humility and equality. T-Zones cannot be created if individuals do not, cannot or will not buy into their shared philosophy. Big picture thinking is too blurry if one of the puzzle pieces is owned by someone who is constrained disciplinary boundaries or imprisoned by a disciplinarily suit of armor. If a new team member is unable to get down from their transdisciplinary pedestal and leave their ego at the door, they will be shown the door if they do not leave of their own accord.

Transdisciplinary team members' interpersonal practices are constrained and self-constrained by their shared ethos and dedication to serve the greater good. However, this form of constraint is not characterized as a bad thing, nor is it portrayed as an unwelcomed

unnecessary constraint forced on them by an administrative higher power. People who operate on the moral high ground at work and in their personal lives do so because it comes naturally. They are willingly driven by that inexplicable something that is all at once themselves, bigger than themselves and indistinguishable from themselves. They are always already situated on the moral high ground. Leaders and team members have learned to trust their colleagues will live up to the expectations of the group because they hold themselves accountable to the same standards of conduct. There isn't any need to enforce rules of conduct in a "*shake your finger kind of way*" (Participant 9) when everyone is on and naturally stays "*on the same page*" (Participant 13).

The clinical director tries to shield the team from people who might threaten their chi. Team members do not need to engage in behaviours intended to drive misfits out of the organization. They easily identify and then quietly observe the trouble-makers digging their own grave. They have grown to trust the clinical director will quickly see and remediate potential sources of toxicity. She seems to have a sixth sense when it comes to egocentricity. In almost 30 years, only a handful of few people have slipped through because she "*is pretty good at finding those, not hiring those people to begin with*" (Participant 10)

Keeping ego in check.

Participant leaders characterize themselves and are characterized by team members as humble and altruistic. Their behaviours are portrayed as instinctive rather than contrived. That is just who they are as people. However, on one occasion I caught a glimpse of the clinical director engaging in a much more purposeful act.

There is a significant possibility that people in the outside world will be able to identify the Clinic after this dissertation and subsequent articles are published. They are the one and only self-identified community-based transdisciplinary neurorehabilitation clinic easily identified using an internet search. This may be an inevitability that poses a practical and philosophical conundrum for the director.

The director's primary concern is that an inordinate amount of attention, questions and telephone inquiries might demand time that she simply does not have to give. I have reassured her calls and questions can be redirected to me and I will do my best to keep the crowds at bay.

Her second concern has to do with ego. Is self-disclosure an act of egocentricity or an act of selflessness? Would a conscious decision to breach anonymity serve their own best interests or represent a gift to the healthcare community at large? Would disclosure help others to learn from and replicate their model of transdisciplinary practice? *“I’ll have to think about that. Would that be ego”* (Participant 5).

The clinical director purposefully engages in an internal quality check of sorts. She actively interrogates her decision-making processes to ensure she stays true to her moral and ethical stance. Decisions of this nature require a deeper and more personal level of contemplation. She is the guardian of the moral high ground and a role model for the team. She takes time to critically reflect on the motivations behind her decisions as well as the practical and philosophical ramifications for the collective.

Summary

The discourse of transdisciplinary leadership is emergent, emerging and elusive. Transdisciplinary leadership and the organizational structure that supports it are a paradox. The core of its ‘issness’ is located somewhere between ‘A’ and ‘not A’ in the included middle.

Traditional and transdisciplinary leaders both work to sustain a growing complex organization and healthcare that best serves the needs of their clients. However, the way this is accomplished by leaders at the Clinic is different from the traditional biomedical approach. After 30 years, the present day leadership team is still guided by the founders’ vision for a new world: a world built on the moral high ground. The creation story provides insights into their vision and the organizational structures needed to create zones of transdisciplinarity and sustain a bigger picture transdisciplinary gaze.

This chapter demonstrates how the founders’ vision is enacted in day-to-day practice. Their discourse, the language used to describe the new world, can be heard echoing in the narratives of present day leaders. The way leaders portray themselves and their practices are validated in the narrative of team members and corroborated by my field observations. They are who they say they are and their personal and organizational ethos is reflected in their discourse and practices.

The theoretical model seen in figure 6.8 represents how the founders', clinical director and original members of the team brought that vision to life. The only difference between the original model and the present day model is the graphical representation of the leadership team (see Figure 6.2).

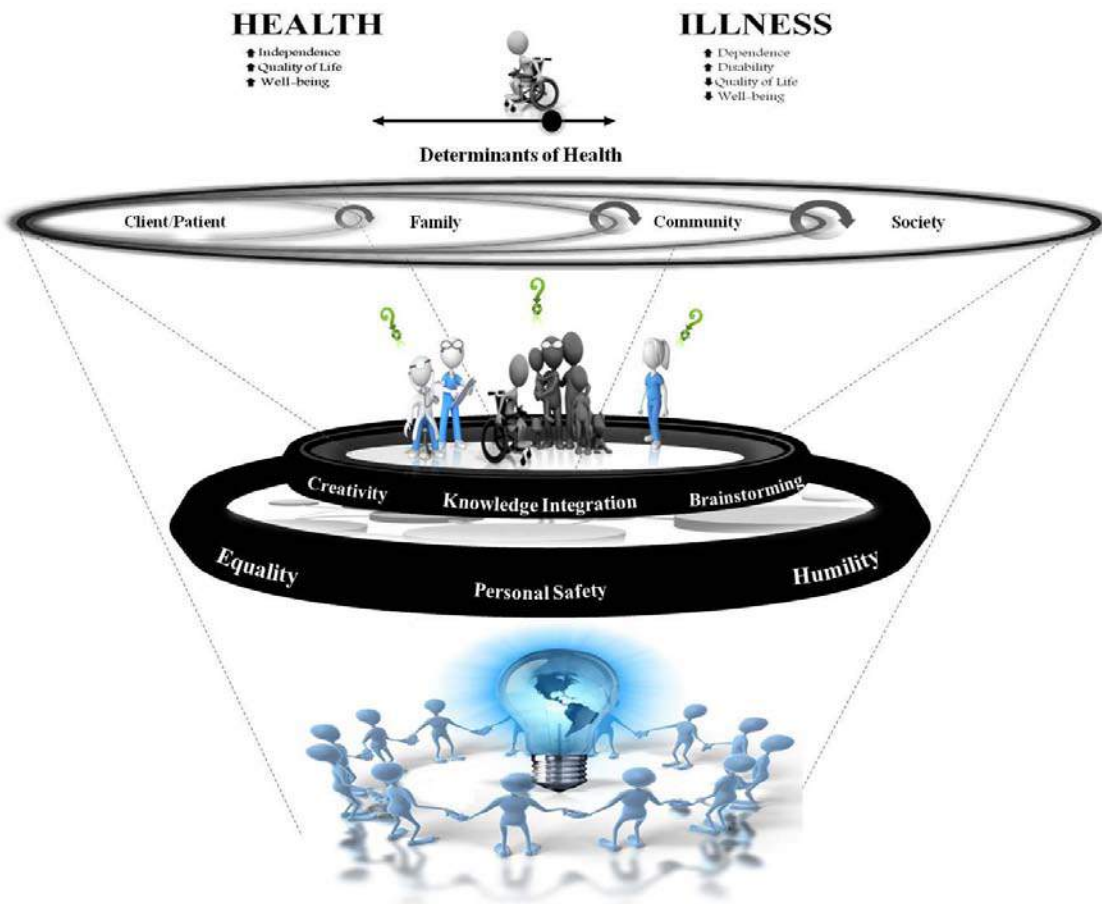


FIGURE 6.2. PRESENT-DAY TRANSDISCIPLINARY PRACTICE MODEL

Transdisciplinary leadership from below is much more than a leadership gaze that sees the bigger clinical and organizational picture. As clients and their real-life circumstances became increasingly complex, the organization and leaders had to grow and evolve to keep up with the demands. The Clinic is a complex open adaptive organization, however, it is also an organization with limited fiscal and human resources. As the organization grew and adapted, the clinical director and leadership team had to grow and evolve to keep up. However, the discourse of transdisciplinary leadership does not invoke the economy of scale repertoire. Serving the

greater good means that sometimes, as business owners, they can only do more with less or no profit. Transdisciplinary leaders are altruistic.

The present-day discourse of transdisciplinary leadership is still a discourse of humility, equality and equal rights. The founders' protected the moral high ground by inviting professionals into the practice whom they knew to be already aligned with their vision for a new world and their ethos. Today, the clinical director does not have this luxury. The organization is in a continuous state of transitions and new employees recruited from the outside world. Preserving and protecting the sanctity of the moral high ground, their focus on the big picture and complex thinking, means proactively weeding out the misfits if they do not leave of their own accord. Egocentricity, individualism and power struggles are unwelcome intolerable drains on the system.

Transdisciplinary leadership is a discourse of power sharing, empowerment and agency. Leaders choose to serve the greater good and their employees choose to follow their lead. The reciprocal unconditional trust built over time between leaders and team members is a key resource for organizational efficiency. Trust in the competency and integrity of the team allows leadership to focus on "*keeping the doors open*" (Participant 10) and provide the team safe haven. The clinical director's more democratic leadership style and team members' profound trust in her judgment obliterates any need for power struggles. Team members empowered with the right to participate in or challenge decisions most often choose to rely on team leaders or consensus of the collective.

Transdisciplinary leadership is a discourse of power under, power generation and the power of the collective. Leadership capitalizes on the notion of strength in numbers. An empowered team of empowered leaders as the power, strength and energy to co-create knowledge and to overcome frustration and drag. Power from below is a discourse that orients leadership practices towards unity, solidarity and the co-creation of group synergies. It is a power that motivates and propels the team and their capacity for creative problem solving in a forward direction. Synergy is the source of energy that creates and sustains T-Zones. Empowerment dissolves hierarchical organizational structures that constrict the clinical gaze and

constrain practices. It is a power that clears the way for team members to connect with another invisible but more liberating, benevolent and selfless source of power above.

The discourse of transdisciplinary employee-employer relationships invokes the discourse of intersubjectivity. Humility, trust, equality and mutuality are key to evolving interpersonal relationships that transcend traditional hierarchical lines of demarcation between boss and employee. Employees are others who are sensitive and vulnerable human beings. Team leaders are kind, compassionate and accepting, Their interpersonal relationships with them are, themselves, a safe haven. Personal intimacy allows for the co-creation of a space where leaders and team members are free to be their authentic selves. Team leaders' authenticity and personal transparency creates organizational transparency.

Transdisciplinary leaders and team members portray themselves as inherently aligned with the organizational ethos. There is no chance they will fall from the moral high ground. However, the clinical directors practices challenge this notion. Alignment with the organizational ethos may sometimes require team leaders to proactively challenge and interrogate their motives. This practice suggests that protecting the moral high ground and staying true to serving the greater good may involve an active but taken-for-granted process of critical reflexivity. Staying on the moral high ground and keeping one's ego in check may actually require a little bit of work.

Chapter 7

The Emerging Discourse of Transdisciplinary Team Membership

With the exception of intimacy boundaries, there is very little variation in participants' narratives as they reflected on questions such as: Who are we and what is our purpose? Who am I in relationship to you, to us, and to them? What are our rights, our duties, and our moral obligations to each? Who are 'they' and why are 'they' so different from 'us'? While deployed differently in the constructions of their narratives, participants similarly orient and locate the traditional model in opposition to transdisciplinary practice.

Participants' narratives corroborate the founders' and leadership team's descriptions of team members interpersonal practices. As a result, the repertoires in this chapter overlap and resonate with the repertoires in Chapters 5 and 6. The discourse of transdisciplinary team membership is constructed from four interpretative repertoires: 'All for one and one for all', 'professional safe haven', 'conflict free zone' and 'fami-we'.

Interpretative Repertoires

All for one and one for all.

In the biomedical model, participants portrayed themselves as emotionally detached and geographically isolated from their colleagues. The division of labor, constrained clinical gaze and focus on individualism are resources for institutional efficiency. Lack of managerial oversight allows the workplace to devolve into a battlefield where it's everyman for himself.

Some participants also portrayed traditional managers as agents of power who purposefully create and maintain workplace inequities. The favored few are given lighter workloads at the expense of the health and well-being of team member colleagues. Team mates who lean towards slackery can take advantage of the guaranteed salary structure. They get paid on the backs of hard-working colleagues. Inequality, moral ineptitude and a lack of concern for the impact on one's employees or team members can create the perfect storm. Frustration turns to anger and powerlessness to hopelessness. Physical and emotional resources can be drained and burnout ensues. For some participants the injustices and disproportion of workload seems so illogical it's almost surreal:

So what I've also seen in a lot of traditional workplaces is that they try to get out of work, you know? They try and do as few hours as you can or turn away clients because you're going to get paid the same either way. And then in those places, the good people get the good people and the bad people get the same pay for doing shit. (Participant 9)

Life is very different at the Clinic. Transdisciplinary team members share a deep level of commitment to every single one of their colleagues because there is no need for competition with peers. The under-resourced transdisciplinary team attends to the needs of each individual (i.e., the parts) so they have the capacity to serve the needs of the many (i.e., the team, clients, families and the community) as a strong united whole. They do not take advantage of each other or the system. Interpersonal relationships and practices are oriented towards collectivism, interdependency, solidarity and reciprocity. All for one and one for all is not about getting rich on the backs of others. It's about having your team members' backs irrespective of your position or tenure in the organization:

I would never hesitate to call somebody and say, "Do you mind going into my office? Or can you cover for me?" They are all so supportive. But I've never heard any resentment being voiced or through body language or anything because you know that they will do the same thing for you. When the tables are switched, they will. I've even seen people actually give up their admin time to help somebody and just say "Well, it's the best thing to do right now, so maybe we'll just make an exchange down the road." I've never seen that before. And they do that, and they have done that for me. But I've never asked anyone for anything that they wouldn't do in return.

I think that's the reason for the lack of burnout here and the reasons why we like each other so much. No one feels like they have to clean up after anyone. And I think here, it's nice that

nobody feels like, “Oh, why am I having to clean up for blah, blah, blah.” (Participants 4 and 9)

Transdisciplinary team members portray themselves and their colleagues as compassionate, altruistic and merciful. Team members provide each other unconditional support because they understand every human being is fallible. Sometimes team members are more organized than others. Some choose to ignore time limits on therapy appointments to ensure clients receive the quality and quantity of care needed. Some participants have experienced horrible personal tragedies during the course of this study. I have witnessed team members carry each other when their colleagues couldn't carry their own. They are kind, loving, giving and forgiving regardless of the circumstances:

I do think that people are very forgiving, too. If you need to take two weeks, we'll cover. I mean, that's an emphasis here. And I think the right people end up there who sort of cover for each other. I think that when someone knows that you are going through something or you are just going through a day when you're just not as energetic or your preoccupied or whatever, then there can be a concession. And you don't necessarily have to ask but there is an understanding. And that just helps us all to feel supported. (Participants 9 and 12)

“*Concessions*” (Participant 12) might seem more provisional rather than unconditional. Providing support to teammates is not exactly a selfless act of kindness. It is another unspoken rule of conduct that no one needs reminding of. Concessions are not so much an insurance policy, but a moral imperative coupled with an implicit trust that always already ensures a safety net and helpful resources will be there when anyone needs a soft place to fall.

“But that doesn't mean that there isn't accountability, you know” (Participant 9).

Accountability is a central in the all for one, one for all repertoire.

Even though none of us ever insult each other or say “Why didn't you do that?” I very rarely ever feel that way. But there's accountability because we're all talking and working together. If

somebody says, “Well, I haven’t really worked on that,” and then if I say, “That was in supposed to be part of the assessment like we had talked about. Why didn’t you work on it?” You just, you just can’t really skate on it in that sense either when it’s a team. Because we can all say, “I’m working on my piece, why are you not working on your piece?” (Participant 9)

Keeping each other in check is a resource for organizational efficiency. The communication and collaboration needed to keep up with a continuously evolving organization and complex evolving clients’ circumstances means no one can drop the ball. Each team member has to work hard to sustain synergies and keep the momentum going. Missteps or laziness can result in time delays and schedule changes inconvenient for colleagues, clients and family members. We *“just don’t have time for that”* (Participant 10). Team members praise the clinical director’s ability to screen out potential slackers: *“The right people end up there who sort of cover for each other”* (Participant 9).

The organizational ethos also emerges in this repertoire. Team members treat each other with dignity and respect even if there is an occasional lapse. Empowered equals engage each other in open and honest discussion about their mutual responsibility to each other and to clients. They reflect on their practices to ensure they are all *“on the same page”* (Participant 13). They are assertive but not threatening or condescending. They work towards helping each towards success, not failure. The success of each individual team member helps ensure the success of the collective.

Professional safe haven.

The safe haven repertoire carries over from the discourse of transdisciplinary leadership but is invoked for a different purpose. Team members, themselves, co-create and sustain the moral high ground:

It’s kind of hard to describe the milieu here because the therapists benefit from each other. I think it’s just the support and being recognized and valued. And everyone loves the milieu and contributes to that, to this atmospheric thing. (Participant 11)

Their combined efforts, shared ethos and commitment to each other create a work environment where it safe for one's professional self to be vulnerable in front of **anyone**. No one will “*try to knock the props out of each other*” (Participant 13). Team members do not need to hide behind closed doors or retreat into the darkness. The deployment of bullying tactics is considered counterproductive in an organization where healthcare providers rely so heavily on each other to be a pillar of strength and support. It's not like the old world where:

They don't trust each other...You could go ask for advice about something and then that person is going to go back to someone else and say, “Well I'm not going back to so-and-so because they're incompetent.” So people are very guarded about their shortcomings there, you know? They don't have any. (Participant 9)

In the old world, the negative consequences of exposing professional weaknesses in self or others seem to outweigh any potential benefits to patients. In the new world, team members not only admit to their short-comings, they purposefully expose them to protect the best interests of clients:

We're not very, I don't know what the right word is... guarded...we're not very guarded about our shortcomings, not like it is elsewhere. Here I can say, like, “Oh my god! I can't believe that I just said that! I'm really sorry! I'm such a dork,” because we're all just human beings. I think that we all feel safe because we all trust that we're all here for the same reason. (Participants 9 and 12)

Quality healthcare for a complex client population requires honesty, integrity and personal insight into one's own strengths and weaknesses. The acknowledgment of professional weaknesses cultivates trust in the clinical judgment of teammates. To identify, own and reveal knowledge gaps or seemingly insurmountable challenges to the group is viewed as an act of humility and grace that garners respect rather than condemnation:

There are sometimes the therapists have to sit down with the other team members and say, “I hit a wall. What do you think?” And so if somebody’s having a hard time with a client, we will be respectful. We’re pretty respectful. (Participant 9)

The transition from a place of fear and mistrust to the sanctuary afforded by the Clinic can take a while to get used to:

I think that I was, initially, really intimidated because they have such great experience here that I didn’t feel like I measured up as a therapist. I was so nervous anytime I had to speak I would get hot flashes! But then I got to a comfort level where I could talk in front of the whole group or bring something up if I thought I was doing something wrong instead of staying behind closed doors. It takes a time to reach that comfort level where you can bring things up in front of everybody and not just say behind doors. It takes a while until you’re like “what am I doing wrong,” in front of everybody, you know (Participants 1 and 2)

Placed in the context of the traditional workplace meta-narratives, this excerpt provides an example of how several participants portray the effects of institutionalized healthcare on healthcare providers. Some participants’ narratives sounded much like the discourse of the institutionalized mentally ill even whether or not they overtly criticized the traditional knowledge/power hierarchy. For example, participants 5, 10, 13 and 14 portray the exchange of one’s authentic human self for credentials, titles and status as a covert form of identity theft. Agency is passively relinquished under the guise of power and status or actively taken up to serve the needs of a fragile ego. Other team members (e.g. participants 1 and 2) do not see how power has been relinquished to thrive or survive in the traditional work environment. Rather, they only feel the effects (i.e., fear and trepidation). Liberation without emancipation can be scary.

Neophyte team member are covertly re-socialized into the transdisciplinarity practice model:

That's the other piece is that they are really supportive and they, you know, every time I would say something, I would get a little bit more confidence because I would get such great feedback from all the different disciplines. "Oh that's a great idea. That's a perspective I didn't have because I don't have your expertise or I don't have your specialty. (Participant 1)

Founders, leaders and team members all describe the team's orientation processes as a sort of rehabilitation in-and-of itself. Arguably, this might be considered re-institutionalization were it not for the fact team members and leaders create a safe place to restore agency, autonomy, self-confidence and identity.

Here again the team struggles to articulate transdisciplinary practices. The intention is not to completely obliterate the biomedical gaze or reprogram the biomedically devout. However, there is no step-by-step manual to teach you how to rid yourself of ego, expose your flaws, fully enact authentic power and participate with all disciplinary colleagues and clients as peers and equals. They do not have employee empowerment supports group or egos anonymous meetings. I do not believe Rosetta Stone® could meaningfully translate or manipulate the discourse of traditional biomedical education to adequately and accurately describe transdisciplinary socialization and training.

Orientation for the fearful seems to involve more coaxing than coaching. The clinical director hires highly capable experienced therapists. *"I think that's kind of the secret and the key to this place is that we're all really good and really skilled in our individual areas"* (Participant 1). Everyone is on equal footing in terms of skills competency. However, in a typical hospital setting, the clinical pecking order might look something like this: Physicians, nurses, other allied healthcare professionals (i.e., OT, PT, speech therapists, social workers, dieticians etc.), unit clerks, technicians and housekeeping. Orders come from the top down and you have to have some seriouschutzpah to argue back up the chain of command. In some settings, challenges to disciplinary or administrative authority, rightly or wrongly, are treated as acts of disrespect or insubordination.

One goal of transdisciplinary re-socialization is to encourage respectful debate and knowledge sharing among disciplinary equals, providing a safe environment in which to do so. The following excerpt is an exemplar of how a tenured team member portrays the ideal power relationship between transdisciplinary therapists and transdisciplinary physicians. *“There are times [physicians] come in and just say, “This is what it is,” you know? And then it’s like, “No, it isn’t.” People will say that right back to them, too. Yeah. And they’re okay with that”* (Participant 13). Chapter 8 will provide more details about transdisciplinary physicians.

The preceding narrative and the nonchalant demeanor of the participant demonstrates how transdisciplinary therapists proclaim and enact their right to freely challenge the traditional disciplinary hierarchy. With time, coaxing and the support of the leaders and teammates, new therapists can evolve and lay claim to a new empowered professional self:

And I think that we are all quite independent people, and I think the independence is important because you’ve gotta be pretty strong. You’ve gotta be pretty strong to work in a setting where you’ve got a lot of people with a lot of knowledge and are able to speak their mind, particularly in a staff meetings, that sort of thing. You have to be able to have a dialogue and still be comfortable in your own skin. (Participant 6)

Confidence-building efforts attempt to ensure that new staff members feel safe and secure as the biomedical gaze is transformed. Just as your eyes need time to acclimate to the glare of the sun, new team members need time to adjust to the transdisciplinary view and a very different way of talking about neurorehabilitation. The transdisciplinary gaze sees a meta-system and the language is not the language of science. Team members gently ease new colleagues into their discourse and practices by modulating light and sound frequencies.

A transdisciplinary gaze sees beyond its own discipline, explores other disciplines and seeks out new knowledge between the disciplines (i.e., in the between). The transdisciplinary team requires a broad source of light to see in every direction and into every shadow. It is not the glare of a pen light from above, but a softer glow that illuminates from beneath. It is a light that seems to make invisible ends of the light spectrum, ultraviolet and infra-red, visible to the

naked eye of the naive. The team does not want to blind the blind they hope to enlighten. The shift from a myopic to panoptic gaze may be so jarring to onlookers or overwhelming to ego healthcare providers might look away before they can see. Instead, they slowly and gently modulate the light spectrum. All is revealed in due time.

The transdisciplinary team also modulates the formal hegemonic discourses of medicine. There are times when the medical discourse is invoked to orient the team to medical issues or medications that might need further investigation or change but *“We don’t do as much diagnosis at the clinic so the direction, I think, is a little different”* (Participants 6 and 9). *“The purpose of what we’re doing is to help the person and to help them achieve a greater degree of independence or better life quality or whatever it might be outside of therapy”* (Participant 1).

Team practices are oriented towards clients’ everyday life circumstances. This requires them to tone down the biologically orienting medical discourse and turning up the more casual liberal discourse of transdisciplinary healthcare. In doing so, they seem to have somehow synthesized the disharmony between two disparate languages so they can coexist at the same time and co-evolve in the same space. The harmonization enriches the character of each language and the practices of traditionally trained healthcare providers. Team members use simple terms and everyday language so everyone understands. Every team member, client and family member can contribute to the discussion in a meaningful way. They don’t use fancy acronyms or scientific jargon. The discourse of transdisciplinary practice is accessible no matter who you are.

The emerging casual discourse of transdisciplinary practice serves an important function in the acclimation process. New staff members are immediately and continuously drawn into zones of transdisciplinarity. Communication is the most crucial component of the job. However, it can take time and courage to find and awaken a professional voice and a confident self, silent and silenced for many years:

You have to communicate with all the team and they have to communicate with me. And I think that’s what’s was originally so hard for me. It was one of the hard things about working here.

The communication piece it's just, it's just, as you come in the door as a new staff member you're just going to be meshed in it. Communication is inherent. I mean it just, it's the expectation. It's the plan. This is how things proceed. But for the most part, I mean if a staff member is newer or perhaps a little shy in their personality they may not be as vocal. But for most of us we are pretty vocal and most of us get more vocal the longer we are here. (Participants 6, 7 and 11).

The discourse of transdisciplinarity helps alleviate anxiety related to linguistic slip-ups. Their more casual language allows team members to explore the knowledge and insight of peers in a way that is non-threatening, understandable and meaningful to them. It is a discourse that invites clerical staff members to comfortably engage in discussions about client care. Members of the discourse community actively call for discursive redirect if they are struggling to understand to understand the foreign languages of science or philosophy. Team members protect their healthcare model by resisting the hegemony of academic and medical discourses that could re-orient practices to a biomedical approach. Keeping the team feeling confident, safe and on the same transdisciplinary page means everyone has to keep it simple.

Once new team members get over their initial fear and intimidation, sharing short comings with transdisciplinary team members is fun, liberating and exciting. Some team members embrace the opportunity to transform into a “CSI” self (Participant 14). Team members celebrate colleagues who bring new challenges to the table. They encourage and relish opportunities to dive into new rabbit holes and create a new solution to an old or complicated problem. The discourse and practice of transdisciplinary team membership orients team members to practices that make zones of transdisciplinarity places of professional safety. T-zones are well-guarded safe havens co-created by team members on the moral high ground.

Conflict-free zone.

Conflict-free zone builds on the professional safe haven and moral high ground repertoires. Team members deploy this repertoire to demonstrate how the organizational ethos operates at the level of individual relationships. Each team member takes personal responsibility

for nurturing and protecting the moral high ground by circumventing, de-escalating or mitigating conflict. If there are transgressions, the offending party tends to the wounds they have inflicted on others:

Even after people have been here for months and years, I continue to shake my head and be shocked that there are no politics, and no employees having tiffs between one another. There is no need for hard feelings or problems or any controversy. You just work together and do what you can to help patients. I don't get a sense that there's a lot of people that go around undermining other team members or it doesn't happen. It doesn't happen.

Sometimes I see a little bit [of conflict], but that's because, when, actually and I will see this, it is far less than the other places I've worked. I mean it is like almost none. I think it is sometimes, well I don't know if conflict is the right word, but, I think it comes like from some of us not feeling appreciated by others. I think they would verbalize that they think we are all wonderful and they really appreciated, but sometimes and maybe appreciate isn't even the right word, it's more like umm, if, something doesn't go smoothly, I don't know. There have been a couple of times when I've felt like people have been a little too abrupt. I was like, "Wow; they didn't deserve to be talked to like that," you know? But then I've also seen them come back and say, "I'm really sorry. I'm having a bad day." (Participants 2, 3 and 13)

Once again, the work environment is portrayed of the antithesis of the traditional battleground. The degree of social harmony at the Clinic is unique and special, *"It feels like a little gem I just found"* (Participant 2). The traditional work environment has, in part, run morally and ethically amuck because of the lack of administrative oversight and enforcement of its own rules of conduct. The administrative gaze at the Clinic does not does closely monitor or intervene if there is the occasional conflict. There is no need. Team members take on the same

degree of responsibility for protecting and preserving the sanctity of the moral high ground as the clinical director.

A superficially injured party may offer a concession to a harried colleague. It is understandable people can be uncharacteristically gruff under time pressures. However, taking ownership for maligned behaviours and asking forgiveness is a cleansing process. People who gossip or try to sully the reputation of transdisciplinary colleagues “*muddy the waters*” (Participant 4). People who create conflict, negativity or try to divert the transdisciplinary gaze by focusing on the flaws of others team members are like toxic spills (Participant 4) threatening the purity of the team’s mission. The gaze must remain crystal clear to serve the greater good and the work environment peaceful.

Fami-we.

Participants’ narratives about interpersonal relationships illuminate faint lines of social division in the organization. The differences do not represent separate factions per se. “*There are just some people on the team who are more prone to developing personal relationships with their work colleagues than others, like maybe full-timers versus part-timers*” (Participant 8). Distinctions do not create feelings of jealousy or divisiveness. “*I think there is a mixture on how people feel about it and I don’t think we try to mold anybody else like us. There’s a lot of similarity here and a lot of diversity here*” (Participant 4).

Some team members analogize feelings of interpersonal closeness to their family of origin: “*I think it just feels good here. It just feels right. It feels very much like a family here*” (Participant 3). These participants are publically open about close and meaningful work relationships that carry over into their private lives. They socialize together during lunch breaks, sit together in team meetings and get together after work and on weekends. The visibility of personal friendships in the workplace creates a felt but unproblematic sense of social divisiveness: “*Of course there are some of the staff that feel like there is an inner circle of people that are sort of a family but then there are the others*” (Participant 2). The inner circle (i.e., the family) is comprised of transdisciplinary therapists and team leaders who have work together for more nearly two decades.

One participant portrayed departmental colleagues as her surrogate family. Work colleagues are not friends or personal intimates. They have created a functional social support network in the work environment because they are geographically dislocated from family members:

I really feel like the people in my own department work so physically close together, like at arm's length away from each other for 8 hours a day, that we have that feeling of personal closeness. Not in the sense that we would want to spend our weekends together or anything, but they feel if they had a problem and really needed help, they could call one of their colleagues for something if they needed to. For some of us, you know, some people just don't have family in the area at all, so the people they work within their department are the closest thing to family that they have. (Participant 2)

Proximity to colleagues and a deep level of trust provides team members a safe place to disclose personal challenges and reach out for understanding and support. The degree of support offered colleagues is not necessarily dependent on department affiliation. However, the degree of self-disclosure is a balance between personal comfort level and the potential impact of non-disclosure on quality care:

Here, if there are things that are dramatic going on in our lives we want it to be common knowledge among the staff. It's not like I'm just going to tell one or two people if it's something that's going to affect my life pretty broadly and could possibly affect my work relationships with clients or the way that I interact with them. I want the rest of the staff to be aware and to let me know if something's going on that maybe I'm not aware of. 'I'm off this week. How this inward stuff is expressing itself? I'd like feedback. I think that we tend to do that last bit a little more within our departments than with the whole team. I am sure that there are

things about each one of us that all of us don't know. That's just the nature of being human. And it's just nice to know that when you're going through a struggle, I personally don't need to know but I can at least give you a hug and say "I hope you're having a good day." (Participant 4 and 12)

Some team members resist the degree of intimacy family imposes on professional relationships. They portray themselves and colleagues as more resilient than traditional healthcare providers because they have stable social support systems (i.e., friends and families) outside the work environment. Team mates do not require intimate family relationships with colleagues. All for one and one for all means they already have unconditional support without disclosing the details. Workplace relationships portrayed as more social and friendly in nature only serve to enhance group cohesiveness:

So like, I tend to think of the group as a more of a professional family. I get the family analogy but I also get that some team members are best friends and have worked together at the clinic for quite a while but I still think of the group as more of a very cohesive team than a family. This is a work environment. This is not a family. This is an atmosphere that is more engaging, more involved, interesting, challenging, etc. But I don't, I guess I would never use the word family.

I also think that the members of the team have well-rounded lives because they value what they're doing outside of here as much as what they're doing at the clinic. So that when they're not here, they have other very fulfilling things, very important things they're doing. They have back-up systems outside of the workplace.

When you hear, and a lot of it is together, like, "We'll go and have a beer," or "We'll meet," you know, so there's a social support within and there's social support outside. I sort of feel like they have a lot of buffers you know? I don't think that the people who

work in the traditional model have really healthy lives outside of work. (Participants 6, 9 and 11)

Participants who deploy the formal traditional discourse of biomedical practice more often constituted collegial relationships as less intimate. One participant's interpersonal relationships were confined by her particular discipline's ethical boundaries. For her, the outward display of friendships in the workplace is on the hairy edge of unprofessionalism. She does have colleagues with whom she socializes outside of the workplace. However, these relationships are kept out of the purview of teammates.

Another more traditionally-oriented participant works on a part-time basis, splitting his time between a hospital-based outpatient practice and the Clinic. He characterizes hospital-based professional relationships as socially distant, professionally bound resources of organizational efficiency. *"Well, you know I can think of my work at the hospital. It's really a specialty clinic, you know? There is some opportunity for the therapist and the doctor to visit"* (Participant 8). That said, he acknowledges the functional advantages the stronger personal affiliations on a transdisciplinary team.

Not that I doesn't think that personal connections here aren't important. That would make the team feel too segmented, you know? There would be too much separation between people.

(Participant 8)

Participant 8's narrative provides a glimpse into how the traditional and transdisciplinary discourses construct team members differently. In the traditional work environment, team members and self are constituted only by disciplinary identities. Professionals interact as object others. Transdisciplinary interactions are characterized by intersubjectivity. Interacting subjects are connected by personhood: a resource for efficiency and team cohesion more important than geographical proximity or traditional disciplinary boundaries and identities.

I was first introduced to the Fami-we repertoire during the team's October, 2011, retreat where they were exploring the question, Who are we as a team? They were searching for a single term that best represented group's feelings of unification, solidarity and affinity for each other as a whole. *"It's been very hard to find a word that really fits what it feels like to be a*

member of this team, you know,” (Participant 13). One of the founders suggested the term *fami-we* might be more a more inclusive term. *Fami-we* allows for all of the similar and divert ways of constituting self and others in the workplace without privileging any particular view. It is a term that reflects and honors the team’s universal respect for diversity and diverse thinking.

Summary

The discourse of transdisciplinary team membership is a discourse of collectivism, solidarity, mutuality, interdependency and reciprocity. Compassionate, forgiving and supportive colleagues purposefully work to orient team member colleagues towards health and personal well-being during times of personal stress. The strength of the collective relies on the strength and personal capacity of each and every team member. Team members openly disclose personal challenges and professional weaknesses. Each team member takes responsibility for creating a safe haven for themselves and their colleagues. Social harmony is a resource for health and organizational efficiency.

Leadership from below is made possible because fully empowered team members preserve the moral high ground and keep each other in check. Participants’ narratives highlight a felt sense of moral obligation to each other and their clients. Team members self-identify practices not aligned with their shared ethos. They take ownership for digressions and make amends with colleagues. The moral high ground must be cleansed of impurities that threaten team relationships or divert its gaze from their mission to serve the greater good.

Transdisciplinary team membership and practices can be intimidating for traditionally trained therapists. Highly skilled open-minded clinicians with a willingness to step out of their traditional defined professional self are sought after. Exposure to the broader transdisciplinary gaze and a new language for neurorehabilitation practice can be overwhelming and disorienting. Team leaders and team members work together to gently immerse new colleagues into the language and practice. They role model behaviours to demonstrate, rather than dictate, how positive productive interpersonal relationships are co-created and sustained.

However, transdisciplinary membership may require alignment with the organizational ethos but does not dictate the degree of interpersonal intimacy. Team members and leaders accept and encourage diversity. They recognize some people are more inclined to develop more

intimate friendships with co-worker that others. There is no expressed jealousy of feelings of social exclusion. There is a knowing that the door is always open for anyone to join the inner circle if and when they choose to do so. Team membership is a discourse of inclusivity not exclusivity represented by their self-ascribed and mutually agreed upon label Fami-we.

Chapter 8

The Emerging Discourse of Transdisciplinary Therapy

The discourse of transdisciplinary therapy orients team members to therapeutic practices and provider/client relationships that are incompatible with an institutionally-based biomedical approach to neurorehabilitation. As the transdisciplinary team's practices have become more and more liberated from the confines of the clinical context over the past 30 years, their practices have become increasingly unique and relationships with clients and family members uniquely personal.

The discourse of transdisciplinary therapy is constructed by participants using the following interpretative repertoires: 'the therapeutic self', 'professional intimates', 'maximum power transfer', 'context embedded practice', 'embodied knowledge' and 'context embedded therapy homework'.

Interpretative Repertoires

The therapeutic self.

When I first started here, I was just trying to do things in line with the other therapists. I think it took at least a year to really understand what it means to be a therapist. Specifically, you know, I think, when you go into a field you focus so long and your schooling is so focused on a disorder and how you fix it but the therapist aspect, that empathy piece doesn't come into play. I think it's the last piece to develop, that counsellor role that you have to take up in helping the clients cope with living with whatever it is they are living with. I think that's the piece, finally being a therapist, that's the piece that starts to develop. When you work here, you begin to understand it and it does shape how you do treatment. So rather than having the person imitate a movement or something, like those pieces of it, when you're doing that you're not understanding or taking into account the person's experience and what they are actually dealing with, you know?

I think that how I've learned was seeing how the other therapists bring the therapist role to the table first and then support it with their skills. That was learning for me. So I think the reason that piece developed in me as a professional is because I work here. I don't think it would have developed to the extent that it is if I had just stayed in a traditional setting. (Participant 1)

Healthcare is an art and a science. The 'science' of healthcare requires professionals to apply knowledge and technical expertise to practice. The 'art' speaks to their capacity to care about, comfort and nurture the human spirit. Together, the art and science is a delicate balance between medical treatment and close connections with patients on a human level. However, the discourse of medical and healthcare education foreground the applied science aspect of care and background the caring. Knowledge and technology are expanding so rapidly in an increasingly under-resourced healthcare system how can we possibly develop closer relationship with those in our care?

Traditional healthcare institutions graduate competent clinician/scientists. Traditional medicine's orientation to skills-based practice provides clinicians ample opportunity become clinical experts. Over time, an anxious and fearful neophyte can become increasingly confident in themselves and their practices. They may earn the trust and respect of colleagues and be recognized by the establishment for their clinical or scientific accomplishments. However, relational theory (e.g. humanism and family systems theory) introduced in an academic curriculum may not be taken up as part of a healthcare provider's professional repertoire after graduation. The medicalized gaze may never see patients as persons who need kindness, compassion and nurturance to heal. The art may never co-exist with the 'science' because this aspect of the professional self can remain under-developed during the course of a career.

Clinical expertise is a co-requisite for employment at the Clinic because the discourse of transdisciplinary therapy calls on therapists to foreground the art of healing. It is not that the human "stuff" (Participant 4, 8, 13) is more important than being an expert at the technical "stuff" (Participant 3, 5). A therapist cannot carry out skills-based treatment, explore real-life circumstances and deploy therapeutic practices during a one hour appointment.

Transdisciplinary therapists must continuously engage clients and families in conversations during therapy to explore health determinants beyond the physical domain. They talk with them about vacation plans, life challenges, interpersonal relationships, hopes, dreams and:

Oops. I forgot how many repetitions that was. Let's change over to the right leg. Ok, so how could you handle that situation differently? Is there anyone in your home town that would be able to help you with that? What does your wife think about the situation? (Field Observation, February 2012)

The therapeutic self is more than just underdeveloped extension of an externalized professional self. But is not simply a less egocentric version of personal self either. It is a part of self that can only emerge, connect and empathize with others after ego is completely stripped away. It is the innermost aspect of being (i.e. our authentic selves) that already exists within but might never have met or interacted with clients as equals and persons in the context of clinical practice.

The therapeutic self is kind and compassionate. In the safety of the inner sanctum, therapeutic selves can merge with one's expert professional self. Their co-existence evolves practice as the therapist becomes whole and their gaze and practices holistic. Professional relationships characterized by mutuality, equality, empathy create a deeper sense of personal connection because transdisciplinary team members and clients can get to know, "you know...with the whole person" (Participant 4).

Professional intimates.

What happens among us as coworkers is kind of the same thing that's going on between therapists and patients and family, that same sort of feeling. I think our relationships with clients is a little more relaxed than you might find, you know, in a different setting. I don't know exactly what it is. But, you know, we do get to know the whole person. Kind of, how they were before and what's brought them to this place and stuff like that. (Participants 4 and 11)

It is not possible to completely know a person when “*you’re working with a client for a short amount of time*” (Participant 8). Transdisciplinary therapists try to imagine what it feels like to be the client. They are deeply empathetic. What is it like for client’s to live, love, laugh or lose hope, strength and sense of self? Transdisciplinary ‘doing’ must be predicated on more than just a superficial understanding of the client’s day-to-day reality. Healthcare providers and clients co-create safe and more intimate spaces (i.e., T-zones) to explore and close the gap between the therapist’s professional perspectives and the client’s experienced reality. Therapeutic interventions tailored to a client’s uniquely situated circumstances are more successful when they are meaningful at a deeper, more personal level.

Some therapists use personal disclosure to create and build more intimate therapeutic relationships. Therapists share their vulnerable flawed selves to connect with clients as human beings. Imperfections are portrayed to clients as a normal part of the human condition; it’s common ground that can bring therapists and clients together on equal footing. Sometimes humor or self-deprecation helps break the ice. The goal is to invite clients to co-create a safe space and a relationship where no one needs or ought to be judged:

I also think that it is important that my clients know that I’m a human being. My recipes don’t always turn out well. I’m not always on time for things and, you know, I think those kinds of things. And because they see those things in us, we’re giving them permission to not be perfect. I think that helps too. I don’t think we know everything that is a benefit or a barrier to them but I think that we know more than most places. (Participant 1)

Professional intimacy does not involve secrecy or violate professional taboos. “*So while it’s still professional, I think we all wax and wane in reference to where we need to draw the line with our clients*” (Participant 6). Exploring someone’s innermost thoughts and feelings just feels more intimate than hierarchical client/provider relationships formed and contained in medical institutions. Transdisciplinary relationships are co-created by equals and co-evolve in a very different and more “*homey*” (Participant 11) healthcare milieu.

Diagnosis and treatments are foregrounded in the biomedical model and therapeutic relationships develop behind closed doors if they exist at all. At the Clinic, relationships and relational practices are visible. Clinical treatments happen beyond public purview:

The atmosphere that's been created here for the clients does feel homey, relaxed and non-clinical for the client. It's clinical behind the scenes of course. I think we have worked very hard to make a friendly atmosphere here. (Participants 11 and 6)

Relationship boundaries vary from provider to provider and client to client depending on each person's comfort level and interpersonal compatibility. Client/provider compatibility may be seldom taken into consideration in the biomedical model. Clients are randomly assigned to and remain with one clinical therapist or one of many multidisciplinary teams for the duration of treatment. This practice may ensure continuity of care, organizational efficiency and cost containment:

At another healthcare center we had designated teams. Like there's a PT, an OT and a speech therapist and OT assistants and PT assistants. When a new a new patient came in, they were scheduled with the team whether they were inpatient or outpatient, you know? They functioned in teams so that the same team saw all the same group of patients, you know? Like patients were assigned to team 'A' or whatever. I mean with your group of patients they were always the same people. (Participant 2)

There is only one team of multiple disciplinary therapists at the Clinic. Some clients choose to limit contact to preferred therapists while others don't mind "jump[ing] around" (Participant 2). Clients are randomly but not permanently scheduled (i.e. not permanently assigned) with a particular therapist depending on appointment availability and client convenience. However, whenever possible intake coordinators play match-maker:

When clients first come to the clinic, when people are needing therapies and we're deciding who they are going to be seeing, often times it is just based on what therapists has openings. But

sometimes it's like, kind of a personality thing, you know? You are calling to make an appointment and they will just start telling you their whole story. So like we'll talk to somebody and be thinking, "I think this person would go really well with so-and-so." Sometimes it's only based on brief telephone conversation and who knows how accurate it is, but we all do that. (Participant 2)

Scheduling decisions based on possible client/provider compatibility are intended to support the development of healthy, long term therapeutic relationships. It isn't an exact science and there is no data to support whether or not it is an effective or cost efficient strategy. There is only a general consensus amongst team members that intake coordinators have an uncanny sixth sense that seem to work. This is likely based on their intimate familiarity with their team mates and the time they spend getting to know clients before they arrive at the Clinic. If a mismatch happens, team members work closely with clients and family members to find provider peers with whom clients feel more comfortable.

The evolving dynamics of therapeutic relationships are openly discussed with clients and the whole team during the entire recovery process. Clients know full well that the therapists share details about therapies and discuss relationships challenges. *"We do get on our feedback surveys that people feel like we are communicating. They feel like we are sharing information amongst each other"* (Participant 5). Team member colleagues try to stay apprised of interpersonal dynamics so the team can respond if relationships begin to deteriorate. *"We check in with them...and say, "Okay, how is that going? How do you feel? What is your relationship? Do you like your OT? Is that a good fit for you? Personality-wise, is that working"* (Participant 3).

Protecting the best interests of the client sometimes requires therapists to acknowledge clients have a greater affinity for their team member colleagues. This isn't a competition to see who's the best at establishing and maintain client/provider relationships:

We're pretty respectful about saying, "I don't want to have this meeting with this person. I don't think it'll go over well coming from me. Do you want to bring it up?" And it's not one person

gets, you know, slammed with everything. It's really because I feel like, "Wow, this person likes you and they don't like me so I think it would come about better." It's just a lot more of that than everybody trying to do the things that would probably not be best for the client." (Participant 9)

Sometimes family members refuse to fully engage in therapeutic relationships or the recovery process itself. Their lack of involvement can obstruct the transdisciplinary gaze by casting a shadow on vital components of the client's complex multidimensional meta-system. Emotional detachment or impenetrable personal boundaries constrain the team's capacity to develop contextually relevant interventions and the client's capacity to heal. Team members make every effort to encourage participation before and during therapy but respect and honor their decisions:

We really want to bring family as much as possible...we have a biased to try to do that. And it can be a challenge with some families to get involved or not. Some don't want to be involved or they have an assumption that they shouldn't be involved because it's the client that needs the treatment. (Participant 6)

Professional intimacy is made possible at the Clinic because therapists see themselves as "folks" helping "folks" (Participants 5, 6, 8, 9 and 10) and "people" helping "people" (Participants 2, 5, 8, 10 and 13). The terms clients and patients traditionally position healthcare providers in positions of power and clients "look[ing] to the professionals to say what the say is" (Participant 1). The terms people, persons, folks, clients and patients are used interchangeably at the Clinic but do not imply or convey absolute power to a therapist or to the team as a whole. 'Power over' is seen as counterproductive to healing, recovery and reintegration into life. Power in relationships is 'power with' and 'power transfer to'.

It can take time to learn "how to do the boundaries just right" (Participant 4). Therapists have to artfully navigate a fine line between a therapeutic relationship and personal friendship. Professional relationships are time limited but the detachment process takes place over a longer

period of time. It's not like the traditional model where *"you sever the connection after"* (Participant 9) after hospital discharge:

I think our relationship with them is a little more relaxed than you might find at another therapist's office. I mean, you're never friends with your clients. My clients are not going to be my new best friends, and we're not going to hang out. But, I might say, well "Why don't we get together over coffee after you're discharged and if there's any loose ends we can tie them up." Or we might take them out to celebrate a birthday if they are ready for discharge. (Participant 4)

Maximum power transfer.

The thing has to be emphasized is we provide the opportunity for a person to be a member of the transdisciplinary team. Some people will not do that because they don't have the ability to do so. Some people will do that because of various aspects of their personality which either prevents them from interacting in that way, or sets it up so they don't want to be that kind of person.

So ... all this stuff we used to give people when we would do a debrief or give them a patient handbook, we always said, "You're a member of the rehab team. You're a part of that." So it's kind of like the opportunity's there but some people either may choose not to be part of it or they may have some aspect of their past history or their generation or, their culture or whatever. Or something that prevents them from interacting in that way. (Participant 13)

Clients arrive at the Clinic in various stages of life and recovery. There are a multitude of factors that contribute to their willingness and capacity to fully engage as collaborative partners in their care while others are *"definitely not intending to be part of the team"* (Focus Group 3002). Some participants speculate that proximity to hospital discharge or a protracted hospital stay may play a large role. When patients fully take up the traditional patient role they can get a

little too accustomed to the drill: “*Look to the professionals to say what the say is*” (Participant 1), assume the position and “*follow along and do it*” (Participant 5).

Clients who continue to wholly constitute themselves as passive recipients of care after hospital discharge may become victims of their own inertia. Traditional health teams provide sufficient momentum to push patients out the door, but not everyone can muster the strength, energy, confidence and resources so “*that they can move forward and heal....in their recovery,*” (Participants 5 and 6) after discharge. Some have become so comfortable in the patient role they know full well if they do not do for themselves someone will step in and do for them. Traditional providers are always there to make the save (see Figure 8.1).



FIGURE 8.1. BIOMEDICAL SEARCH AND RESCUE PRACTICE MODEL

Once again, the discourses of traditional and transdisciplinary are irreconcilable. The expectation clients will take control of their recovery journey can be a rude awakening for clients used to being the passive recipients of care:

We're not here to rescue folks. And while the clinic can't completely fix your problems, they can teach you how to function with what you have now. We certainly can....reduce the stress level. But the bigger theme is that, indeed, they got into that situation because of this, that or the other thing. How can we even

it out for them so that they can go through their recovery? You are hoping for people to improve and get better and stronger and take on more stress. (Participants 2, 6 and 8)

Unfortunately, some clients and families never take up the responsibility for managing their own healthcare needs in spite of the team's best efforts. Instead of reaching out to resources in the community or asking for help from family and friends, they become dependent on healthcare providers to "fix" (Participants 1, 9 and 14) them. Absolute resistance to assume control results in zero effort to engage with the team as equal partners in their own recovery and life circumstances:

Some people can come in...and they know what they want and they're going to move forward. And some people can come in...and feel sick and hurt and fix me. Sometimes I see them becoming more dependent waiting for me to fix it. I see them pull back. And I'm wanting them to be a full partner and motivate them to take charge of the strategies I'm teaching, the education I'm providing...I want them to take hold of and start integrating into their life. Sometimes I don't know that they always get that that's their, they're driving or even directing. (Focus Group 3002)

Sometimes clients and families are not prepared to actively engage with the team because they are so lost and overwhelmed in the aftermath of hospital discharge. "They are not ready at the beginning. You can't dump all that stuff on people at the beginning. They're stressed and they don't know what to do" (Participant 5). It takes time to find the right pace. Push-back can be a positive indicator clients are engaged in the empowerment process. It provides the opportunity for clients and therapists to co-create shared understandings of the client's capacity to take up a leadership role and negotiate a plan to move forward:

On occasion I've tried to push somebody to be part of the team and decision-making and it just doesn't happen. We've all been there and that's kind of really painful but that's part of your job and

you've just got to do that. But sometimes I just didn't know where the stopping point was, but they let you know. (Focus Group 3002)

The team usually begins client/provider relationships with a biomedical approach. The team works through the traditional approach of diagnosis and treatment design to get the ball rolling. A tangible treatment plan is as a starting place from which to gradually increase clients and family involvement in the treatment decision-making process:

I think when they first come in we're driving the bus because we're doing the assessing, we're teasing out their strengths and weaknesses, and then we as the therapists are developing that initial treatment plan. I say, "Based on our first meeting this is my take on what, in my professional judgment, what we need to address in your therapy to make you better."

The treatment plan is something they can then grab and they can generate what they need to be able to do better on their own because of the scaffolding that we provide. (Participants 5 and 7)

However, therapists do not maintain a power position thereafter. They deploy empowerment practices (e.g. mentoring and coaching) to inspire clients and cheer them on. This is a process of socialization into the role as transdisciplinary client similar to the way new therapists are introduced into transdisciplinary team practice. Empowerment by socialization is intended help build the momentum needed to move forward in recovery:

It empowers them because they are ready. They are not ready at the beginning. You can't dump all that stuff on people at the beginning. They're stressed and they don't know what to do. But they learn. It's like a job. And we tell them, "This is like a new job for you and you have to learn how to move into your next role. You're the CEO of your treatment plan and all this." And I say to them at that point, "I'm kind of like your coach and your cheerleader. But you're doing all the work. I'm coaching you, advising, and I'm cheering you on." But I say, "Since you are the

CEO of your treatment plan, you let me know if there's something I'm not addressing that should be, or something that you quite frankly don't want to address." I think that's the term that we started using years ago. The client is the CEO of the treatment team. So we try to get that to them (Participant 5; Focus Group 3002)

Over time, *"they need to own it"* (Participant 5) if clients are going to successfully reintegrate back into life and become less dependent on family and healthcare services. Transdisciplinary therapists hope clients will become increasingly passionate about their recovery and take pride in their accomplishments. Regular meetings with multiple cheerleader team members provide clients with ongoing encouragement and positive reinforcement. They do not want clients to become frustrated, lose momentum and head back down the path to illness, dependence and decreased quality of life. Team members uncover and respond to new challenges with innovative strategies every step of the way. *"Our goals for the client are about empowerment and growth"* (Focus Group 3002). Anything less could be detrimental to recovery.

Ownership requires accountability. Clients are provided little opportunity to drop the ball:

And, like I mentioned before, we fill out little sheets every week about this is what I'm doing with this person or even to know this person no-showed. Those things are very helpful to know because I've had clients who lie to me. And then I pull out this sheet and I say "That's amazing, because you no-showed here and you no-showed here." And it puts some accountability and I think on a lot of people who have been in the traditional system, nobody keeps tabs on you. So, you know, I think it's good and bad for the clients. But in general it's good. I mean I think they don't like necessarily knowing we're all talking about you if they're messing with us. (Participant 9)

Appointment no-shows are a red flag for team members. A history of missed or cancelled appointments is not only a waste of time and resources, it is a clear indication clients are not sufficiently invested in their recovery. Clients are held accountable for holding up their end of the bargain and confronted if they are caught being dishonest. Therapists engage clients in discussions to uncover and understand the reasons behind absences. They work together to find solutions to challenges such as transportation or scheduling issues.

Transdisciplinary team members universally believe clients and family members must fully understand how physical injuries impact their uniquely situated life circumstances. Clients are likely to become more fully engaged and “take ownership” (Participant 3) if they understand how their brain injuries are contributing to the concrete challenges they face in the outside world:

We sit down with the client and we go over the results of their testing. Where their strengths and weaknesses were. And then we show them the treatment plan which includes their long-term goals and short-term objectives as well as their frequency of therapy and how long they'll be coming, the duration of therapy. (Participant 9)

Assuming ownership of recovery is enhanced when therapists pay attention to the congruence between test scores and the client's capacity to move towards recovery and reintegration goals. Measureable improvement in the clinical context may not translate into actual gains in real life:

I think always as therapists we measure outcome and we measure people reaching their goals. Traditionally, our job is to be able to say, “Hey, someone's measurement increased by 56 seconds as opposed to 6 seconds.” Or maybe they can stand to dress themselves instead of sitting. Big deal! What does that mean? You can sit to dress. But here is an adult who always stood up to dress and put their pants on and they couldn't do that. Someone can do beautifully on that testing and fall apart in their home environment, you know? This person may be testing well on paper, looks pretty good on paper, but dying out in the real world. So

your measurement does really say anything and I think that poses a challenge (Participants 5, 7 and 12)

Redefining a new and meaningful sense of self cannot be gauged in inches. The transdisciplinary gaze, therapist, coach and mentor needs to “*stand shoulder-to-shoulder, arm-in-arm every step of the way telling them everything they’re doing well*” (Focus Group 3002) from the clinical setting, home and back again.

Context-embedded practice.

The social work gaze is trained to peer inside the client’s real world context out there “*on the fringe and the horizon*” (Participant 5) beyond and invisible to the biomedical gaze. Traditional and transdisciplinary social workers are both portrayed by participants as the only members of the healthcare team with the gaze, role and skill set to assist clients and families navigate in and around broader health and social institutions to meet contextually relevant needs. They are systems engineers who work at the “*interface*” (Participant 7) between social institutions and the “*family system*” (Participant 6) and experts at mining, organizing and interpreting data from all aspects the client’s complex meta-system. Social workers are masters of logistics with the capacity to match the complex needs of the unique and uniquely situated family system with the resources available to them in their community.

Traditional hospital-based social workers typically provide clients, families or care-givers with knowledge (e.g. pamphlets or resource manuals) about community-based resources. They do not follow clients and families outside the system into the community. The traditional social work role is not designed to ensure clients connect with and remain connected to community resources needed to achieve and maintain an orientation towards health. The social work gaze extends into the client’s meta-system but, like other members of the multi- or interdisciplinary team, their practices do not. Clients with complex health challenges can bounce around from agency to agency and specialist to specialist for years after hospital discharge just to get a final finite medical diagnosis:

A lot of people have been to a lot of other providers by the time they are referred to the clinic. They have seen, not necessarily therapists, sometimes therapists, but definitely a lot of other

medical specialists. It's pretty common they've seen the neurologist and a rheumatologist and the whole gamut of everybody and had all the tests done.

It's pretty common for it to be 10-20 years or even just a few years down the road after hospital discharge and people have changed doctors a few times before they get here. Sometimes people will go online and find us themselves. So the patient might be thinking, "Well, this doctor has done all they can for me, so I need to find a new doctor", you know?

And there have been people who, I mean, it's been years and they've been to multiple doctors you know to figure out what's going on with them and they are telling me that they tried this and that. And they continue to go to new doctors because they're not well, so the patients just keep searching. And then the doctor refers them to us, you know? A doctor that the patient sought out years down the line (Participant 2: Focus Group 3002)

Participants' narratives shine a less-than-favorable light on traditional post-discharge care and referral processes. Hospital systems and physician practices are designed to push people, not products, through under-resourced organizations. However, the historically situated biomedical model and hospital systems engineers reproduce community-based team practices aligned with the discourse of industrial systems design: *"systems engineering... helps mold all the technical contributors into a unified team effort, forming a structured development process that proceeds from concept to production to operation and, in some cases, to termination and disposal"* (Systems Engineering (n.d.). In: Wikipedia. Retrieved October 19, 2013, from http://en.wikipedia.org/wiki/Systems_engineering).

Two long-term team members are particularly sensitive to the impact of hospital systems' push through model of healthcare. They voice distain for traditional healthcare providers who, they speculate, lack compassion and empathy for clients with complex recovery challenges. Physicians oriented by the traditional paradigm of reductionist thinking do not embrace the

opportunity to engage in complex thinking. Objects (i.e. illnesses) that cannot be seen or understood or “fixed” (Participants 1, 9 and 13) using the medical gaze cannot be cured using traditional means. Rather than addressing knowledge gaps, some providers project feelings of professional inadequacy onto the patient. Clients and families can be left alone to understand the implications of their diagnosed or undiagnosed illness and figure out how to manage complex health issues in the context of their everyday life circumstances:

I think that by the time the patient gets to the clinic, about one in four feel like they have felt dumped and dumped and dumped. And for a lot of them it's ones that have a lot of different issues like pain issues and a little bit of psychiatric but they probably have a brain injury too. So these people get referred to rehab or counselling or to a physician, but nobody wants to deal with them because they can't really show a lot of insight when they don't have good functioning brains.

And there are doctors who will give us some kooks, you know? Psychiatric patients that I think they just want off their plates, you know? Somebody passes them along. And I very much feel that some of the specialists who do refer patient here give us their kind of trash bin cases that they say, “I don't know, it's not, nothing is showing up on a brain scan, and I don't know and so go to the clinic.” I mean, I don't really know. Maybe they really don't.

(Participants 9 and 13)

Some community-based providers may purposefully amplify the voices of clients and families to explore factors impacting health and well-being in the context of their uniquely situated context. They may have no other choice when physically confined within the walls of the institution. However, brain injured clients may not have the cognitive capacity to provide a sufficiently detailed health or healthcare history. They may not remember or understand what treatments were done ‘to’ them in the hospitals or their own homes let alone the clinical rationale driving therapeutic interventions.

Understandings may be further constrained by clients' and family members' limited understandings of how financial, social or environmental factors are pulling them **all** towards illness. Their gaze may not see or understand the complex interplay between the multiple multi-level factors impacting health and recovery within their own meta-system. When healthcare providers are trapped in the clinical context, any hopes of developing clearer big picture understandings about the client's world out there may be nothing more than wishful thinking.

The traditional discourse of community-based client-, person- or family-centered health promotion and illness prevention similarly orients traditional and transdisciplinary providers to practices aimed at strengthening self-care capacity, increasing knowledge and skills, creating awareness about risk factors or motivating and supporting behavioural change. However, the traditional community-based health promotion gaze starts with the client and looks outward but still sees the disease/diseased from a distant detached power position above. Patients or clients are seen as unique and uniquely situated but treatments are embedded in theory, convention and the discourse of medical best practice. Traditional community-based healthcare services and healthcare providers are physically "*embedded in [the client's] community*" (Participant 12) but their gaze, practices and providers are still clinically-based. Perhaps health systems and community-based providers simply can't seem to get to "*a different level*" (Participant 5) level because, like their acute care counterparts, they are always looking down.

The transdisciplinary gaze does start with the client and looks outward. However, transdisciplinary practice is not embedded in superficial or incomplete understandings of a life in stasis. The transdisciplinary gaze has to be informed by the gaze, knowledge and practice of everyone involved in the client's healthcare journey. Close relationships and collaborative partnerships with providers, clients and family members are essential. The team needs to develop the most comprehensive perspective possible before beginning to design therapeutic interventions.

Client-centered context-specific practices are designed to simultaneously influence the client's meta-system on multiple levels over time. "*Some of these situations are such that we are beginning the planting of seeds because, for some things, it takes months, and months, and months*" (Participant 6). Therapeutic interventions are designed to take root, grow and evolve in

the client's meta-system as the client (re)orients towards health, well-being, independence and reintegration into life. Transdisciplinary practice itself is always already context **embedded** (i.e. home, work and community).

The transdisciplinary team uses community-based resources in the client's home community whenever possible. They help clients become acquainted with the staff and facility to ease their transition to independence after program graduation. Participant 5 once again refers to the notion that patient empowerment involves a process of re-socialization into the community. Team members help clients and families become familiar with the physical layout of the facility and, in some cases, help them to build trusting relationships with community-based providers who can help them along the remainder of their recovery journey:

We have, of course, great resources so we tap into those and from several angles. We try to help people connect as soon as possible whether it is a swimming pool which is why we don't have a pool on-site for PT. So essentially we can go meet them at that community center; we can do the therapy there, they are used to the dressing rooms, they know the entrance, they can take the city transportation. We go off-site to connect them in the community. So we help people hook into community programs and services that are already there existing. We might right away say, "You know, we could spend a lot of time here immediately on gait. We can do some, and addition you can go Tuesday and Thursday mornings to the University an hour and a half and you can get one-on-one gait work with music therapy." It's phenomenal and all those are all free services. But that requires them in their role to be very engaged in getting that in place. (Participant 5)

The difference between contextually relevant and context embedded practice is challenging to articulate. Metaphorically, it's a bit like archery. Traditional healthcare providers may design targeted interventions to influence some aspect of the client's health or health circumstances. However, multiple attempts may continue to miss the mark since they are

shooting blindfolded from the confines of their office. The transdisciplinary gaze and therapies are not constrained by institutional boundaries. They are free to explore the client's meta-system up-close and personal.

Team members may not need to physically enter into the client's real-world environment if the client's needs are not terribly complex. The gaze can remain well-informed and therapies taken up by client's and family members in their real-life context because the team has ongoing detailed feedback. Clients and families are often able to understand, interpret and relay information about individual, system and subsystem effects of therapeutic interventions. However, if the situation is particularly complex or interventions are perpetually ineffective, one or more team members will visit the client's home or work environment.

Transdisciplinary subject-object understandings and context-embedded interventions are co-created and co-evolve with team members, clients, family members, teachers or employers depending on the physical context and the client's context-specific needs. Therapies are also adaptable. They can be modified to harmonize with any number of contexts or new therapies developed to suit distinctly different environments.

Context-embedded practices are possible because the transdisciplinary team has the capability to translocate their gaze and practice from the Clinic into the client's real world environment. This can be an essential component of therapy for some clients to successfully re-establish their lives and evolve a new sense of self but requires active involvement of the people who will be living or working with the client during and after the reintegration period:

We've come up with some really great ideas for functional tasks that clients can do that are meaningful for clients. It's like a project and each therapy has its own part in the project. We're in such close contact with each other, meaning PT and OT and counselling and speech, that when we're looking at somebody going back to their job or going back to school, OT will assess the needs at the worksite and another therapist will become more in tune with what they need.

So we look at the skills and the things that they need for the worksite. OT will communicate with the boss or the supervisor and then we look at certain skills. If somebody needs to do a lot of multi-tasking, OT and speech might set up a certain scenario where they might be sitting at the desk working on something. We'll give them a worksheet, we'll call them on the phone or we'll interrupt, you know? So we'll set up some parallel situations that they might come in contact with.

And if the client has a really unique job, we'll do a phone conference with the counselor and OT and speech as well as the patient and his or her boss. And then the boss will give a mock situation for a customer situation that was going to be coming in. So our patient had to talk about how they would handle this in initial interview. So we try to really make it realistic in this regard.

And sometimes what we give them doesn't work. A client might say "No, what I really need is how do I take all this information from people?" So then we bring in some different things like graphs and organizers. And then the client will go, "No, no. That's not what I need at all." So in one situation it all boiled down to that it was more auditorially getting the information. It wasn't about written language at all. It was more about how could they take on all this information. So it was really interesting, you know? It's a good example of trying to meet their needs and listening and having the client be the CEO of their therapy team. (Participant 7)

The transdisciplinary team's communication network provides clients an added advantage because clients, family and team members co-create and re-create multiple T-Zones throughout the day. They're an ensemble cast rotating in and out of discussions depending on

whose knowledge and expertise are needed. The extent to which knowledge is shared and new knowledge co-created amongst transdisciplinary team members allows translocated therapists to simultaneously translocate the gaze and practice of the entire team. It's more involved than just *"pick[ing] up the phone and talk[ing] to each other if we need to"* (Participant 12). *"I feel so part of the team. I don't feel alone at all and when I am working with a client. I feel like I am working with a team all the time"* (Participant 3).

Embodied knowledge.

Transdisciplinary team members spend so much time working with clients and family members in their real-world environments, co-creating T-zones and brainstorming in 'the between' they develop remarkable in-depth understandings of cross-disciplinary knowledge and practices. Team members take the time to translate formal discipline-specific discourses into causal everyday language so that everyone understands. They dialogue with each other, clients and family members until everyone at the table is *"on the same page"* (Participant 13).

Long-term employee retention, close interpersonal relationships, team socialization practices and the complex needs of the client population are some of the reasons why the team and team members have exceeded the founders' vision for an organization where everyone is on the same page. The Clinic is a perpetual learning environment where team members have unfettered access to cross-disciplinary knowledge and opportunities for new knowledge generation.

Two participants portray learning, knowledge uptake and application to therapy and co-treatments as a) a physical feeling of internal growth and evolution and b) the felt embodiment of other. Knowledge co-created in the context of ethical and intimate professional relationships is more than just knowledge of other or the complete understanding of other's knowledge. For one team member it feels as though she is knowing seeing other. Embodiment of other requires team members to develop the capacity to disembody. They must purposefully disengage and distance themselves from their own disciplinary stance to see and appreciate the viewpoint of one or more alternative disciplinary perspectives:

I think at a philosophical level there is an understanding of what each other does per discipline. It is. And not just by words. It is

knowing that if I've done a shared session with another discipline I know exactly what they are looking for, what they are thinking, where they are coming from. So there is that philosophical understanding and sharing of our information across our therapy specialties. That gives me a perspective on the client that I, you wouldn't have in a traditional practice.

So it helps us, they help round us out and think about ways you know to work with this person in the real life, you know, and these stickler problems that they have and how to get around that. So I've tried to learn from the people that were therapists who are working outside of my realm to try and figure out what was going on with the client. (Participants 3, 5, 7 and 13)

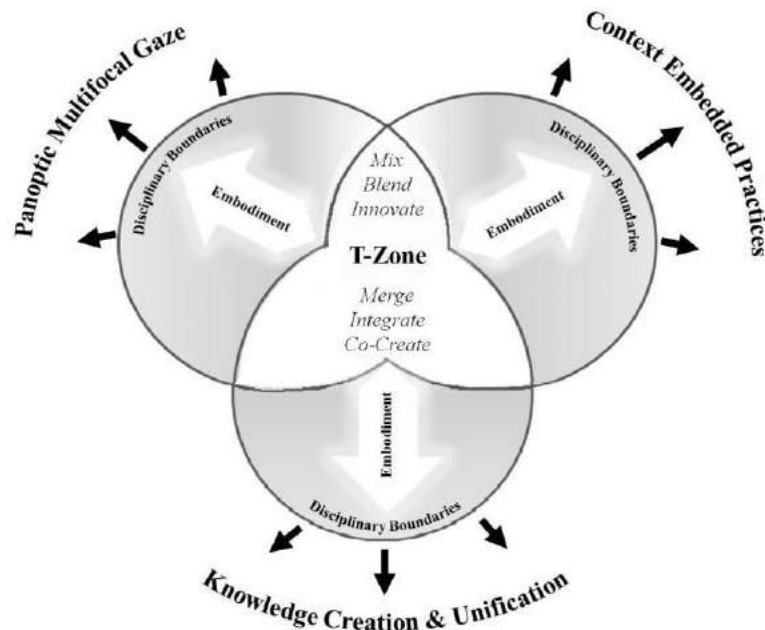


FIGURE 8.2. TRANSDISCIPLINARY ‘THINKING’, ‘BEING’ AND ‘DOING’

Pushing disciplinary boundaries is not about practicing beyond the limits of one’s professional licensure. Every one of the disciplines has “*educational underpinnings*” (Participant 14) and practices that overlap with cross-disciplinary colleagues to varying degrees.

The transdisciplinary team's integrated transdisciplinary practice models allows them to continuously expand the knowledge, practice and gaze of the collective (see Figure 8.2).

Conversely, the discourse and practice of traditional medicine has the power to shrink anyone's disciplinary practice repertoire down to a size that best serves and sustains the institution's economy of scale. The transdisciplinary team can exploit the disciplinary knowledge/practice overlap by making visible the actual breadth and scope of each discipline's knowledge and practice:

When I first started here I didn't know anything about what the other team members did. I had to read about what occupational therapists did and what speech language did. I had no idea. And part of my training was that I had to sit in on sessions and I went..., "I had no idea that's what you did," you know? So when a new staff member comes some people will meet with them and say, you know, "This is my role. This is what goes on," and give them some parameters on how to contact them, or use them and what we can do as a team. We explain the different aspects of our discipline and all those other sorts of things, like what I hope I can do to be an advantage. And I'll also say, "Hey, we've got this piece going on here and I want to make sure that you're aware of these things" (Participants 6 and 9)

T-zones and collaborative therapy practices help illuminate the spaces between the disciplines created by the traditional knowledge/power hierarchy. The team illuminates, bridges and oftentimes obliterates knowledge/practice gaps created by fragmentation and specialization in medical institutions. They help each other comprehend, appreciate and take up cross-disciplinary theories and frameworks and mentor colleagues so they can integrate new knowledge into their own therapeutic practices. *"Crossing over of the skill sets... embeds [cross-disciplinary knowledge] more"* (Participant 11).

The embodiment of cross-disciplinary knowledge is a resource for organizational efficiency and therapeutic efficacy. Healthcare providers with the expertise willing to step away

from disciplinary paradigms and open up to new ways of seeing, thinking and doing healthcare “*can do a little magic*” (Participant 6). Transdisciplinary team members push their self- and institutionally-imposed disciplinary boundaries because it is in the best interests of the client. Even “*some of the disciplines [and team members that]...tend to be more clinical and non-outside-the-box thinkers*” (Participant 7) are willing to get out of their box because it’s “*kind of fun*” (Participant 8).

Customized evidence-based practices.

The discourse of transdisciplinary therapy does not characterize practice using terms such as “*standard practice*,” “*standard package*,” (Participant 9) “*standardized plan*” (Focus Group 3002) or “*standard[ized] approach*” (Participants 6 and 9). They do not have a “*cookie cutter approach*” (Participant 12) to much of anything! “*From early on we couldn’t just say, ‘Have him come in here and just do this little rote things every time.’ It has to be related to be related to the world*” (Participant 7). Standardization’ is a term only used by participants to legitimize medical treatments and unique customized context-embedded transdisciplinary therapies. Team members do not go off willy-nilly and design treatments without scientific basis. They do not put clients in harm’s way. The traditional discourse of medicine orients transdisciplinary physicians and therapists to gold-standard, evidence-based practices.

Therapists portray themselves and their work as liberated and the organizational structures and leadership practices as liberating. Therapists and context-embedded practices are oriented to and by discourses of humanism, holism, evidence-based practice, client-centeredness, creativity and innovation:

The work that we do here is very unusual in that the work isn’t just cut and dry, you know? Like the particular injury or the particular illness where there is a cookie cutter solution to it. Occasionally somebody will come in and they just have a bad foot or something and they really, that’s really all they need and all they want is a little physical therapy to take care of it. But I think in general, it is bigger than that. It is more about treating the whole patient and treating them as human beings.

We do have to adhere to standards, keep abreast of the literature and we do have to follow best practice guidelines and research. Every therapist has a standard protocol, standardized care plans related to the diagnostic component. In the end, I think that the challenge of rehab is really continuing to look at how to do things better. How to make the changes. How to stay focused? How to still use the basics. (Participants 6, 7 and 12)

Transdisciplinary therapists ‘zoom in’ to treat the pieces and parts to optimize physical functioning but ‘zoom out’ to see if and how therapies will impact client’s capacity to meet recovery challenges. Context-embedded practices require transdisciplinary practitioners to be more flexible and creative in their approach. They are still bound by the same time constraints as their traditional counterparts. However, the team has become so extremely efficient that they have the time to customize meaningful and contextually relevant interventions. Therapies and long- and short-term client goals and treatment plans are tailor made to fit each client’s unique health and health circumstances. They are modified as needed to meet evolving real-world needs:

It’s just that everybody’s different so we bend the goals and objectives to meet the client’s needs. So I feel like all of the therapists will very much modify that for the person more than I’ve seen anywhere. They really work with them. Not one person has the same situation or problems they are bringing. One stroke is not the same as all other strokes. There are so many other dynamics certainly in areas like therapy and counselling and there is always the ability to try to customize what you are doing with clients. So, our work] is more about treating the whole patient and treating them as human beings. (Participants 6, 7 and 8)

Hands-on skills-based practices are like reading, writing and arithmetic. Psychomotor skills are the fundamental aspects of clinical practice learned in the educational academy and modified only when called to do so by new evidence. “*Getting back to basics*” (Participant 6),

positions physical therapies and medical treatment as the easy part. Figuring out which theoretical approach(es) will help each client and/or family progress through recovery is more challenging but also the more exciting aspect of their work.

Participants 6 and 7 reflect on how cross-disciplinary theories and theoretical frameworks provide some guidance for therapeutic interventions. However, they are not only limited breadth and scope they are disconnected from each other and do not take into consideration the client's role in therapy. Team members work together in the disconnect between theoretical models to tailor an approach that aligns with the client's needs and wants:

There are lot of theoretical theories that use the team aspect, like reflecting teams. So I think this kind of practice fits well with drawing on theories like marriage and family therapy, systems theory and even coaching theory if you're a counselor. But things that aren't exactly like this or that particular situation, so there is also a lot of making it up as you go along.

And I also think that the client's personality piece, how they got there and the diagnostic component, both of those avenues are important. The percentage would really be up to the therapist and how they felt that needed to move forward as well as the client ... [and] the family members depending on how involved they are or not. (Participants 6 and 7)

Transdisciplinary interventions and a unified team approach is developed by deconstructing the bits and pieces of established theoretical frameworks and reconstituting them into a client-, family-, context-specific and context embedded approach. Coaching practices may feel like incessant nagging for some clients; a demotivating turn-off. The team needs to keep the client's switch fully engaged in the on position. The “*reflecting team*” (Participant 7) doesn't jump to label client's as bad, difficult or non-compliant if the client isn't changing their behaviour(s) or doing assigned homework exercises between appointments. Providers reflect on the myriad of reasons why their approach failed, pull out their theoretical bag of tricks and try something else. Clients may lose ground and head back down the pathway to illness if they do

not work on therapy exercises in the real-world setting. Some clients have to learn, practice and adopt the customized life-skills designed to help them (re)create a life filled with purpose and meaning, “*You need to get your homework done,*” (Participant 7).

Context-embedded therapy homework.

Homework designed to help clients reintegrate into their real world involves a little more than just strengthening exercises. Traditional therapists “*give you a Thera-Band and teach you how to tie it to the door knob and teach you how to do exercises that you never do, or do them twice, because you hate it. They’re horrible. They’re boring.*” Participant 12 speaks from personal experience. If therapy exercises or tools to rebuild life-skills are not culturally and relevant, practical meaningful and fun, clients are less likely to do their homework and family less likely support them. *There are real life problems and real life situations that they are dealing with and learning from, kind of simultaneously that they are doing in therapy*” (Participant 1).

Therapists have to be creative and clients and family members have to be intimately involved in the (re)design process. Some homework is quite ingenious and designed to get the entire team involved in the process. In this example, the therapist created a notebook for a client and her husband to keep track of her schedule and jot down the daily sequence of events. The notebook served as a tool to help her exercise her memory. It was also a diary for her to reflect on memories created with her family but soon forgotten in the aftermath of her stroke:

I have a client who has some pretty significant memory and attention issues and she’s in her 70s and she needs to use a memory book as a tool. She needs a calendar, she needs her daily agenda written down, and she needs to refer to that. She can’t just go through life not knowing what’s coming up next. And so I made up this memory notebook for her and sent it home and I gave both she and her husband specific instructions. “I need this to come back to therapy every time because I’ll be adding more information.” And also there’s room for OT and PT to put their

information in as well if they have some worksheets or guidelines or suggestions.

And then, I will bring, at the end of our therapy session, I will bring him in and show him, “Okay, here’s what she’s doing today. Now you guys are going to go eat, go out to eat for lunch, right? And so where are you going to eat?” And if he knows, I’ll write that in...so it’s whatever, Applebee’s or sometimes..So I said, “Well, let’s write that in. Drive home.” So it seems really obvious, but I said we have to put that in. She needs this structure. So it really does take training the family for that, for that tool that she needs to use. (Participant 7)

Group therapy is another approach that involves fully engaged participants and homework. Therapists do not assume the traditional teacher/student power position. They do not give canned lectures, hand out generalized information brochures or provide instructions on how to progress through the stages of change on their own. Transdisciplinary therapists do not provide clients with the usual recipe for failure. Serendipity often leads therapists to discover several clients are simultaneously struggling with the same complex challenges. They dialogue with co-workers to find individuals facing the same hurdle and then develop and co-facilitate customized working groups. Is this the spontaneous eruption of new and unique therapy groups approach? *“That’s exactly what happens”* (Participant 5).

However, this type of group therapy is by no means a walk in the park compared to the traditional didactic approach. Groups at the clinic are designed to help participants bolster their own capacity to understand and manage their own life challenges and to build strength, resiliency, hope and commitment to their recovery and their future well-being:

We have been so good and so creative in our out of the box thinking, that we have been able to develop groups for small amounts of people. Literally sometimes three people, that’s our rule. Three people can be a group, plus the staff. And it can be anything from an OT and a counselor having a group with women

on women's assertiveness issues and how after chronic illness or injury, how you pull back into that in your life.

And we have had OT and PT working together on sort of a 'commit-to-be fit' process. So people 6 to 8 people will get together in a group and share across types of diseases or injuries in terms of what makes it work for them. And they look at nutrition, look at time management, stress management, look at abilities, and set your goals and decide what it is you want to accomplish in the week and holding each other accountable so that the therapists are there to facilitate and guide and structure and provide resources as we need to.

It's a working group. And this is not an insight-based psychotherapy setting. They have homework and they have agendas. This is a doing and reflecting. "Let me tell you what works for me," so they are supportive of each other and some accountability. So everyone is sharing, "This is what I would like to accomplish. (Participant 5)

Clients and family members have access to support groups and therapy groups after they graduate or, using traditional terms, discharged from the program. Some clients struggle to find meaning in their lives and need the support of client peers to move forward. Some come upon unanticipated boulders along their recovery journey, reach out to the Clinic and join therapy sessions that best suit their needs:

Rehab is an ongoing effort for these folks, no matter the event or the type of diagnosis that they have. It goes on throughout the rest of their life. We don't just put people out the door. [Like]..in the hospital. (Participants 6 and 8)

Summary

Transdisciplinary team members are expert clinicians. Clinical mastery allows them to develop and foreground therapeutic relationships and practices to a greater extent that is possible

in the biomedical model. Therapists bring their kind, caring and compassionate human selves to the clinical encounter. Participant narratives demonstrate how therapeutic relationships are aligned with the organizational ethos of humanism. Clients and family members are treated with respect and dignity. They are equal persons in need of help to (re)orient towards health and health practices to live a rich and meaningful life.

Team members aim to enhance the capacity of clients to be as independent as possible. Power is gradually transferred to clients so they do not become overwhelmed, frustrated or demotivated. Empowerment practices are intended to reduce reliance on healthcare providers and family members as much as possible. Clients are provided with a tangible recovery framework (i.e. homework exercises and community-resources) and deploy practices that motivate clients to continue moving forward in their recovery. Unlike the traditional model, close relationships and the ability to translocate practice and the cheerleader into the client's real-world environment facilitates the (co)evolution of therapeutic strategies. They bring the spunk and energy needed to propel clients towards health and build their capacity, energy and motivation to propel themselves.

The degree to which clients can or choose to take up the role of “*CEO*” (Participant 7; Focus Group 3002) and take control of factors impacting their health and well-being varies from client to client. Some clients are too physically impaired and will continue to rely heavily on support persons to help meet their day-to-day needs. Other clients resist participating as fully engaged members of the healthcare team. They are oriented by the discourse of medicine to the role of passive patient selves. They subjugate themselves to the (healing) power of healthcare providers because they want to be fixed rather than become equal partners in the fixing. There are times when transdisciplinary teams have little choice but to align themselves with the discourse and practices of medicine and ‘do to’ instead of actively ‘doing with’.

Some clients have become so accustomed to an acute care approach they do not see patient-as-partner as a legitimate practice model. This is partly due to difficulty explaining the validity of the transdisciplinary approach. The causal discourse of transdisciplinary therapy cannot compete with the power and respect afforded the formal discourse of science and the

power of the medical institution to sustain its position at the top of the knowledge/power hierarchy.

Transdisciplinary team members and their approach to neurorehabilitation are not portrayed as better than a medical approach or traditional healthcare providers. Community-based providers are almost as handicapped as their hospital-based counterparts. Their gaze may not be constrained to the biomedical domain but they cannot fully see or understand the context of the client's complex multi-level, multi-faceted meta-system. The discourse of client- and family-centered care targets client specific and contextually relevant therapies. However, practices are confined to the clinical context and traditional providers may be blind to their actual relevancy and effectiveness.

Clients may not comply with provider-prescribed behavioural change interventions if they are not practical, meaningful and enjoyable. The discourse of context embedded practice orients transdisciplinary therapists to practices that are. Therapists explore and exploit aspects of the client's home environment, family dynamics and support systems that promote and sustain an orientation to health and well-being. They enter into the client's personal and real world to help tweak or (re)design strategies that fit better with the client's personality, personal interests, culture or social environment.

The translocated integrative transdisciplinary gaze and practice is informed by the knowledge and gaze of all the disciplines even when team members are working one-on-one. Team members develop such a profound understanding of their cross-disciplinary colleagues' knowledge and practice that they can detach from their own disciplinary lens, see and understand from the perspective of other. The transdisciplinary gaze is panoptic, multifocal and multi-disciplinary.

It was difficult and, sometimes impossible to identify which team members is or an OT, a PT or a speech therapist during team meetings and focus groups. During co-treatments is it hard to discern where OT practice end and PT begins. Therapists often work together in the fuzzy space where disciplinary knowledge and practice overlap. Individual therapists have learned practices within their disciplinary scope that have remained under-developed in the biomedical model. Physiotherapists deploy strategies that might traditionally belong to family therapists or

social workers. Disciplinary boundaries can “*loose[n up]*” (Participant 4) and teams become more efficient if providers can see and exploit the overlap.

I often wonder how the healthcare system, professional practices and interpersonal relationships might evolve if everyone in our healthcare community liberated themselves from the need to define self as discipline ‘X’? What would happen if we stopped judging ourselves and our discipline as superior or inferior to others? What are the possibilities if we resist the biomedical discourse when it calls on us to claim exclusive rights and ownership over practice that really belong to all the disciplines? What would you lose and what would be the collective gain if we transcend the boundaries, expand the overlap and shrink the space in between?

Chapter 9

The Emerging Discourse of the Transdisciplinary Physician

Physicians are the only multiple disciplinary team members with power to legitimize the knowledge and practices of all other disciplines. This is not the case at the Clinic. Participants use the de facto transdisciplinary governance repertoire to explain how a model of disciplinary equality operates in a system typically designed to sustain a power imbalance.

Some transdisciplinary physicians play an administrative role in the regionalization processes for the local health authority. While in the traditional system, the biomedical discourse fully re-orientes transdisciplinary doctors to practices that impose the biomedical approach on community-based neurorehabilitation. Regionalization by assimilation reveals how transdisciplinary philosophy and practices disappear from view when physicians assume traditional leadership roles.

Interpretative Repertoires

De facto transdisciplinary governance.

Physicians hold de jure power and authority in the medical system. Their power is earned and taken up through conventional means and is viewed by society as the only legitimate power in healthcare. Traditionally, doctors hold decision-making power and give direct allied healthcare providers. I'm fairly certain most healthcare providers would not expect a physician to proclaim, *"You really want the therapists to be making the decisions, right"* (Participant 15). This statement is an example of the disharmony between the traditional disciplinary hierarchy and a transdisciplinary governance structure. Shared disciplinary power and a collective gaze is not compatible with the traditional medical paradigm.

Transdisciplinary physicians and therapists both portray the traditional system of physician power over as an obligatory nuisance in their community-based neurorehabilitation setting. Over-burdened under-resourced referring and transdisciplinary team doctors do not have time to develop complete understandings of the team's reintegration therapy and practices. *"You've got the layers and the layers and the layers of [administrators] in most healthcare systems"* (Participant 6) that create system wide inefficiencies.

Medical knowledge does not ‘trump’ knowledge of any other discipline in the transdisciplinary paradigm. The discourse of transdisciplinary physician leadership resists the traditional knowledge/power hierarchy and (re)locates medical knowledge and practice to a position of equality. It’s important to note Participant 15 did not say, “*You really want the therapist to be making **some** of the decisions.*” This physician believes therapists should be making **all** the decisions. Transdisciplinary therapists hold power de facto.

Equalization of power helps the team circumvent the inefficiencies created by the traditional power hierarchy. Transdisciplinary and referring physicians do not delegate authority. Physicians abdicate absolute power de jour. It is common practice for physicians to confer final finite therapy decision-making to transdisciplinary therapist colleagues. The team has repeatedly demonstrated the effectiveness of therapist leadership in community-based neurorehabilitation. Over time, these physicians have developed an implicit trust in transdisciplinary therapists’ clinical expertise and decision-making capacity:

We have kind of earned their respect over time because of our reputation, because of our work on and off with the key, certainly the neurologists, most of the internists, a lot of the PCPs, the neurosurgeons. They know that when they send somebody here, they’re going to get everything they need and they support it. They will support it with orders that we request. (Participant 5)

Transdisciplinary physicians must relinquish all rights to administrative power and control afforded them by virtue of their disciplinary affiliation if they wish to continue working at the Clinic. If a physician’s practices remain rigidly aligned with the discourse of traditional physician leadership, the team revolts and the physician is sent packing:

*So when you bring new physicians into the clinic there may be some power struggles. We have had a couple of docs that we **just** couldn’t work with. They wanted to run everything. I think that we’re all, most of us, are of the personal opinion that we are lucky we don’t have doctors like in the traditional model. When [the*

doctors] are talking with us, they are...just on a different level

(Participants 5, 8 and 13)

Transdisciplinary physicians are embraced because “*they are the type of doctors whose style isn’t related to their title. It’s just their style*” (Participant 6). They do not portray themselves not are they portrayed by teammates as others even though they work on a very part-time basis. The doctor’s role is integrated into a system propelled by interpersonal synergies. The discourse of transdisciplinary team membership calls on physicians to connect and interact with cross-disciplinary colleagues as persons. They are not portrayed as friends. They are more like a part of the team’s extended fami-we.

Abdication and equalization of power, personality fit and alignment with the discourse of transdisciplinary team membership allows physicians to play a much more vital and powerful role. They act as consultants and peer-to-peer mentors because they are persons with the capacity to transcend the traditional physician-therapist power divide. They inform and enhance the transdisciplinary gaze and cross-disciplinary understandings because they are willing and eager to enter into ‘the between’. Transdisciplinary physician leadership is leadership from below. They stand united and share power equally with the collective:

The doctors amaze me at how willing they are to just sit and brainstorm and talk about, you know? If I come in and say, “Gosh I’m struggling with this client.” And maybe it’s something that really takes some talking through and figuring out and I need to know, “Okay, how much of this is psychological versus physical?” Or “Does this medication make a difference on what’s going on with this, that.” Or the therapists may be treating this element over here but this person has a bipolar disorder underlying or maybe overlying everything that is going on. So when I need an opinion they are so willing to be a part of that conversation and that kind of thing. (Participants 3, 5 and 6)

The Clinic’s governance model and lack of traditional physician oversight creates a feeling of liberation. Therapists have more flexibility to modify evidence-based practices and

feel a greater sense of autonomy but not in the traditional sense. Practice autonomy and clinical decision-making are not contained within a circumscribed disciplinary knowledge-base or clinical practice setting. Therapies do not follow clients along medicine's linear admission, treatment and discharge trajectory. Transdisciplinary therapists are free to accompany clients through the twists and turns of their recovery journey and customize context-embedded practices along the way:

We don't do as much diagnosis at the clinic so the direction, I think, is a little different. And because physicians are not here all the time they don't really change how we function in the therapy treatment process.

I think staff just kind of carries on which I think that adds to the independence that we have, you know? The pattern of work is different and in some ways there is more freedom because the staff is able to just carry on without having to go up through that additional layer, that overlay of having a physician here all the time. I don't know if freedom is the right word. Maybe it's more around flexibility. (Participant 6)

Regionalization by assimilation.

The leadership team worries about the future. There is a very real possibility the Clinic will be bought out by the hospital system when all of the business partners retire. Regionalization practices impose global policies, practices and governance models that force community-based organizations to comply with the system's biomedical approach. They have concerns that the transdisciplinary approach and organizational ethos will be lost in the transition.

I think if the larger hospital system was seriously looking at integrating us in it we'd have to sit down and talk about whether or not we could make it work and still keep the integrity of the program. If we did ever go that direction we would have to hope that it's in a way that we can keep the integrity of what we do and

the structure of what we do and make it work within their system. Thankfully that's not going to happen any time soon! (Participant 10)

One transdisciplinary physician participant holds a senior leadership position on the committee leading regionalization for neurology, neurosurgery and neurorehabilitation services. His narrative provides insights into the challenges facing smaller community-based facilities:

From a hospital systems perspective, I think there is a place for a transdisciplinary rehabilitation to stay philosophically intact if in a larger hospital system. You could easily bring in the same kind of concept that you have at the clinic and just bring them into the group and their part of the services. You do neuropsych evaluations and then appropriate to the treatment plan and you still bring in the other member of the team as long as things are done within the pod of the larger entity. The system has already done that with the stroke program and with trauma, for example. So I could even see the clinic become integrated into the system,from traumatic brain injury from the point of when they arrive on the trauma service to when they have they are released from the system in some way. If all of that is under one purview, then having one program that is effective at a certain stage in the process becomes useful. So I think they can be transdisciplinary integrated and it would solve some of the funding issues associated with smaller private clinics in the region. (Participant 15)

Participant 15 speaks from his traditional physician lead self when he explains the perks of regionalization for the Clinic. The hospital system would relieve the Clinic's financial challenges but at what cost? The team would no longer co-create and co-evolve client-centered context-embedded practices with clients and family members. Clients would return to their silent silenced stasis, assigned treatments by healthcare providers. The goals of therapy would not direct client and therapy practices towards family, work or community reintegration. Patients

would be set loose into the darkness to find their own way to unknown un-nameable ‘somewhere’ far beyond the medical gaze. Under one purview (i.e. one gaze), transdisciplinary therapists and clients would be back under the watchful eye and control of medicine.

The biomedical discourse can only describe and reproduce itself. The transdisciplinary physician cannot see any reflection of his transdisciplinary self or practices when he speaks the discourse of traditional medicine. It’s as though his transdisciplinary self suddenly vanished. Here one minute and gone the next at the flip of a discursive switch. There is no quazi-integrated transdisciplinary /traditional doctor/person self-constituted in the included middle. ‘Transdisciplinary blindness’ seem to be the only terms that come close to describing this most striking phenomenon.

Physicians’ roles and practices are portrayed as mutually exclusive because the discourses are so disparate they precluded the co-existence of both ways of ‘being’ and ‘doing’. Transdisciplinary physicians’ practices really **do** combine aspects of the tradition and transdisciplinary approaches but only in the transdisciplinary practice setting. Doctors cannot seem to see how they have intertwined two different practice models because they have no integrated traditional/transdisciplinary self who can speak two different languages at once.

Transdisciplinary physicians’ are fully aligned with the discourse of transdisciplinary team membership at the Clinic. They brainstorm, dialogue and discuss complex problems with allied healthcare providers. However, doctors engage in “*didactic discussions*” (Participant 15) in acute care setting. This terminology reorients physicians to a teacher-student relationship and elevates them right back into positions of power over therapist colleagues. The medical perspective informs the other disciplines but knowledge exchange is not multi-directional.

The discourse of transdisciplinary therapy is not deployed to describe physician practices at the Clinic. The discourse of fiscal constraint orients physicians to traditional disciplinary practices in the transdisciplinary setting. There are no financial resources to pay physicians for anything other than direct patient encounters. The Clinic is so financially stretched they cannot afford to pay physicians outside of the existing billing structure. The fee-for-service model deprives physicians the time needed to fully evolve an integrated traditional/transdisciplinary self and practice model. Their gaze is confined to the medical domain unless they are called on to

help understand and resolve complex medical issues preventing clients from moving forward in the recovery process. Time spent outside of the treatment room goes unpaid. The doctors see patients back-to-back and focus on “*physician-related....stuff*” (Participant 6) they have spare time to casually dialogue with team members or attend staff meetings.

Therapists deploy strategies similar to their hospital-based counterparts when there isn’t a physician on site. Physician knowledge and power is only accessible via telephone.

Unfortunately we’re not always able to have physicians here physically as often as we would want. I wish that we had more access. I wish we had a physician onsite just to have more information and knowledge at the ready. We get it now, but we have to wait sometimes. We have to wait until we have access. I mean if there’s a purely physician-related question then yeah, you get on the phone and you have them paged and you get those things taken care of. But we have to make sure we’re corralling our questions for when they are here. So we can get them on the phone and ask a question, but it is always very limited and just by phone. (Participants 5 and 6)

I asked Participant 15 one final question before the conclusion of our interview: “*If the clinic became part of the larger system, could a transdisciplinary program maintain its philosophy and practice as an oddball if all of the other outpatient facilities are about standardized care and oriented towards physical outcomes?*” He thought about it for several moments. “*That’s a good question.*” He hadn’t really thought about it that way before. He wasn’t sure who, if anyone, occupied a position in the organization who might be able to consider the implications and value-added of the Clinic’s very different way of doing business.

Summary

The discourse of the transdisciplinary physician orients doctors to relational practices aligned with the organizational ethos of equality, social harmony and personal safety. They enjoy opportunities to co-create T-zone and explore the unknown. They are included middle thinkers who take pleasure in helping teammates understand the intricacies and medical

complexities needed to evolve client-centered practices. Team members and physicians do not share the same level of professional intimacy. While they are well-liked and held in high esteem, the physicians are seen as peers and colleagues but not friends. Therapists portray physicians as having little time to participate as fully engaged members of the transdisciplinary team at either a professional or social level.

There are no financial resources to compensate physicians, or any other team member, for time spent discussing complex client circumstances and help the team to develop context-embedded practices. Time spent co-creating T-zone and exploring ‘the between’ is a donation to the greater good. Physicians are invited by team members to gaze upward and outward at the bigger picture and co-evolve innovative strategies and interventions. Physicians generally fade in and out as needed. When they step outside of the Clinic their transdisciplinary self disappears altogether.

Physicians blind to the philosophy, practices and organizational structures that sustain their own model of transdisciplinary practice cannot advocate on behalf of the Clinic. It seems to disappear when they turn away and speak the language of traditional physician leadership. The discourse of traditional physician leadership and regionalization is a discourse of assimilation. It is not their fault. Traditional training and established systems of power are like an earth magnet. Their language has the power to spin healthcare providers around and sustain an exclusionary gaze on itself.

An egalitarianism practice as a model would not likely be granted legitimacy by the medical community or taken up by hospital systems. The team is in a position to resist the traditional power hierarchy because the Clinic is a private business. Disciplinary equality is only possible because professional relationships and practices are located outside of the healthcare system proper. However, the team must still work within the broader systems of power that sustain the traditional institution of medicine. *“There will always be that layer, because they are our doctors and we know we have to work under the orders of the physicians”* (Participant 5). The institutions of medicine and healthcare education reinforce and reproduce the model of medical supremacy. The legal establishment holds physicians ultimately accountable for all

therapeutic interventions even though each healthcare provider is licensed and liable for their own disciplinary practices.

The purpose of this dissertation is not to delve into a theoretical discussion about the practicality or sustainability of the medical knowledge power hierarchy. However, the participants' narratives certainly raise some provocative questions. Why does this system of power and authority still exist if it creates inefficiencies in the system? Why are physicians held legally accountable for interventions designed and executed by expert clinician colleagues if they do not fully understand the rationale or legitimacy of their customized context embedded practices? Why? *"That's [just] the way the system works"* (Participant 15) and you can't fight the system.

Chapter 10

Summary of the Analytic Chapters

The purpose of this chapter is to summarize and discuss key findings related to the development of the Clinic as a transdisciplinary organization. I will begin with a discussion of the three essential ingredients for organizational efficiency: 1) transdisciplinary philosophy, 2) an organizational orientation to employee health and sense of coherence and 3) the moral high ground. This chapter also includes a salutogenic reading of the transdisciplinary team's therapeutic relationships and capacity building practice and a brief discussion of the relationship between study findings and previous publications in the transdisciplinary literature.

Transdisciplinarity, Sense of Coherence and the Moral High Ground: Resources for Organizational Efficiency

The Clinic is a fiscally under-resourced organization. The fee-for-service payment structure does not remunerate any team members for time spent in collaborative dialogue with each other or with outside agencies. However, the facility is able to grow and thrive because the founder and clinical director have developed the structures and sociocultural resources to maximize organizational efficacy.

The Clinic is an open complex adaptive system. It does not need to undergo massive physical expansion or human resource restructuring to create or evolve new healthcare services. Because the majority of staff are part-time, scheduling flexibility allows multiple programs and multiple providers to rotate through and throughout the organization as needed. The scheduling system allows the team to schedule and track multiple same-day patient appointments, overlap appointments to accommodate co-treatments and ensure optimal use of the physical space. The organization shape shifts over time to meet the evolving needs of the client and the community. The team structure and function shape shift daily to accommodate program scheduling and staffing requirements.

'Sameness' is not a business model compatible with an organization that aims to meet the unique and uniquely situated needs of each and every client. Standardization and assimilation practices that promote efficiency in regional hospital systems preclude the freedom and flexibility required for a transdisciplinary team to create, customize and evolve client-specific

context-embedded therapies and life strategies. Inflexible rules and policies would create and sustain inertia in this type of practice setting. Relinquishing disciplinary boundaries and exploiting the skills and knowledge overlap between team members throughout the organization has promoted organizational efficiencies and innovation. Sharing responsibility and ownership for the collective success rather than delineating roles and responsibilities seems to be another key way the Clinic is able to afford opportunities to extend their practices into client's homes and the community.

T-Zones, Complexity and Included-middle Thinking.

The transdisciplinary team uses every opportunity to engage other team members in discussion whether in formal meetings, via telephone, email, the clinical record or spontaneous hallway conversations. There is a continuous stream of dialogue within and between disciplines, leadership, support staff, clients and family members and outside healthcare providers and agencies. Ongoing chaotic communication patterns are a vital resource for organizational efficiency and complexity management. 'Checking in' and 'checking back' reduces the need for client-specific meetings unless an individual is not moving forward in their recovery. Formal staff meetings are more efficient and productive because providers are already well-informed and up-to-date. Team meetings are solution-focused brain-storming sessions rather than problem-oriented 'run downs' about physical status, treatment updates or discharge plans.

The complex communication network eliminates redundancies at the level of the individual provider encounter. Providers do not need to spend time eliciting a health or treatment history. This allows physicians and therapists more time to engage clients and families in therapeutic dialogue before, during and after therapies. Providers are free to explore the complex interplay of health determinants impacting health and recovery and the client's perceptions of their strengths and challenges. They have time to discuss the degree to which therapies and life strategies are being taken up in the client's real-world environment and consider other alternatives as needed.

Salutogenesis.

Salutogenic (i.e. health-oriented) organizations are mindful of the interdependencies between contextual and individual factors that promote individual and collective well-being

(Mayer, 2011). Employees with a healthy sense of coherence (SOC) view their work and work life as meaningful, predictable and manageable (Antonovsky, 1987). Team performance, organizational efficiency and interpersonal relationships are believed to be enhanced when managers, employees and the team have a strong SOC (Mayer, 2011).

It was not my intention to explore whether or not the Clinic is a salutogenic-oriented work environment. However, a salutogenic discourse emerges throughout participants' interviews and an orientation to employee and co-worker health and well-being was a key attribute noted during my field observations. Table 10.1 is a comprehensive but not exhaustive list of the organizational and personal resistance resources that help cultivate a healthy individual and collective sense of coherence at the Clinic. I plan to re-examine this study data using a salutogenic lens for a future publication.

The Moral High Ground

According to participants, the moral high ground is the most essential ingredient needed to optimize organizational efficiency and transdisciplinary practice. Participants do not deploy this repertoire to question the morality of all 'others'. Rather, the moral high ground repertoire signifies the importance team members place on the original founder and his vision for a new world grounded in and imbued with civility, peace and social harmony. Group membership is not about being any 'better than' the rest of the healthcare community.

The moral high ground represents moral agency rather than the traditional expectation of forced compliance. The team is highly efficient because each team member chooses not waste precious time engaged in negativity. Ethical selves do not need to be morally governed. The clinical director is free to carry on her beloved role as therapist because, as a whole, the organization runs itself. Her leadership practices are a unique blend of peer, equal, therapist and leader, in that order. The moral high ground is a 'protectorate' but only in the sense that the clinical director defends its borders from egocentricity and hostile takeover. Peace, equality and goodwill and employment longevity are key to transdisciplinarity.

There is a certain 'je ne sais quoi' about the organizational culture. The team has found a point of equilibrium that balances high frequency energy with unequivocal calm. It is difficult to describe but palpable the moment you walk in the door. It is a humbling experience to be in the

Table 10.1 A salutogenic discursive lens

SOC Component	Repertoire	Workplace GRRs	Personal GRRs
Comprehensible	Transdisciplinary ‘thinking’, ‘being’ and ‘doing’ is chaotic and challenging but my work is understandable	<ol style="list-style-type: none"> 1) T-Zones <ul style="list-style-type: none"> • Disciplinary equality • Knowledge unification/integration • Included middle thinking • Peer-to-peer teaching/mentoring • Complexity management 2) Peer expertise and longevity 3) Safe work environment 	<ol style="list-style-type: none"> 1) Educational and Experience 2) Persistence 3) Longevity
Manageable	Workplace challenges and stressors are kept in check because of the resources at my disposal	<ol style="list-style-type: none"> 1) Safe work environment 2) Overlapping roles/tasks 3) Reciprocal support (tasks) 4) Accountability 5) Social support/familiarity (colleagues) 6) Flexible work and work schedule 7) Transdisciplinary Leadership <ul style="list-style-type: none"> • Accessible and responsive • Competent, trustworthy & altruistic • Distributive power sharing • Fosters/nurtures, collaboration, cohesion and synergy • Protects moral high ground 	<ol style="list-style-type: none"> 1) Educational and Experience 2) Personal support systems 3) Healthy coping mechanisms 4) Outside work interests 5) Resiliency and hardiness 6) Self-confidence 7) Respect for diversity
Meaningful	My work and my workplace hold value and personal meaning. My work is important, rewarding, motivating and worthwhile.	<ol style="list-style-type: none"> 1) Personal and professional autonomy 2) Immediate positive & constructive feedback 3) Interpersonal relationships 4) Orientation to client’s ‘life success’ 5) Collectivism 	<ol style="list-style-type: none"> 1) Positivity and self-confidence 2) Compassion, humility & altruism 3) Personal choice & buy-in 4) Collectivism

presence of such compassionate and selfless human beings. They are healthcare providers who embrace and nurture their clients, families and each other. At its core, the moral high ground is more than just an organizational ethos. It is the established way of life at the Clinic.

A Salutogenic Interpretation of Transdisciplinary Capacity Building

The goals of the transdisciplinary team's client-provider relationships and capacity building practices are informed by transdisciplinary philosophy and salutogenesis. The team aims to enhance the ability of clients and family members to understand their strengths and health challenges in a way that is contextually relevant and meaningful. They work diligently to foster independence and health *"no matter what the complexity of the situation or the hazards of life"* (Nicolescu, 2002, pp.87). They assist clients and families to shape their life experiences and bolster their capacity to envision and shape their own futures (Antonovsky, 1979). These goals are accomplished by co-creating, co-evolving and supporting health and recovery resources that promote *"meaningful, manageable and coherent life experiences"* (pp.89).

Capacity building efforts are more likely to be successful in the long term if power and decision-making are gradually transitioned from therapist to client. Clients and family members are less likely to become overwhelmed if they been able to successfully draw from a stable but growing arsenal of internal (e.g. self-confidence) and external health-promoting resources (Antonovsky, 1979). Team members retain decision-making authority during the initial phase of therapy. Physicians and therapists act as mediators as clients begin to take control of their recovery. They sometime limit therapy choices to ensure client's and family members' efforts result in predictable and orderly outcomes. Power relationships transition from a shared to independent decision-making model as soon as the client's health and health-related circumstances allow. Success depends on the balance between the power offered and the client's readiness and willingness to take it up and take over. Capacity building, like recovery, is a process and a journey.

Transdisciplinary team members are, themselves, a valuable health resource for clients and families (Antonovsky, 1979). Synergistic relationships with multiple therapists helps to propel clients towards independence from family and the healthcare system. The combined efforts of the team, client and family members are directed towards maximizing the capacity of

client to take (back) control of their health, health circumstances and recovery challenges. Capacity building practices are enhanced through the “*dialogical creation of a new narrative and...the opening of opportunit[ies] for new agency*” (Anderson & Goolishian, 1992, pp. 28).

Providers continuously explore, interpret and discuss client, family member and their own perceptions and understandings during therapy interactions. Over time, close trusting therapeutic relationships help clients re-build their physical capacity, self-confidence and (re)define a new sense of self. The ‘science’ of medicine and therapy is back grounded to bring the ‘art’ of healing and the client and family narratives to the foreground (Nicolescu, 2012). Their panoptic social determinants of health perspective helps to illuminate the far recesses of the client’s complex multidimensional multilevel ‘multi-verse’ (Gergen, 2001). A multi-minded inclusive approach helps the team seek out and exploit otherwise hidden pearls of knowledge and opportunities for recovery and healing.

Capacity building practices are also amplified because the translocatable transdisciplinary gaze is more personal and more intimate. The gaze is not confined within the walls of the Clinic and power over the client’s health and recovery held “*within the providence of the [medical] institution*” (Antonovsky, 1979, pp. 53). Transdisciplinary physicians and therapists have, over time, evolved the ability to engage (i.e. embody) and disengage and disengage the multiple disciplinary perspectives of their team mates. This, in conjunction with access to a client’s inner and physical realms help the team develop therapies and life strategies that are socially, contextually and culturally relevant, practical and meaningful. Capacity building practices are as congruent with the client’s values, beliefs, culturally-based roles and relationships (Antonovsky, 1979) as they are innovative, fun and ‘do-able’.

A client’s ‘truth’ is beyond all of the disciplines (Nicolescu, 2012). The transdisciplinary team’s professional and therapeutic relationships enable the unification of disciplinary and client/family knowledge in a manner that closely aligns with the client’s own thoughts and life experiences. Deeply profound understandings evolve in the spaces between individual perspectives. When the team, client and family members fuse their individual perspectives they have the capacity to co-create and co-evolve a more inclusive (i.e. holistic) integrated appreciation for the client’s real-life circumstances.

Transdisciplinarity invites new levels of perception that enhances understandings by creating representations of subject-object interactions that, while still incomplete, are more broadly encompassing and unified (Nicolescu, 2012). Salutogenesis ensures therapeutic relationships and capacity building practices help clients attain and maintain an orientation towards health and well-being, sustain a healthy sense of coherence and follow an understandable, meaningful and manageable path towards independence, recovery (Antonovsky, 1979) and community re-integration. Together, these theoretical approaches help to illuminate the nuances integral to the enactment of transdisciplinary neurorehabilitation.

Discussion

It is difficult for me to summarize the transdisciplinary organization in a theoretically coherent way. This is beyond my scope of expertise and the aims of this dissertation. However, the organizational structure warrants further investigation and exploration with experts in the fields of business and organizational development. For now, I envision the transdisciplinary organization as a solar system with T-Zone circling a unified, unifying core. The gravitational source? The transdisciplinary team itself.

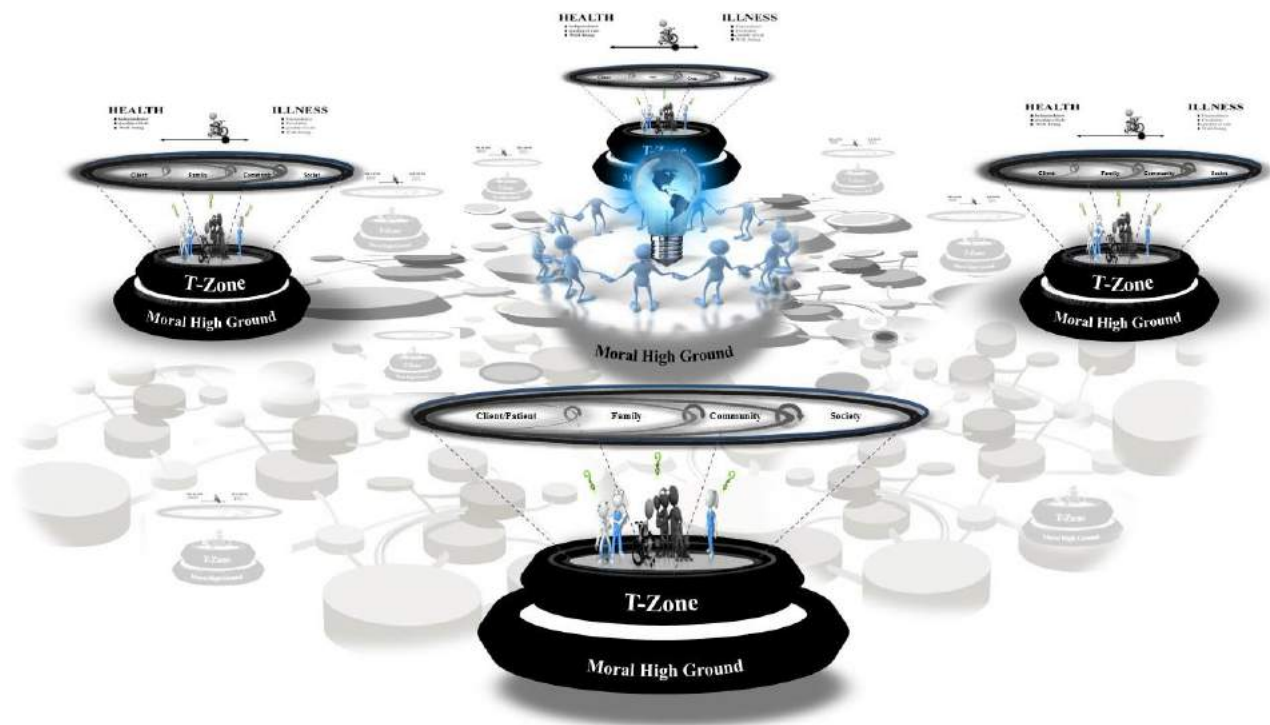


FIGURE 10.1 THE TRANSDISCIPLINARY ORGANIZATION AND TEAM PRACTICES

The literature review conducted by Stokols et al. (2008) did unearth factors that support transdisciplinarity in academic research teams and community coalitions. Their findings (see pp. S107-109) also bear a striking resemblance to the factors found to facilitate transdisciplinarity in this community-based clinical practice team. There are, however, some noteworthy exceptions.

The details of precisely what a shared organizational ethos entails, how it enacted and how it contributes to a healthy work environment, employee well-being and longevity were not described in the publications reviewed by Stokols et al.. This study, however, has uncovered some of those missing pieces. For example, team members actively engage in a process of critical reflexivity to evaluate their personal conformance to behavioral norms. The team leader reflects on her alignment with the moral high ground to ensure her actions contribute to the betterment of the collective as opposed to serving the needs of her own ego. Team members take ownership for behavioral missteps and make amends with their co-workers to avoid conflict. Fully empowered team members and close interpersonal relationships allow for gentle confrontation without conflict, resolution without outside mediation and forgiveness for transgressions. Since the team polices itself, the clinical director's role is focused on eliminating actual or potential threats (i.e. new team members).

As another example, team member willingness to all but dissolve the traditional disciplinary knowledge/power hierarchy and boundaries allows for more than just knowledge sharing. Over time, the continuous exchange of information has allowed cross-disciplinary knowledge exchange to enter into the realm of knowledge embodiment. Hardiness, resiliency, a passion for complex problem solving and dedication to serving the greater good appears to have magnified each team member's capacity to detach from their disciplinary perspective and bolstered their capacity to integrate cross-disciplinary knowledge into their own disciplinary and practice repertoire.

These are just some of the powerful insights needed to begin the process of deconstructing the context-specific team and organizational dynamics that may contribute to the success or failure of a chronic illness program. A one-size-fits all approach may or may not work in like-communities or patient groups because healthcare reform initiatives are evaluated using standardized measures (e.g. physical outcomes). The real answers to why a program

succeeds or fails might actually be found in the multitude of factors located in the linkages between the organizational, community and client/family meta-systems. How those complex dynamics might be defined or measured may provide a fruitful area for future research. This may also be an exciting vantage point from which to reorient the healthcare reform gaze.

Chapter 11

Conclusions

WHO's (1978) recommendations to adopt a broader determinants of health gaze has been taken up in the community-based healthcare sector. However, providers on the front line have little if any instructions to guide translation of population health recommendations into practical context-specific context-embedded interventions at the level of the individual and family. Under-resourced physician-led primary healthcare teams remain focused on risk management, physical illness and medical treatment (Wagner et al., 1996).

At the other end of the spectrum, population and community health teams target community level health challenges. These efforts are aimed at maximizing a specific community's health profile and increasing their capacity to effectively manage their own health and health challenges (WHO, 1978). Some community-based programs touted as the gold standard for healthcare reform have actually proved to be unsustainable over the longer term (Potvin et al., 2003; Paradis et al., 2005). Unfortunately, it may not be possible to fully understand why health-promoting practices have not been implemented systematically in the healthcare sector or how inefficiencies have persisted for over 30 years.

The traditional discourse of medicine, current practice models and theoretical frameworks limit the ways healthcare services are thought about, delivered (Mumby & Stohl, 1991) and 'transformed'. The discourse of healthcare reform orients the government, traditional healthcare providers, academics and health services researcher to a stable set of policies and conventions that determine what healthcare is and what it can evolve into. This is inherently problematic if recommendations for new chronic care service delivery models only reflect a revised version of acute care practices. Reshuffling existing health services and the chronic care model as more broadly engaged and collaborative may only serve to replicate the same system-wide inefficiencies (Harris et al., 2005; Health Council of Canada, 2007; Wagner et al., 1996; Grumbach & Bodenheimer, 2004). The Health Quality Council (2013) speculates healthcare reform failures are likely related to a high degree of variability between communities. Others hypothesize chronic illness programs fail to take into account local, contextual differences and contingencies at the program level (Greenhalgh, 2009).

When I began this thesis I believed the discourses of healthcare reform and medicine, together, can only sustain and reproduce the rigid historically situated model of change that drives healthcare reform. I now believe that ‘transformation’ of the healthcare system is possible. However, I think that it is imperative for providers, administrators and government officials to take a closer look at whether or not the natural way of doing the business of healthcare has somehow talked us out of doing things in a ‘radically’ different way. Perhaps the time has come to rethink how the discourses and tenants of primary healthcare and population health promotion are perpetuating morphostasis rather than change.

The Emerging Discourse of Community-based Transdisciplinary Neurorehabilitation

The discourse of community-based transdisciplinary neurorehabilitation is an alternative but still emerging discourse. Team members have struggled to articulate the core essence of their practices for over 30 years. It is social reality where taken-for-granted understandings have no words to speak, even when called on. Job descriptions do not detail a moral code of conduct and there are no capacity building playbooks. There is a world of tacit understandings that could only be understood through mentorship and socialization until now.

Like the discourse of medicine, the discourse of community-based transdisciplinary neurorehabilitation is a ‘big ‘D’ discourse (Gee, 2005). It is a discourse that constitutes a different version of the medical institution. It provides the team with a different set of values, beliefs and assumptions about who they are as persons and healthcare providers, who clients and families are in relation to them and how they should go about the business of healthcare. The discourse compels transdisciplinary team leaders and team members to act in ways that sustain their chosen version of reality. Their discursive practices are a powerful source of unification and synergy.

Team member participants universally agree it would not be possible to sustain their practice paradigm in the traditional world of healthcare. The discourse of medicine does not orient healthcare providers to practices that reduce the spaces between the disciplines, integrate and embody cross-disciplinary knowledge or evolve unique complex client-centered and context-

embedded practices. The collective power of the transdisciplinary team is able to sustain and reproduce a shared organizational ethos and shared practice conventions because they are not part of a hospital system governance structure. The discourse is powerful in the context of the clinic but does not yet have the power to challenge or change the face of healthcare.

The Transdisciplinary Discourse Community

The term ‘discourse community’ is used to describe a specified, bounded group who have particular, identifiable ways of using and interpreting language. In professional discourse communities (e.g. a healthcare team, a university department, subscribers to the Journal of Social Psychology), systems of values and beliefs are embedded in their everyday talk (Little, Jordens, & Sayers, 2003; Swales, 1987b) and played out in their social and professional practices. Over time, community members may develop particular ways of communicating and establish rules for the conduct and interpretation of speech. They use particular ways of speaking about their world to define disciplinary knowledge, practice and maintain of power relationships (Drew & Heritage, 1992; Fairclough, 1991; Fisher & Todd, 1986; Foucault, 1972).

However, Fairclough (2005) maintains that organizational effects (e.g., patient outcomes, team effectiveness) are neither linear nor simplistic. They are produced through a very complex interplay of communication, social/professional discourse and interaction, organizational structures, policy implementation and varying local circumstances (i.e., in multiple layers of a multidimensional reality). Members of a particular discourse community may also use and interpret language differently as the context of their interactions shifts (Pithouse & Atkinson, 1988; Rance, 2005). Therefore, the settings where discourse communities practice can offer a variety of different context-specific opportunities for interaction in which roles, processes, professional practice and acts of power and resistance are created and enacted (Goffman, 1959; Hydén, 1997; Pfeffer, 1981; Smircich, 1983).

Thomas Kent (1991) questions the functional utility and theoretical foundations of the concept of ‘discourse community’. If understanding and knowledge are merely relative to a particular discourse community, “*nothing exist[s] to authorize one set of practices or beliefs over another*” (pp. 42) and there is no possible way to know or understand the world outside of the community’s shared representations. Members of disparate discourse communities who do

not share similar perceptions, knowledge and understanding should not, theoretically, have the capacity to communicate or understand each other. To assert that discourse communities are not so significantly disparate that communication and understanding is still possible between them, renders the concept of 'discourse community' redundant (Kent, 1991).

Discursive psychologists argue it is not possible to empirically determine the existence of a discourse community. Once a discourse is circulated in the public domain and taken by the general population, the group boundaries they supposedly represent would become blurred (Edwards & Potter, 2002). For Potter and Wetherell (1987), discourse is not limited to particular social groups and they do not advocate their methodological approach as a way to delineate group boundaries. From their perspective, interpretative repertoires are more like a public catalogue of linguistic resources available to everyone regardless of group membership.

Regardless, it is my perspective that the transdisciplinary team studied for this project is a bounded discourse community. Over the past 30 years, the team has developed particular ways of communicating and established rules for the conduct and interpretation of speech (Hymes, 1972; Swales, 1987a; Little et al., 2003). Terms and discourses deployed by team member participants to construct themselves, their colleagues, work environment and their practices would not likely be understood by many in the medical community. Repertoires such as 'the included middle', 'zones of transdisciplinarity', 'leadership from below' and 'context-embedded practice' may seem nonsensical. Traditional healthcare providers may draw on similar word lexicons, but the way the transdisciplinary team cobbles the words and discourses together paints a vivid picture of a world decidedly different from the world of traditional medicine.

Research Methods

The orientation of a transdisciplinary team as a discourse community aligns this project with the social construction perspective in which social interactions, organizational practices, the use of language and social discourse create shared or divergent understandings of the transdisciplinary team, its team members, the clients and their health/healthcare practices. From this perspective, conversation (discourse) was a) the focus of inquiry into knowledge generation, meaning-making and practice and b) the means to understand transdisciplinary rehabilitation practice, situated within the context of a broader healthcare organization.

I did not choose to conduct a quantitative study for this project. This approach would require I objectify and study the Clinic as a ‘healthcare machine’ with fixed processes and circumscribed departmental and disciplinary boundaries (Kernick, 2002). None of the quantitative studies reviewed for this project provided a broader understanding of the underlying mechanisms through which complex, multi-factoral human recovery and transformation occurs or how practices were enacted. Even the qualitative studies from the chronic illness and mental health literature were not designed to uncover the processes through which a multiple disciplinary team helps clients to sustain an orientation toward health and move forward in their recovery journey. Instead, I used a cased study approach to study the organization as a complex self-eco-organizing meta-system (Morin, 2008) in which language and social practices are both composites and constitutive of the multi-level multidimensional whole. Bronfenbrenner’s Ecological Model (1977) provided an ideal framework to study each level of the complex, multi-level, multidimensional organization within its naturally occurring, socially and environmentally situated contexts.

Studying language and social practice at the Clinic using the analysis of interpretative repertoires within an ecological framework invited a dialogical approach to discourse analysis (Morin, 2008; Bakhtin, 2009). Comparing and contrasting discourses and discursive practices (i.e. language in use) within and between participants across all levels of the organization allowed me to evolve much more profound understandings. The construction of more enlightening and inclusive ‘meta-narratives’ helped me to capture the nuances of practice and allowed the alternative discourse of community-based transdisciplinary neurorehabilitation to emerge.

The most challenging aspect of my chosen approach was related to the emergent nature of the transdisciplinary discourse. This study has uncovered more repertoires than any other I have located in the literature. In their struggles to articulate a practice that almost defies description without using discourses of medicine (i.e. big ‘D’ and little ‘d’), participants provided highly complex, detailed and voluminous accounts. The sheer volume of data required a complex data tracking system which included electronic records and a copious amount of paper copies. The analytic process was both challenging and time consuming.

Irrespective of the challenges, a case study and blended analytical approach allowed me to uncover a nuanced description of the shared values, beliefs and theoretical perspectives of a transdisciplinary team and how they are enacted in the team's social and professional interactions and practices. I believe that replication of this study methodology using interpretative repertoire analysis may, over time, help to evolve a shorter, more efficient method. Methodological simplification may provide more enticement for healthcare reform researchers to investigate and, eventually, help other teams work towards a transdisciplinary service delivery model.

Individual and Family Capacity Building

The transdisciplinary team studied for this project is an example of a theoretically grounded but radical alternative to the existing health services paradigm. The team integrates a population health lens, salutogenic theory and transdisciplinary philosophy to maximize the capacity of individuals and families to attain and sustain: 1) *“the best possible physical, mental and social conditions [for themselves] so that they may resume and maintain as normal a place as possible in the community”* (WHO, 1985, pp. 15) and 2) the *“socially and economically productive lives”* (WHO, 2006, pp. 2) they envision.

The discourse of community-based transdisciplinary neurorehabilitation is a discourse of capacity building: building the capacity of individual clients and family members to reclaim power over their health and day-to-day health circumstances. I believe the team is better positioned to meet this population health goal because they are not oriented to or by discourses of medicine or population health. The focus of the transdisciplinary team's capacity building efforts are not at the level of the community. The focus is on the client's ecosystem, functional relationships and the client's and family's subjective interpretations of health and social circumstances (Stewart et al., 1985; Antonovsky, 1987) because the team uses a determinants of health framework (DOH) and an ecological approach to guide practices.

Constructs such as ‘client-centeredness’, ‘empowerment’, ‘hardiness’ and a biomedical or population health approach to capacity building fail to capture the totality of the deeply personal and highly complex process of each individual's recovery experience. Human beings are complex and diverse. Our biological, psychological, sociological and spiritual dimensions

are so intricately woven, that any effort to study one dimension using one theory or paradigmatic perspective in exclusivity may inadvertently marginalize the very nature of this unique multidimensionality. Healthcare providers are always wiser to consider "*the full range of human responses*" (Calkin, 1984, pp. 27) using a broader perspective and a "*higher level of consciousness*" (Newman, 1993, pp. 156) that better reflects the complexity of human existence and change. Capacity building requires a broader, open and more inclusive framework to guide rehabilitation practices but not constrain the gaze, therapeutic relationships or individualized client-centered context-embedded capacity building interventions.

Study Contributions

This study is the first of its kind to uncover how a rare community-based transdisciplinary neurorehabilitation team integrates a population health perspective, transdisciplinary philosophy and a salutogenic approach to maximize the capacity of individuals to take control of their health and health circumstances, reintegrate into the community and workforce and reduce reliance on family and the healthcare system. This project also illuminates how a complex open adaptive business model and communication network, a shared organizational ethos, employee longevity and a de facto healthcare governance structure support transdisciplinary team practice and organizational efficiency. Overall, the study methodology and case study approach provide the basis of comparison for future research aimed at understanding and evaluating the structure and function of healthcare teams working in chronic healthcare.

Study Limitations

The case study method is well-suited to studying contemporary events, when behaviour is occurring in a real life context, and cannot be manipulated (Yin, 2009). However, there are some specific limitations to this method that should be noted. Although the intent of the case study method is to study a particular phenomenon in a local context, the results cannot be generalized to all other contexts. The findings from this project are more suited to theoretical applications such as recommendations for policy amendments and/or providing direction for practice and future research.

Meta-stories provided a more tangible and concrete place from which to begin the discourse analytic portion of my research method. However, the meta-stories and the interpretative repertoires that emerge from them do not contain an ‘ultimate truth’ about traditional or transdisciplinary practice, the work environments or the people who work there. *“The texts are comprehensible, the context is unknowable”* (Campbell, 1988, pp. 58). I do not claim to have had the last word on the enactment of transdisciplinary practice in this or any other transdisciplinary practice setting. There are no unequivocal facts or irrefutable ‘findings’ located in this dissertation.

There are voices and perspectives missing from this study. Some team members joined the team after study completion or left before we had begun. Some team members wanted to participate but could not find the time. Others simply chose not to participate at all. As a result, some versions of this story may or may not be represented. We may never know how and why non-participants accounts resonated or differed with the meta-narrative. The only certainty is that their contributions would have added our bigger picture, shared understandings.

Finally, it is possible that the ‘case’ for this study is not a singularity but a rare multiple disciplinary team oriented to and by transdisciplinary discourse and philosophy. I see no downsides either way.

Implications for Research, Practice and Scholarship

It is not possible to reduce the wealth of insights provided to the clinical and academic healthcare communities by study participants into a one or even several pages. I am certain everyone who reads their narratives will evolve new understandings and inspiration. From a transdisciplinary stance, it is not possible for me to see beyond my own life habitus or disciplinary and scholarly perspectives to offer up a finite takeaway message. To do so would be contrary to a paradigm oriented towards infinite possibilities. I will share some reflections as I begin my own journey into the realm of post-secondary teaching and transdisciplinarity research.

The most challenging aspect of studying transdisciplinary team practice in healthcare is locating a transdisciplinary team in healthcare. The literature is replete with studies whose authors claim to have studied transdisciplinary team interactions or measured the impact of transdisciplinary practice on clinical outcomes. However, these teams bear little resemblance

to the transdisciplinary team studied for this project. I am not certain why the philosophy of transdisciplinary practice is absent this body of literature. However, I am able to say with more than a modicum of certainty that its absence has created a phenomenon I refer to as ‘transdisciplinary blindness’. As a healthcare community, we seem to see transdisciplinarity where it does not exist but we cannot see or name it when it does.

I believe there is one particularly sound reason why transdisciplinary blindness has gotten the best of us all. Transdisciplinarity is a philosophy of science. The language and the texts are not easy to decipher let alone comprehend. It has taken many months to write this dissertation in a way that I hope the clinical and academic healthcare community can understand and take up in a meaningful and practical way. It has been one of the greatest challenges of my scholarly career to bring a ‘sense of coherence’ to transdisciplinary philosophy.

Some transdisciplinary practice teams may see themselves clearly reflected in the discourse of transdisciplinary practice. Others might find their transdisciplinary team may not be quite so ‘transdisciplinary’ after all. I hope that this dissertation provides a touchstone for healthcare teams to gauge their philosophical and ethical foundations as an organization and as group of human beings. Transdisciplinary practice is not for the faint of heart. It challenges us to the very core of who we are as people. It requires us to strip away our academic and professional titles and accomplishments, expose and then embrace our own shortcomings and the shortcomings of others. Who amongst us can leave our egos at the door and fully relinquish power ‘over’ to the power of the collective? Who is willing to humbly serve the greater good? Who amongst us can?

From a practical perspective, the enactment of transdisciplinary practice will be particularly challenging in established healthcare setting. How do you dismantle a traditional hierarchy, adopt a de facto governance model or train a manager to lead from below? How will the medical director respond to his or her new role as ‘peer and equal’? What percentage of the organization will take up a new version of ‘professionalism’ that includes more personally intimate relationships with clients, family members and each other? Perhaps staff longevity and close personal relationships will bode well for more mature organizations who wish to evolve a

transdisciplinary organization and transdisciplinary practice model. Clearly we have a long but exciting road ahead of us in the search for answers to these and many other complex questions.

The implications for practice and research related to isolated community-based practice teams is quite intriguing. Does the discourse of transdisciplinarity exist in practice settings outside of the Clinic? To what extent does it orient healthcare providers to a similar version of healthcare service delivery? It would be possible to use the methods in this study to research a variety of teams. For example, studies of multi- and interdisciplinary discourse communities could investigate team cohesiveness, salutogenesis, sense of coherence, alignment with transdisciplinary philosophy and their effectiveness in engaging patients and families as well as community support agencies. This would provide a novel and powerful way to understand the essence of health reform at the interface of chronic care programs, individual, families and their uniquely situated meta-systems.

It may be wise for post-secondary institutions to consider the profound impact a transdisciplinary curriculum might have on existing healthcare and future reform. Interdisciplinary education does provide access to cross-disciplinary learning opportunities. But to what extent would those programs prepare students to work in a transdisciplinary organization such as the Clinic? While some interprofessional health sciences schools claim to promote cross-disciplinary learning, do they promote transdisciplinary ‘thinking’, ‘doing’ and ‘being’? Are students ‘exposed to’ or ‘enmeshed in’ theoretical paradigms of ‘other’? There is a difference between having a working knowledge of other disciplines skill sets and having to capacity to disengage from one’s own disciplinary stance and become ‘knowing seeing other’.

From a practical perspective, it is vital for educators and clinical preceptors to become immersed in transdisciplinary as a philosophy of team science. Educators who are able to gaze outside of their own disciplinary boundaries and peer into ‘the between’ are more likely to seek out new and innovative opportunity for cross-disciplinary learning and collaboration. Educational institutions that wish to promote a transdisciplinary paradigm should first begin with educators with capacity to nurture qualities such as collectivism, humility and civility. Preceptors and mentors, themselves, should be screened to ensure they have characteristics needed to train future transdisciplinary researcher and clinicians.

There will need to be careful consideration given to the potential mismatch between a transdisciplinary healthcare curricula and the realities of traditional practice. The words of one of my former nursing students may serve as a reminder to heed this warning. After teaching a third year class the benefits of using a determinants of health lens to collect patient assessment data in the acute care setting, she asked, “Donna, where we supposed to chart all of this?” There was, in fact, no place for the population health gaze to inform multi- or interdisciplinary team practice in the hospital setting. The electronic medical record did not accommodate a nursing narrative and a ‘charting by exception’ policy favored brevity as a resource for efficiency rather than communication and dialogue. The medical gaze and nursing practice were confined to the treatment of the disease/disease.

Research to better understand the potential benefits of transdisciplinary research must be advanced in two priority areas. Qualitative studies must be undertaken to explore a) if and how transdisciplinary philosophy is taken up and enacted by self-identified transdisciplinary teams and b) how transdisciplinary philosophy is enacted differently across practice settings. Cost-comparative research should be undertaken to determine if transdisciplinary practice a) is cost-effective at the level of the organization and b) has the potential to reduce the direct and indirect costs of chronic illness.

The implications for studying and implementing a salutogenic and ecological capacity building approach at the level of the individual and family are seem to be a promising area for future research aimed at reducing the burden of chronic illness. The transdisciplinary team studies seems to have found a highly effective way to engage and activate clients and family member to help propel them towards health and independence from family members and the healthcare system. At the level of the organization and community networks, the findings of this study have uncovered a new perspective on health principles to guide future healthcare reform initiatives. These principles will need to be researched and tested, but the value of a theory that is ecologically integrated across domains and levels provides a direct and coherent link between social policy and practices that sets the expectations of patient and family engagement, program expectations and team practices and relationships. A Salutogenic approach is beginning to gain popularity among those working with chronic and complex conditions such as dual diagnosis,

cancer and mental health of seniors and adolescents but there is no coherent link between health promotion and salutogenesis. However, uptake of this theory will not likely occur until it is introduced into healthcare curriculum.

At the conclusion of this study, I will begin to analyze client (n=6) and family member (n=4) interviews collected during the course of this current study. The purpose of this sub-study is to investigate the mechanisms through which the transdisciplinary team changes the way in which patients and families talk about and understand their capacity to comprehend health challenges, mitigate vulnerabilities and foster independence and health. I intend to request an amendment to the original ethics approval to increase client and family member participation.

While this study makes a significant contribution towards our understandings of how transdisciplinary philosophy is taken up and enacted in a chronic illness practice setting, it is still a very preliminary first step. It will take some time before there is a sufficiently rich and diverse body of literature in this area to fully appreciate if and how transdisciplinary practice might impact or even change the face of healthcare, research and practice. Until then, the possibilities for future research and knowledge generation are limitless. Welcome to the world of transdisciplinarity; the realm of infinite possibilities.

Conclusion

From my personal perspective, the perpetual re-orientation of the healthcare system has left me feeling perplexed and somewhat 'dis'oriented in the latter half of my 26 year career. It wasn't until I traced the history of healthcare reform in Canada from a constructionist perspective for this project that I began to realize that the power of the biomedical discourse may have us talking ourselves in circles. Studying the transdisciplinary team at the Clinic has revitalized my dwindling hopes that there really is an alternative approach to chronic illness recovery and rehabilitation.

This study has uncovered a new language and an infinite realm of new possibilities for a different type of organizational reality and healthcare practices. However, I would like to take the opportunity to revisit one of my earlier questions: Are we making headway towards 'health for all', running in place or circling too high atop the airport to see there might be an alternative approach? I suppose it depends on your discourse.

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Appendix A:

LETTER OF INFORMATION AND CONSENT

Transdisciplinary Team Members

UNIVERSITY OF
CALGARY

COMMUNITY HEALTH SCIENCES

The Dialectical (Re)Construction of Health Capacity in the Context of
A Transdisciplinary Neurorehabilitation Team:
A Case Study

Researcher: Donna Baird, RN, MN, PhD Student

Principle Investigator: Nancy Marlett, PhD, Associate Professor, Community Rehabilitation and Disability Services, Department of Community Health Sciences, University of Calgary, Calgary, Alberta, CANADA.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research project is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the study:

The purpose of the study is to learn about how the transdisciplinary team at the Clinic assists clients to return home and to reintegrate into the communities where they live, while also supporting family members/significant others. To the best of our knowledge, this project will be the first of its kind to conduct an in-depth study of a transdisciplinary practice team that works with clients who have complex, multidimensional health issues. From talking with you and watching you interact on a day-to-day basis, the researcher hopes to learn about your own experiences as well as the strategies that you use when working with your team, the clients and their family members. We hope that the information from this study might inform health professionals, administrators and policy-

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PI: Dr. Nancy Marlett

Consent Version Date: January 5th, 2011

makers about how a transdisciplinary team functions, and provide positive recommendations for how teams might work more effectively in other health care settings.

Description of the Study:

Interviews: If you consent to take part in this study you will be interviewed between May and August, 2011. The interview will be arranged at a time and location that is convenient for you and will last from 1-1 ½ hours. The interview will be tape recorded, and will be later typed by the researcher or a typist. After the typed version of the interview has been reviewed, you may also be asked to answer some follow-up questions and/or to clarify any questions that the researcher might have about the content or meaning of your responses. Follow-up interviews may be over the phone or in person, and will last from 30-45 minutes.

Observations: Day-to-day observations of the transdisciplinary team's interactions will occur on an informal basis. If you consent to take part in this study, we would also like your permission to observe you working one-on-one with clients and their family member(s), if and when it is convenient for you. The researcher will make notes about her observations, which you will have the opportunity to see and discuss. If at any time during a meeting with the client or with your co-workers you feel that the researcher should not be present, you may ask the researcher to leave. You also have the option of participating in the interviews only, if you prefer not to have the researcher observe your one-on-one meetings with clients/family members.

Voluntary Participation:

Only the researcher and the faculty supervisor will know that you are taking part in this study. However, if you wish to arrange for your interview to take part outside of the Clinic to ensure your privacy, we can arrange to conduct your interview(s) at another location, at a time that is convenient for you. All tape-recordings will be kept in a locked filing cabinet and will be erased at the end of this study. Computer files of data obtained will be password protected as well. The typed transcripts of your interview will be coded to protect your privacy and stored in a locked cabinet where it will be kept for five years. After completion of the study, typed transcriptions and any notes taken will be shredded. Data from the interviews, in the forms of excerpts, may be used in the presentation of

findings for teaching purposes. At no time will your name be identified on any documents.

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardy. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

If you have questions now or in the future concerning matters related to this research, please contact: Dr. Nancy Marlette, Principal Investigator: 403-220-5657

If you have any questions concerning your rights as a possible participant in this research, please contact the Director of the Office of Medical Bioethics, Faculty of Medicine, The University of Calgary, at 403-220-7990.

Please check ☒ all that apply:

- ☐ **I agree to participate in the interviews for this study**
- ☐ **I give permission for the researcher to write down her observations about my interactions with other team members.**
- ☐ **I give my permission for the researcher to attend one-on-one meetings with clients/family members, and to write down her observations about these interactions.**

Participant Signature

Date

Investigator or Delegate Signature

Date

CHREB Ethics ID:

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Appendix B: FAQ

The Discursive (Re)Construction of Health Capacity: A Case Study of a Transdisciplinary Neurorehabilitation Team

FREQUENTLY ASKED QUESTIONS *for Team Members*

What is the study about?

This study has been designed to investigate how the health care professionals at the Center for Neurorehabilitation Services work together as a team. Specifically, we are interested in better understanding how your 'transdisciplinary' health care team assists clients to reintegrate into their own homes, families and communities, while providing support for and responding to the needs of their family members.

To the best of our knowledge, there have not been any previous research projects that have tried to understand how a transdisciplinary team functions on a day-to-day basis. Therefore, we believe that by talking with members of your health care team, patients and their family members will be able to better understand how your team works together to assist clients to meet their goals during rehabilitation. Hopefully, this will provide a well-rounded, detailed picture of how a transdisciplinary rehabilitation team works.

The information and feedback from this study may help researchers to make positive recommendations for changes to policies and team processes in other areas of health care. This study may also provide a basis from which to compare the differences between transdisciplinary, interdisciplinary and multidisciplinary health care teams. Any recommendations for positive change may, ultimately, help policy makers and health care administrators to implement strategies that promote more effective teams that enhance the capacity of patients and families to successfully manage their evolving health issues during recovery.

What would I have to do?

Everyone who agrees to participate in the project will be asked to take part in an interview that will take about 1-1 ½ hours. During that time, we will have the opportunity to talk about things such as your role on the team, how the team works together, the clients experience with the team, challenges that team members face and any areas for improvement. You may also be asked to speak with the researcher for a second time to clarify the content and meaning of data obtained in the first interview. These second interviews would likely take approximately 30-45 minutes. All interviews will be audio-taped and later typed by a transcriptionist or the researcher. You will be invited to attend 2-3 focus groups with your fellow team members during the study to talk to the researcher about her understandings and interpretations along the way.

For those team members who are interested, the researcher would also like to accompany you during your work day if you are going to be working with clients and families one-one-one. We would require that you ask patients and their family members permission for the researcher to attend these sessions as she will be taking notes during the session. The researcher will share her notes with you and discuss her observations. However, if you prefer, you can choose not to have all or a portion of the researchers notes included as part of the research project.

Finally, the researcher would like to take notes of her observations of the team during your routine, day-to-day interactions in the Center.

A Case Study of a Transdisciplinary Neurorehabilitation Team

Who are the Researchers?

Donna Baird is a PhD student at the University of Calgary, Department of Community Health Sciences, Faculty of Medicine. This project is being carried out as part of her PhD program. Donna is the primary contact person for this study and will be conducting all of the interviews and field observations for this study. Her contact information is:

Donna Baird, RN, MN, PhD (c)
Email: dlbaird@ucalgary.ca
Cell: 970-686-0949

Dr. Nancy Marlett is the Principle Investigator for this research study, and is Donna's PhD supervisor. Her contact information is:

Nancy Marlett, PhD
Associate Professor,
Dept of Community Health Sciences
University of Calgary,
Email: marlett@ucalgary.ca
Office: 403-220-5657

What are the ethics of this project? Can we refuse to take part?

Your decision to take part in this study is strictly voluntary. You may refuse to take part without jeopardy or repercussions of any kind. If you decide to take part, you will be asked to sign a consent form to participate in a) individual interviews b) observation of one-on-one sessions with clients and family members and c) observations of day-to-day interactions with other team members. You also have the right to withdraw from this study at any time, even after you sign the consent form. If, after an interview, you wish to change your mind about taking part, you may call the researcher and ask that your audio taped interview be destroyed.

We do not believe that there are any risks to you as a result of your participation. The researcher will be able to provide you with a [list of resources](#) available through the Poudre Valley Hospital System if you become distressed for any reason. You have the right to ask the researcher any questions concerning this study at any time.

Confidentiality

Only the researcher and the faculty supervisor will know that you are taking part in this study. Individual interviews will take place at the Center for Neurorehabilitation Services. However, if you want to take the extra precaution of ensuring that no one is aware of your participation in this study, arrangements can be made to conduct your interview(s) at another location at a time that is convenient for you.

All tape-recordings of interviews will be kept in a locked filing cabinet and will be erased at the end of this study. Computer files of data obtained will be password protected as well. The typed transcripts of your interview and any notes taken during the study will be stored in a locked cabinet and be kept for five years. After completion of the study, typed transcriptions and field notes will be shredded.

Data from the interviews, in the forms of excerpts, may be used in the presentation of findings for teaching purposes. At no time will your name be identified on any documents. Interview data may also be used in a future study, but prior ethical approval will be obtained.

If you have any questions concerning your rights as a possible participant in this research, please contact the [Office of Medical Bioethics](#), Faculty of Medicine, The University of Calgary, at 403-220-7990.

Appendix C: Data Collection Timeline

Date	Data Collection Strategy	Hours	Total Hours
August 2011	Meetings (3): -Clinical Director (3)	3.5	Total Hours: 4.0 -Field Hours: 0
September 2011	Meetings (1): -Clinical Director Interviews (6): -Participants 1-6) Field Observations (4): - Casual Observation (3) - Staff Meeting (1)	0.5 9.0 10.0	Total Hours: 19.5 -Field Hours: 10
October 2011	Meetings (1): -Clinical Director Interviews (2): -Participants 7 & 8 Field Observations (6): -Team Retreat (1) -Casual Observations (4) -Staff Meeting (1)	1.5 2.0 18.5	Total Hours: 22.5 -Field Hours: 18.5
November 2011	Interviews (4): -Participants 9-12 Field Observations (4): -Casual Observation (3) -Staff Meeting (1)	6.0 10.5	Total Hours: 16.5 -Field Hours: 10.5
December 2011	Field Observations (3): -Casual (1) -Staff Meeting (1) -Focus Group (1)	6.5	Total Hours: 6.5 -Field Hours: 6.5
January 2012	Interviews (2): -Participants 13 & 14	3.0	Total Hours: 3.0 -Field Hours: 0.0
April 2012	Meetings (2): -Clinical Director Interviews (1): -Participant 15 Follow-up Interview (2): -Participants 5 & 12 Field Observations (4): -Casual Observation (1) -Therapy Observations (4) -Participants 3, 7, 5 & 9	4.0 1.5 3.0 8.0	Total Hours: 16.5 -Field Hours: 8.0

Date	Type of Interaction	Hours	Total Hours
May 2012	Field Observations (2): -Therapy Observation -Participants 8 & 9 -Focus Group (1)	10.0	Total Hours: 10.0 -Field Hours: 10.0
June 2012	Follow-up Interviews (1): -Participant 7 Field Observations (5): -Casual Observations (5) -Staff Meetings (1) -Shadow (Clinical Director) -Therapy/Leader Role -Shadow (Participant 9) -Therapy/Admin Duties -Therapy Observation (1) -Participant 7 -Focus Group (1)	1.5 27.5	Total Hours: 28.5 -Field Hours: 27.5
July 2011	Follow Ups: -Participant 5	1.5	Total Hours: 1.5 -Field Hours: 0.0
March-October 2013	Feedback Meetings (4): (Analytic Feedback) -Clinic Founder (2) -Clinical Director (2) -Analysis Feedback	2.0 8.0	Total Hours: 1.5 -Field Hours: 0.0
October-November 2013	Team Review/Critique (20): (Analytic Chapters 5-8)	0	Total Hours: 10.0 -Field Hours: 0.0
			Grand Total: 140 -Field Hours: 91

Appendix D: Interview Guide

Transdisciplinary Team Members

PREAMBLE: To begin our interview, I'd like to learn more about you; who you are as a person, a professional and a member of the transdisciplinary team.

1) Tell me about your professional background and career before coming to the Center?

Prompts: Roles in past positions?

Relationships with other providers? Patients? (Examples)

(In)effectiveness about role/model of care? (Examples)

2) How would you describe your current role at the Center?

b) What is it that you do with/for patients? Families?

Prompts: Relationships with other providers? Patients (Examples)

3). I'd like to better understand how the team works together. What is a TRANS-disciplinary team?

b) What are the core values/beliefs of the team as health professionals?

c) Who's in charge?

4) How does this TRANSdisciplinary team" differ from an INTERdisciplinary team? MULTIdisciplinary team? (Prompts: Roles/Relationships/Communication)

5) What might a typical clients/family member experience when they go through this particular rehabilitation program? (Prompts: Programs/Activities)

b) How is this program different from other neurorehab centers?

(Prompts: Web site: Reintegration home/community/Requirement for support person)

6) I'd like to pose a hypothetical situation: An announcement has just been made that the Clinic opening up a second center. You and the team can keep or change any aspect of the program or the transdisciplinary team and/or the program at the new site.

a) What aspects of the PROGRAM would you want to keep at all costs?

b) What aspects about the PROGRAM would you want to change?

c) What aspects of the TEAM would you want to keep at all costs?

d) What aspects of the TEAM would you want to change?

6) Is there anything else you feel is important for me to know?

(Adapted from: van Dijk, T. A. (2001). *Discourse, ideology and context*. (Second draft, July 3, 2001). Retrieved from : www.hum.uva.nl/teun/cda.htm)



Appendix E: Focus Group Power Point Slides

Transdisciplinary Model of Care at the Clinic:

Transdisciplinary
Rehabilitation
Team

Focus Group #2

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In Preparation for our first Focus Group, you will find attached the slides for a presentation to you as well as the 'dialogue' that accompanies each slide.

The purpose of the presentation is:

- A) To clearly articulate my/our current understandings of:
 - i) Your transdisciplinary practice team at the Clinic
 - ii) How the transdisciplinary teams goals, mission, vision and functioning differs from a biomedical approach
- B) To elicit your feedback, comments, suggestions
- C) To understand and document the teams role in the community and within broader health systems and institutions

Please DO:

- A) Take to time to read over the slides/notes and consider the words and meaning of the dialogue for you/your team.
- B) Scribble oodles of notes, comments, thoughts, objections and, most importantly, alternatives to what you read if something isn't just right!
- C) Come to the focus group prepared for lively discussion and debate!

Please DO NOT:

- A) Share these preliminary thoughts/ideas/diagrams outside of the Clinic until the team feels that this work 'Hits the Nail on the Head'!

PLEASE NOTE

This focus group is part of our overall research project.

We will be *audio taping* this session.

If you would like to participate, I will ask that you sign a Consent Form

Looking Forward to Seeing You There!

THE CLINIC

Slide 1:

The mission of the Clinic to provide community-based, outpatient and comprehensive neurorehabilitation and neurodevelopmental therapy through a transdisciplinary approach to care. The transdisciplinary team is comprised of a multitude of licensed professional healthcare professionals and an amazing support staff that ensures the Clinic runs smoothly.

The transdisciplinary team works to enhance the capacity of clients, family members, and their support persons to understand health challenges in the context of their everyday lives and in the communities where they live, no matter how complex or stressful their life situation may seem.

By empowering clients to identify their inner strengths as well as their personal, family and community resource, the team supports client toward health and independence by supporting their confidence and ability to manage their evolving life and health challenges on a day-to-day basis.

In doing so, the team at the Clinic have successfully support clients to reintegrate into their families, leisure activities, work environments and communities both during and after neurorehabilitation. Let's take a look at how clients, families and the transdisciplinary team accomplish these goals.

What is 'Health'?

Biomedical Approach



Slide 2

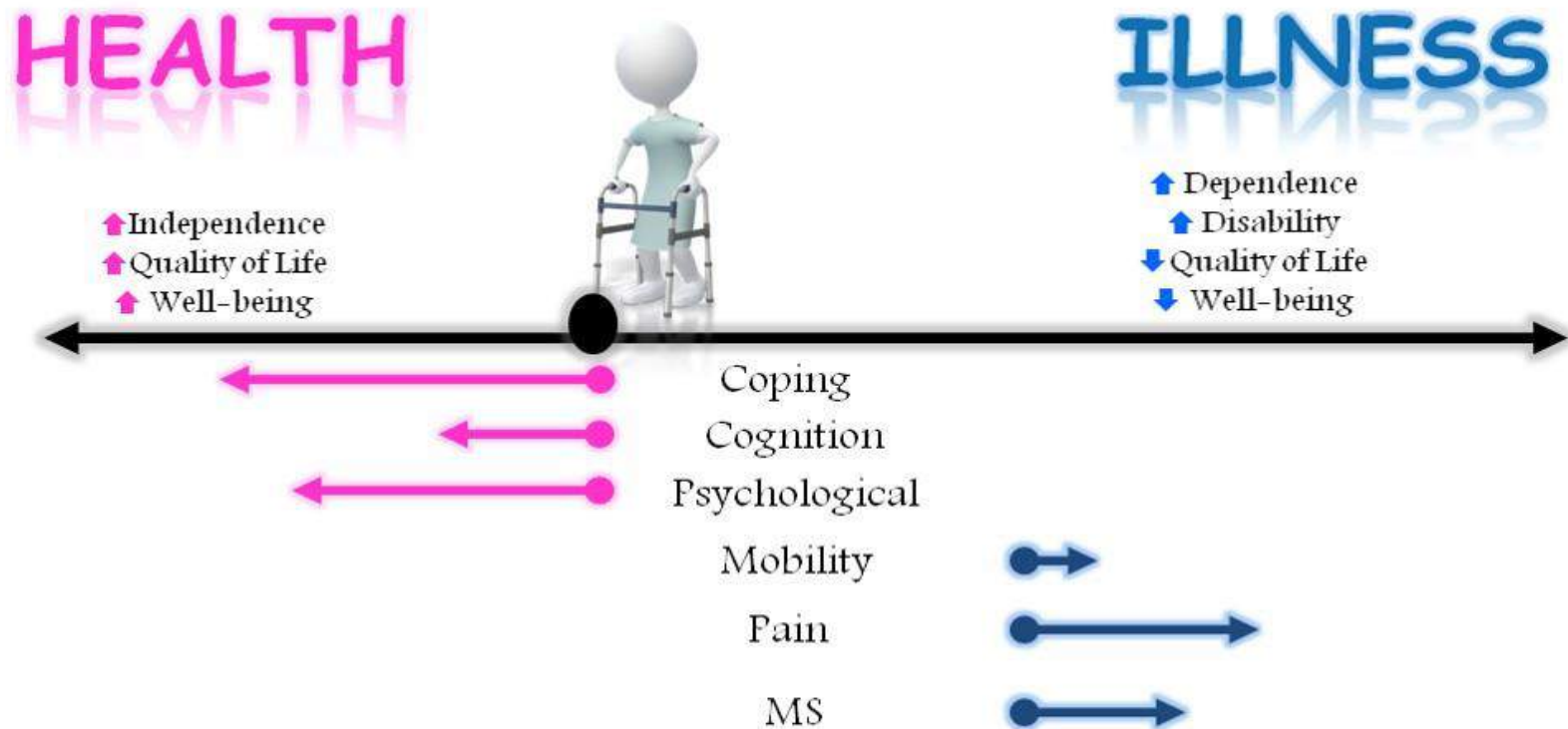
In the traditional model of healthcare, such as the care received in a hospital setting, health and illness are mutually exclusive; You are either sick and high risk for a serious illness ... or you are healthy, occasionally needing to see health care professional such as a doctor, physiotherapist or psychologist.

Health is a state in which all of our bodily systems and their physical functions are working normally. From this perspective, Health is like its own, isolated island, and illness is a separate place from which we are all trying to desperately to avoid or escape.

This either/or view of health and illness is often referred to as a biomedical approach. This means that client assessments are focused on the injured part or a disease. The focus of treatment is symptom management, maximizing the client's physical functioning or cure. Often times this approach leaves clients and families alone to make sense of their experience and to redefine a new sense of self in the context of their new physical limitations and life circumstances.

Towards 'Health'

CNS/Transdisciplinary Approach



Slide 3 (p. 1)

At the Clinic, the transdisciplinary team does not see health or illness as ‘fixed’, either or concepts. They view health and illness as occurring on a continuum. The team recognizes that a unique, holistic approach to understanding the client’s situation and the factors impacting their health/illness journey, beyond any physical symptoms of limitations, is required.

A **transdisciplinary** health/illness continuum means that clients can be simultaneously moving towards health in some areas of their lives and moving towards illness or disease in others. It is the combination of many factors in the client’s life that determines their place (i.e., balancing point) on the continuum.

In our example (↗ Animation), you can see that the client is initially oriented towards health, independence, improved quality of life and sense of well being. This orientation towards health occurs EVEN in the context of decreased mobility, increased pain, and worsening symptoms of MS.

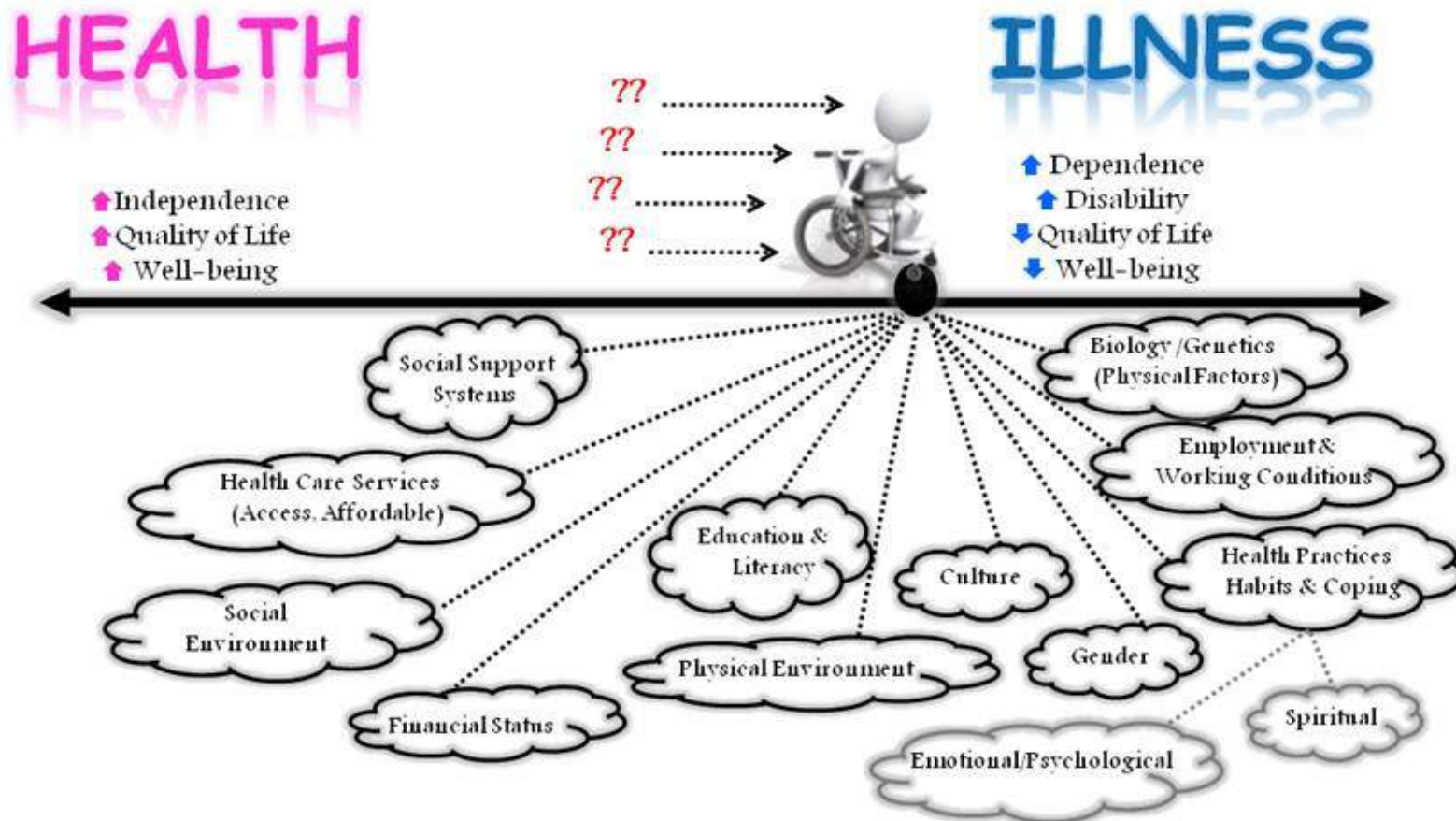
So how might this same client’s position of the continuum change such that they become oriented, or re-directed towards illness (↗ Animation)becoming increasingly dependent on others, becoming less mobile and having a decreased sense of well-being and quality of life?

Even though her cognitive challenges continue to improve (↗ Animation), the client’s psychological health and ability to cope with her life and her health circumstance may take a turn for the worse as her mobility, MS symptoms pull her towards the illness end of the continuum,

But how do we know what combination of health, illness and life circumstances are at play, shifting the client towards illness? (↗ Animation)

Towards 'Illness'

CNS/Transdisciplinary Approach



Slide 3 (p. 2)

These ‘factors’ that determine one’s orientation towards health/illness are called the Determinants of health. (↗ Animation)

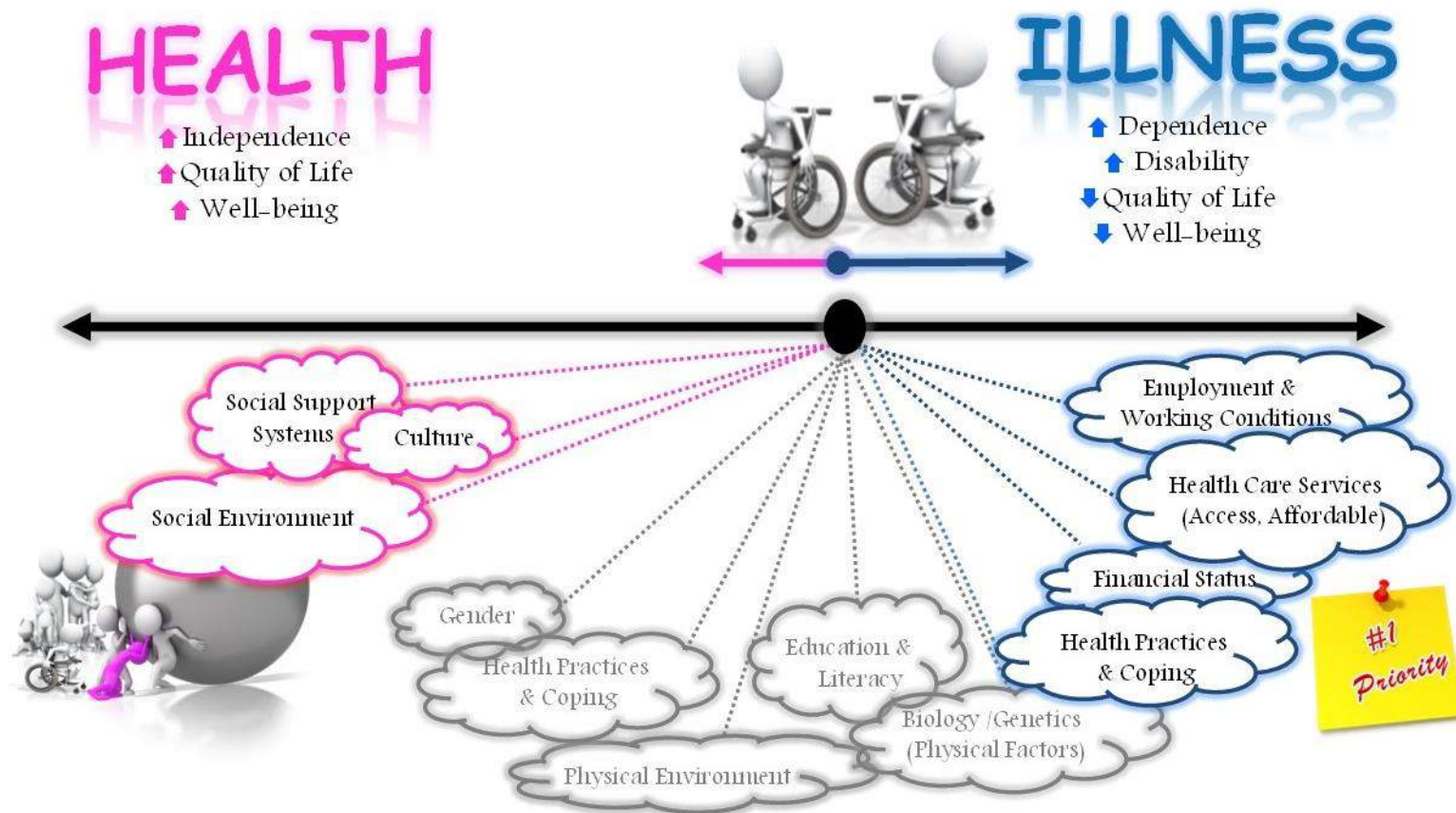
The Determinants of Health are circumstances in which we are born, where we live, work, grow up & interact with others. They Include factors at the level of the individual , such as (↗ Animation) their physical systems and physical functioning such as mobility and cognition, sex or gender expression, health practices(good & bad habits) such as smoking, drinking and exercise behaviors, coping strategies, level of education & reading ability, cultural beliefs & practices as well as their financial circumstances. In an assessment of Health Practices and Coping strategies, factors such as psychological, emotional and spiritual well-being (↗ Animation) have also been found to impact health, illness and recovery in both clients as well as in families.

At the level of the client’s family and community (↗ Animation), the social support that clients receive, their job status and the conditions under which they work, as well as the characteristics of the social and physical environments can all influence their position on the health/illness continuum.

Lastly, the broader systems, structures & institutions that influence the individual, families and their communities (↗ Animation), such as one’s access to hospitals & the available of state/federal run health programs, also have an impact on our orientation towards health or Illness. These larger institutions and structures are, in turn, impacted by social policies (↗ Animation), affordable insurance coverage, the extent of health insurance coverage and the political culture or climate at both the state and federal levels

Where on the Continuum?

Determinants of Health



Slide 4

Social Determinants of health rarely impact one's orientation towards health or illness in isolation. Often, it is a cluster of factors that come together and influence the client's position on the continuum.

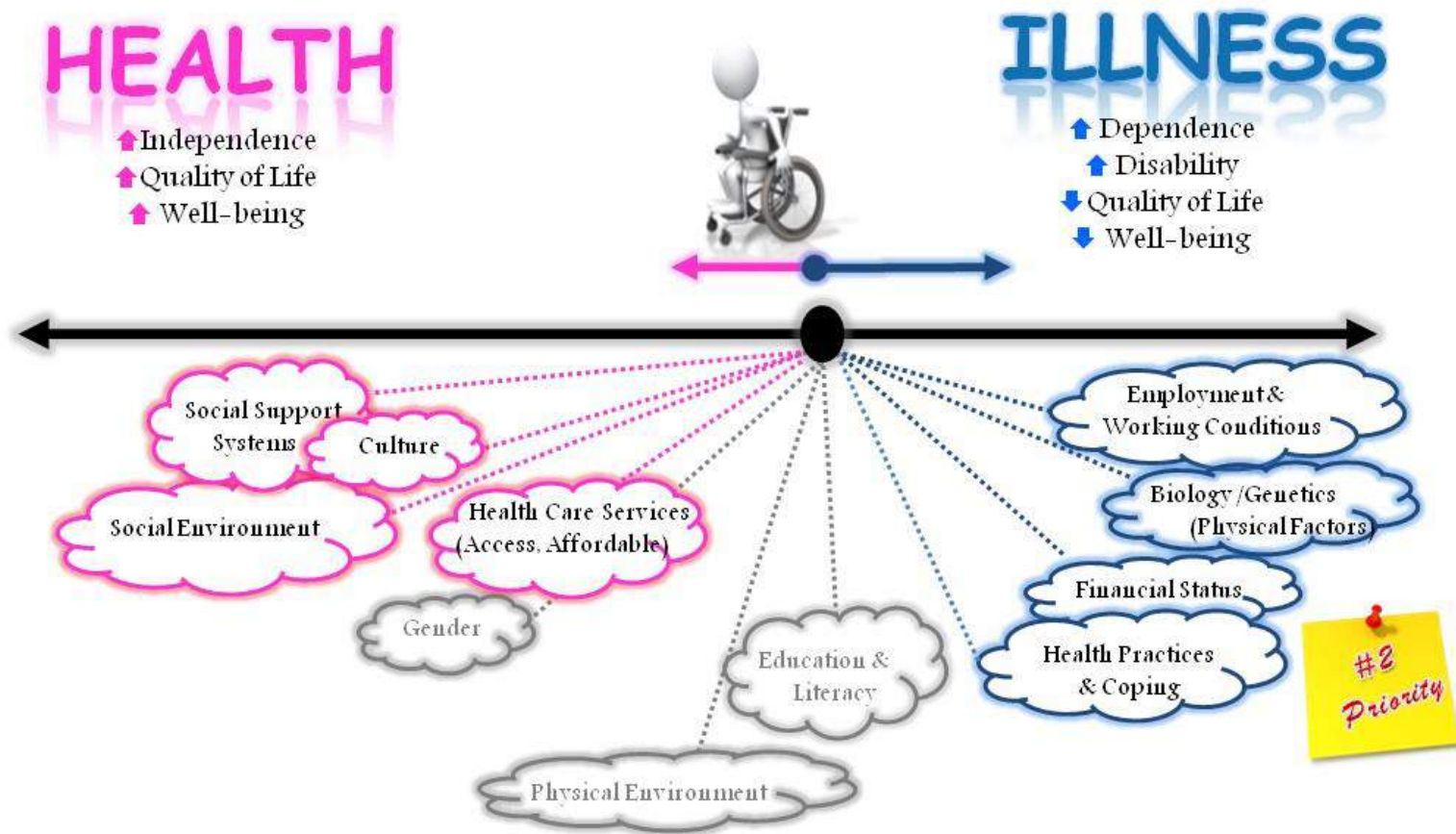
In this example, (↗ Animation), we can see that losing one's job, income, health insurance and access to health services, might pull the client towards illness. However, the client's strong cultural values and beliefs as well as the strength of family and community ties may still provide sufficient support and resources for the client to maintain an orientation to health (↗ Animation), even in the face of these new burdens and stressors.

At the Clinic the transdisciplinary team recognizes that while prioritizing (↗ Animation) the client's access resources that might help relieving their financial burden and facilitate access to care, this must take place while SIMULTANEOUSLY (↗ Animation), bolstering the client and family's capacity to manage their life and health circumstances even in the face of potentially overwhelming financial burdens.

Therefore, in addition to problem solving and developing a plan of care to begin work on priority areas/issues, the team ALSO works with the client/family to support their interpersonal/family relationships (↗ Animation). By working with, and supporting clients/families in this manner, the transdisciplinary team hopes to enhance the confidence and ability of the client/family to identify and maximize their strengths, resiliencies and resources.

Where on the Continuum?

Determinants of Health



Slide 5

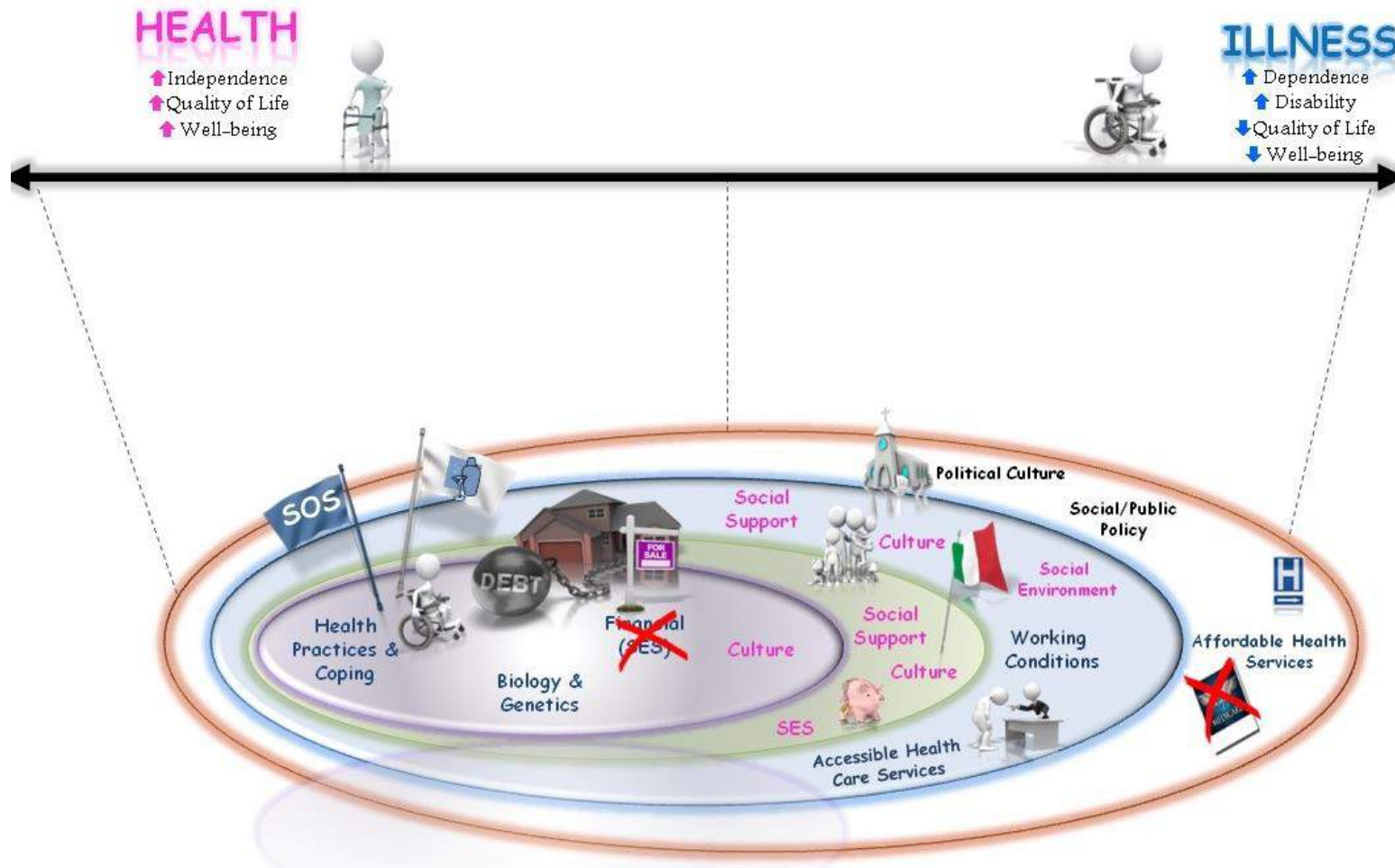
The team at the CLINIC also recognized that life, health and illness are not static. Recovery is a dynamic journey that is often complex and multi-faceted. Therefore, after initial challenges and stress seems to dissipate (↗ Animation), yet another set of circumstances might arise or become evident that become another priority area (↗ Animation).

The client's disease may worsen, & life and illness stressors may become overwhelming. If a situation seems hopeless and unmanageable, the client emotional and psychological health might suffer. The client, or even their family members, may begin to use alcohol or other medications to cope. Once again, transdisciplinary team works with the client & family to understand the context of the client's situation, and to bolster their confidence, ability and motivation to manage their situation. By instilling hope and confidence, the team strives to empower clients/families to overcome challenges, to foster independence and to re-orient towards health and healing.

While this diagram is helpful to understand the how the transdisciplinary team and CLINIC works, life does not happen along a 2 dimensional health/wellness continuum. The reality of life happens in the context of the client's unique family and community, influenced by the larger systems and institutions where we live.

Determinants of Health

2 Dimensional & Isolated?



Slide 6

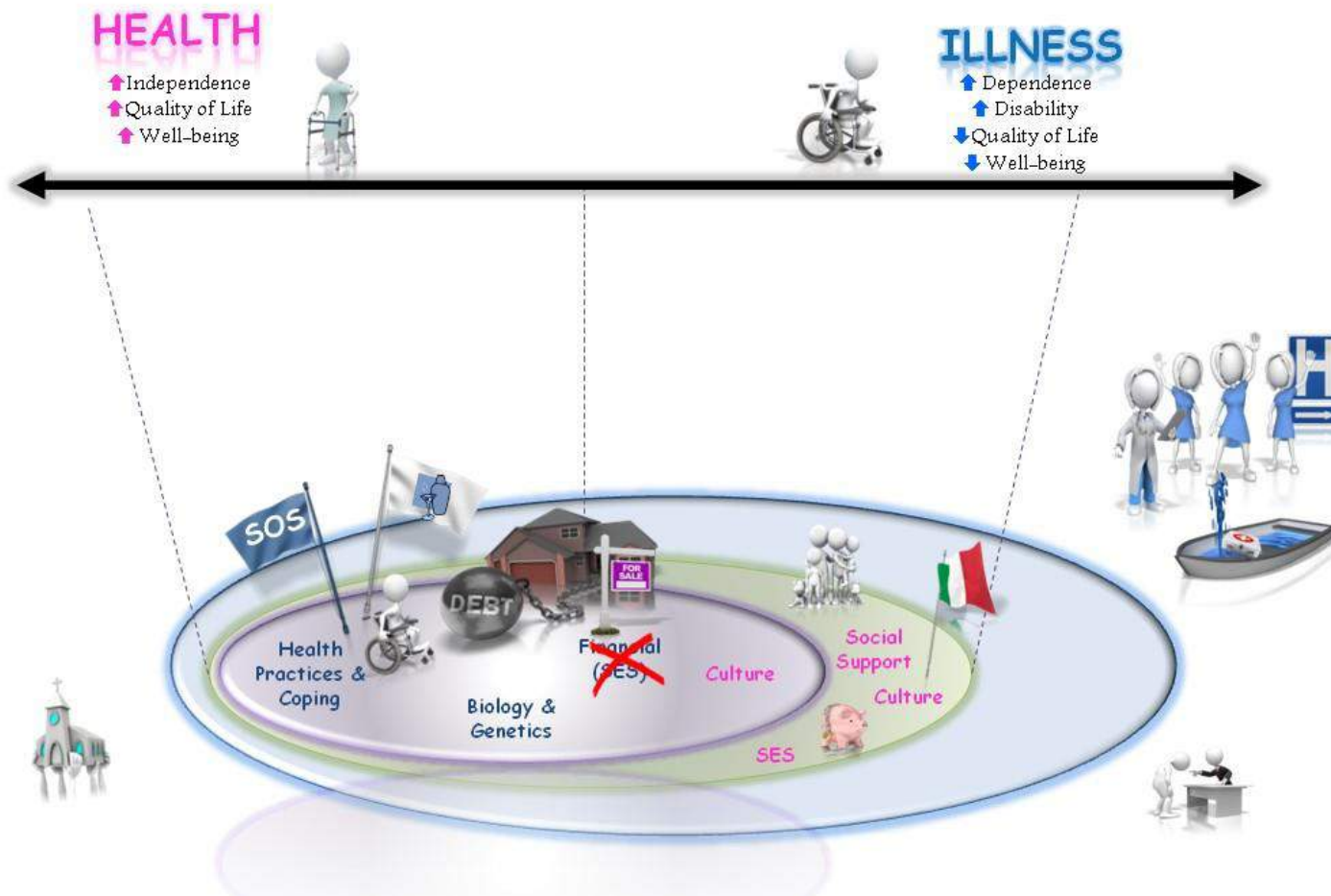
Just as health and illness do not occur in isolation, in most instances, the client's world is not entirely disconnected from their family, friends, and their community or from the broader social systems and institutions (⚡ Animation). The client's family, friends or support persons are often both connected and accessible to the client and may be able to provide much needed support and resources (⚡ Animation). These layers and connections are represented by the different colored, but interconnected circles in the diagram.

From this perspective, we can now see that the client's position on the health/illness continuum is not only influenced by individual factors **(Purple)** but also by factors at the level of friend/family **(Green)** (⚡ Animation). It is key to remember that Health Determinants at any level can influence the client's orientation towards health **OR** toward illness. If their relationships are positive, family members, friends and support persons can provide resources such as social support (⚡ Animation) and help maintain cultural ties (⚡ Animation) to help overcome challenges, burdens and stressors.

Or perhaps the family has access to financial resources (⚡ Animation) to help relieve financial burdens. Or they can provide much needed assistance to find more affordable accommodations for the client. However, there may be challenges that are well beyond the capacity of the family to help if the client disease is progressing, they are no longer to live independently or if they are having difficulty with psychological or emotional health. For help in these areas, the client may need to reach out to the next level; to resources in their community (Blue) (⚡ Animation).

Determinants of Health

2 Dimensional & Isolated?



Slide 7

Factors or Health Determinants at the community level (Blue) can not only impact client but also his/her family. These factors may be either health promoting resources, such as social support from the church (⚡ Animation), or their own cultural community (⚡ Animation), from a clean and healthy physical environment or supportive and tightly knit neighborhood or community environment (⚡ Animation).

At the same time, factors such as unemployment, loss of health insurance or the inability to access healthcare or wheelchair inaccessible health service (⚡ Animation) may provide challenges to the client's health orientation on the continuum. For the transdisciplinary team, (⚡ Animation) ALL of these factors and their impact on the clients health/illness orientation must also be taken into consideration.

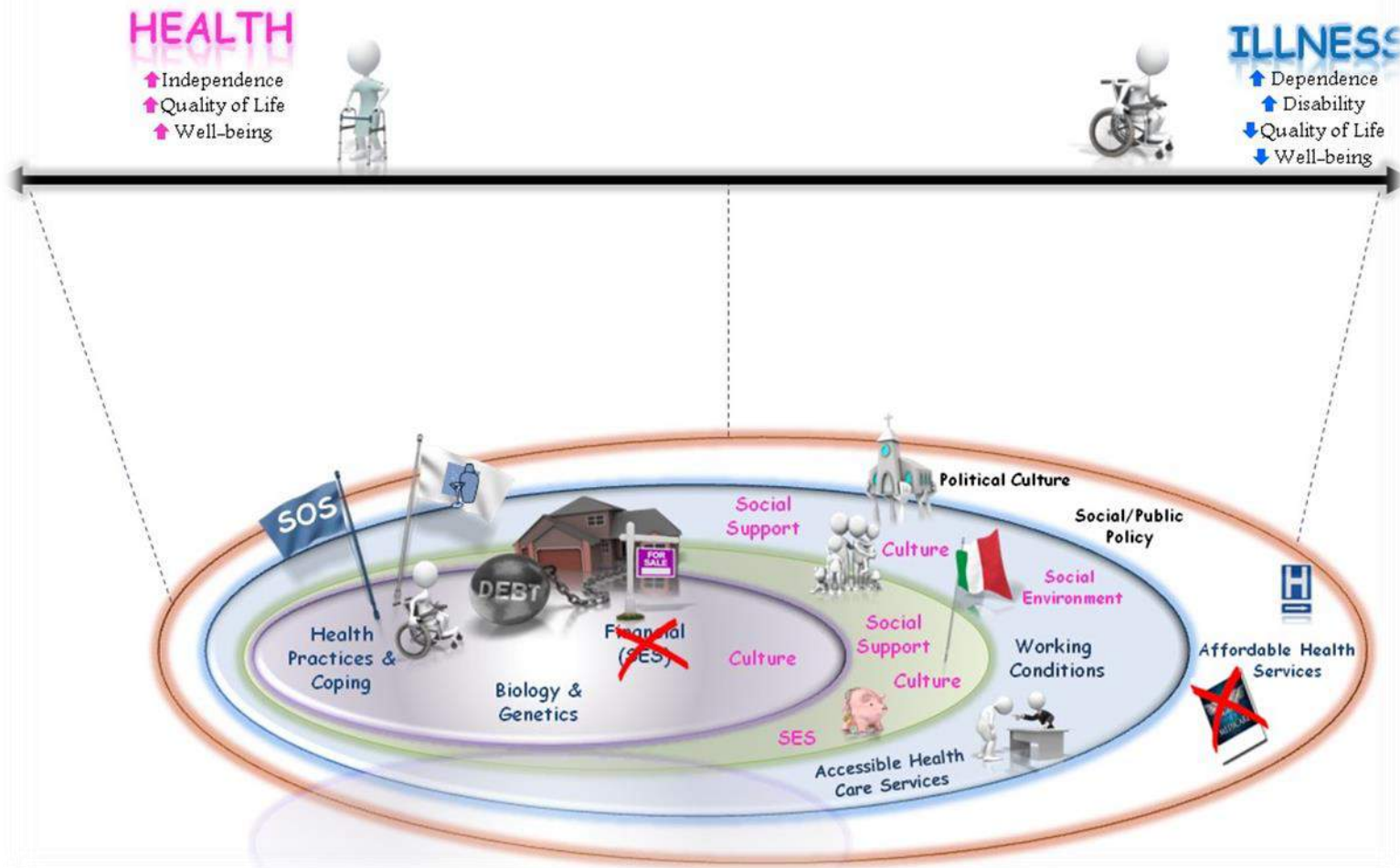
As we can see, the individual, family and community levels are now forming a much more complex and inter-related system, or META-system, in which the client/family interacts.

Finally, the client, family and their community are also linked to and impacted by larger institutions **(Orange)**. But as was the case with the client, these institutions do not exist in isolation (⚡ Animation). They exist as a level intimately interconnected within the client's meta-system (⚡ Animation). Here, Issues such as public and social policy (⚡ Animation) as well as the political culture/climate (⚡ Animation) can influence the client's access to resources such as (⚡ Animation) hospital or public health services and health insurance.

As we can now see, the health or illness orientation of what SEEMED to be an isolated client is actually influenced by factors that operate on a number of levels. And the client interacts with each of these levels either directly or indirectly. For some, these interactions within and between each level of influence occur on a day to day basis, for others much more infrequently. The frequency and degree to which a client interacts with or is influenced by each level of the meta-system varies from individual-individual and from family-family, creating a unique set of circumstances for each and every client.

Determinants of Health

2 Dimensional & Isolated?



Slide 8

At the Clinic the transdisciplinary team sees itself as situated (🐾 Animation) at the interface between the community in which they are located and the larger social and healthcare systems.

Because they believe the client's position on the health/illness continuum is influenced by all levels of the meta-system. The transdisciplinary team at CLINIC works with Clients and families to understand how health determinants, strengths and resources are at work in the client's day-to-day life. This includes the level of the individual (🐾 Animation), the level of the client's family, friends or support persons, at the level of their community as well as at the level of the larger social systems and institutions.

The team ALSO tries to understand (🐾 Animation) how the client & family interact and interface with each other, how the client and/or families interact with and are influenced by their community and how ALL of these levels interact with larger institutions and social systems.

For example (🐾 Really Cool Animation): Does the client have the ability, motivation resources to visit with their family (wheelchair client goes to visit family)? Does the client/family have access to health insurance and acute care hospital services if needed (ambulance rushes client to hospital)? Does the client's/families have access to and utilize resources in their community, such as the Clinic (wheelchair client goes to CLINIC), that will support them in their journey towards health, improved quality of life and independence if that is their goal? (Client returns home using walker)

In order to support the client's journey, the transdisciplinary team also understands that the client's situation is not static, but can change over time, or even at moment's notice (🐾 Animation).

Therefore, the transdisciplinary team is comprised of a wide range of health care professionals, and the family and support persons at every step of the way, from care planning to graduation. In this way, the team, the client AND the family can be responsive to the *evolving* life and health circumstances.

Transdisciplinary Team

The T-Zone of Creativity

- T- Sharing Perspectives about Client/family circumstances
- T- Blending of Professions/Client/Family Insights & Understandings
- T- Developing a Care Plan with Client/Family
- T- Brainstorming Creative Solutions to Challenges
- T- Novel Therapy Design
- T- Evaluating goals/progress



Slide 9

The transdisciplinary team's functioning is deeply rooted in transdisciplinary philosophy. The clinical director facilitates open, egalitarian & client-centered that is client-centered communication specific to the client/family unique circumstances. The team is not-hierarchical.

T-Zone, or zone of transdisciplinarity, represents the core of their transdisciplinary practice. Since each team member comes from their own, unique disciplinary perspectives, and the clients from their own unique set of circumstances, team members respect that **NO ONE** disciplinary, client or family perspective could possibly understand the complexity of client/family circumstances, or the interactions within each unique meta-system.

NO ONE professional discipline, client, friend or family member perspective has at its disposal, an understanding of available health-oriented resources to enable client's families to manage their unique day-to-day and evolving life circumstances. **NO SINGLE** professional discipline possess the knowledge, treatments or therapies to unilaterally assist and empower client's to reach their goals, when those goals involve reintegration with the family, community or work setting.

As such, the missions and goals of the Transdisciplinary team are incompatible with ego-based, autonomous or territorial conduct amongst its health care professionals when, in terms of professional practice (click), a sharing and blending of professional, client, friend and family insights and understandings is required to develop a client-context specific plan of care.

Therefore, the core of transdisciplinary practice, the T-zone, is a place of reconciliation and unification of what could be divergent/incompatible points of view between the transdisciplinary team members themselves, or between team members, client or family members.

Team/client meeting and interactions provide a safe environment for **Brainstorming**, which allows for deep level of creativity and out-of-the-box problem solving. All members of the team strive to remain open to the **infinite** number of possibilities at their collective disposal. Often-times, these results in a blending or combining of therapies, and novel client/family-specific approaches that could not have arisen from a single individual perspective or disciplinary ideal.

Transdisciplinary Team

Empowerment, Capacity Building, Independence

CLIENT & FAMILY

- T- Identify, bolster & support *strengths*
- T- Empower to identify/utilize new & existing *resources*
 - \$\$, social support, community-based programs, health care services
- T- Assist clients/family to better **understand & manage** life circumstances
- T- Motivate and empower clients to *overcome challenges* (new/existing)
 - lost relationships, financial hardship, changes in roles/responsibilities, physical functioning



- T- Build capacity of clients/family to be health-oriented
 - healthy & confident to maintain health-orientation
- T- Empower clients to be *flexible/creative* to meet everyday challenges (*new coping strategies*)
- T- Empower client/families to find **new understandings & meaning** in their lives
 - to find pleasure & satisfaction in life, roles & relationships

Slide 10

WHERE TO FROM HERE?



Appendix F:

LETTER OF INFORMATION AND CONSENT

Document Analysis

UNIVERSITY OF
CALGARY

COMMUNITY HEALTH SCIENCES

The Dialectical (Re)Construction of Health Capacity in the Context of
A Transdisciplinary Neurorehabilitation Team:
A Case Study

Researcher: Donna Baird, RN, MN, PhD Student

Principle Investigator: Nancy Marlett, PhD, Associate Professor, Community Rehabilitation and Disability Services, Department of Community Health Sciences, University of Calgary, Calgary, Alberta, CANADA.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research project is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the study:

The purpose of the study is to learn about how the transdisciplinary team at the Center for Neurorehabilitation Services assists clients to return home and to reintegrate into the communities where they live, while also supporting family members/significant others. To the best of our knowledge, this project will be the first of its kind to conduct an in-depth study of a transdisciplinary practice team that works with clients who have complex, multidimensional health issues. From talking with you and watching you interact on a day-to-day basis, the researcher hopes to learn about your own experiences as well as the strategies that you use when working with your team, the clients and their family members. We hope that the information from this study might inform health professionals, administrators and policy-makers about how a transdisciplinary team functions, and provide positive recommendations for how teams might work more effectively in other health care settings.

CHREB Ethics ID:

1 of 3

PI: Dr. Nancy Marlett

Consent Version Date: January 5th, 2011

To ensure a comprehensive understanding of how the transdisciplinary team at the Center for Neurorehabilitation Services works together and with their clients, it is helpful to include information in the study (i.e., documents) that might add to the researcher's understandings of the team's activities as well as the broader health care system.

If you agree to provide any printed documents to the researcher for this study such as policies, brochures, web pages or minutes of meetings, all names will be removed prior to their analysis. Printed documents will be reviewed, compared and contrasted with interview data obtained from patients, family members and member of the transdisciplinary team.

After the documents have been reviewed, you may also be asked to answer some follow-up questions and/or to clarify any questions that the researcher might have about the content or meaning of the documents. These follow-up questions may take 30-45 minutes to complete. All documents provide to the researcher for analysis will be kept in a locked filing cabinet for a period of 15 years, after which time they will be physically destroyed (shredded).

Written Consent:

Your signature on this form indicates that you have understood to your satisfaction the information about the inclusion and analysis of the documents listed below in this research project and that you have the authority to provide this information. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities.

Documents provided by the undersigned participant for analysis in this research project are as follows:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project. Further, you have institutional to provide these documents to the researcher for analysis. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw your consent to use these documents at any time without jeopardy. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

If you have questions now or in the future concerning matters related to this research, please contact: Dr. Nancy Marlette, Principal Investigator: 403-220-5657
If you have any questions concerning your rights as a possible participant in this research, please contact the Director of the Office of Medical Bioethics, Faculty of Medicine, The University of Calgary, at 403-220-7990.

Participant Signature

Date

Investigator or Delegate Signature

Date

CHREB Ethics ID:
PI: Dr. Nancy Marlett
Consent Version Date: January 5th, 2011

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Appendix G: Script Used by Therapists to Obtain Verbal Consent

There is a student named ‘Donna’ who is doing a research study at the Clinic. She is interested in learning about the experiences of clients and families in the health care system during their recovery. She is also studying how our team works with clients and families here at the Center. She would like to sit in on your next meeting with (name of health care provider) if that is ok with you and your family member/support person. She will not be taping your conversation, but she will be jotting notes while you are talking. She might write down things like the kinds of things you discuss your health care professional.

If you allow Donna to sit in on your meeting with (insert name of health care provider), she will use the information that she writes down in her research study. Your name will not appear in her notes, so no one will be able to link you to anything she writes down. Her notes are locked in a filing cabinet every day so no one can access them. After the study is over, field notes will be shredded. If there are any topics that you do not wish to talk about in front of her, Donna will leave the room so we can discuss these subjects privately.

Do you have any questions? Donna would like you to think it over and let (your health provider) know when you get to the center if it’s OK for her to sit in on your meeting with (health care provider).

Appendix H: Transdisciplinary Meta-Narrative

The Evolution of Transdisciplinary Team Practice at the Clinic

The history of this place is really kind of interesting because it's not like we started out with this plan, "Oh, We're going to set up this transdisciplinary program," but I think that's what we did. And I mean, well of course we didn't even know what a transdisciplinary program was. But it just kept growing and it eventually evolved into this thing (1014: 105-111). I think it emerged initially because we wanted our work to include the whole picture of neuro rehab (1008: 184-186). But we did have an inkling of, you know the direction we were going all along because we had these different people there and you want to say, "Well you know it's, they're kind of working together" (1014: 231-233).

And during that time we'd come up with different models, you know? We called it different things. We came up with multidisciplinary for a while and then we thought, "Well, multidisciplinary is not right because multidisciplinary means that there are just these four characters and what we have is this thing where the disciplines they just kind of overlap" (1014: 233-235). So there was always that sort of wanting to work within a system that we're all on the same page. We didn't want people all doing their own thing because it, that's not what we do here (1009: 58-59). We wanted to create a world where the focus became the client. That's gotta be number one. And you don't worry about what you're doing in this or that (1014: 203-206).

So for us, transdisciplinarity was just about egoless people coming to share their knowledge and figure out how to help these people (1014: 122-123). We cared. There is this common nurturing thread here and shared a common vision in terms of trying to come up with first of all, strategies that really helped the people function better in their day-to-day activities (1014: 85-86). And from the start, the leadership championed a holistic approach (1008: 186).

Of course, it used to be more hierarchical when we first started out and it was really tough for a lot of reasons. There was a lot more sense of control because we were creating systems and the support staff and administration were trying to figure out what documentation they needed and so on. So they were running and they were learning. Looking back on it I can understand why it felt more controlled. But over the years, we've all kind of been

evolving. The director has evolved and everyone has been allowed to evolve. And that's been the great thing (1011: 21-37)!

If you look back from where it started this you can see all the disciplines that have been added from the history to see how this place has evolved. And there's a reason it's evolved (1006: 537-539). And think that is has grown is what seems to be important, you know (1008: 141)? The only problem with what happened was that it evolved to where every place that had the most difficult client they had to deal with, was sending them to us hoping we could tease things out. And some of those got very, very difficult (1013: 95-98). So the patients changed. The general thrust changed. They're sicker. They are more involved, more complicated and they're older (3003: 8-10). And we developed a number of new interventions that nobody had quite figured out. So I think we were pretty successful there (1014: 87-88). We opened, I think, people's eyes, too, to what rehab could do for people (1013: 114-115).

So I think we wanted this to be the antithesis of the traditional model. The kind of model that was, you know, everybody should be treated equally. And the work that everyone does, each person's contribution, everyone's piece, deserves to be treated with respect (1014: 290-291). And from day one we were that way. We were the antithesis of the traditional model (1014: 279-280). And when we first started out what was especially insisted upon was that people act in that way. And I mean, well of course we didn't even know what a transdisciplinary program was (1014: 109-111). But I think it's still expected here, but not in a shake your finger sort of expected here, but it's just the way it is (1003: 136-138). It has really become the anti-medical model and the egos and hierarchies that we were striving for from the beginning (1013: 182-183).

Recruiting Team Members into the New World

I think before I started working here, they presented it as being sort of comprehensive care. I hadn't been in a place that had comprehensive care that everything could be done under one roof. I thought that was fantastic. And I think they presented it as being a place where there was actually some feedback about your work from the other team members (1009: 190-198). So I think that was just about getting you to be a part of a team. So I liked that it was comprehensive, that you get feedback and just that I would learn a

lot more about healthcare, I think, than what I'd had experience with.

And I think the selling point to me was, you know, it's special because you get to see if you were right. And you get to see if that treatment panned out or if that was helpful and that is what the big appeal is. And I can, I'll write a report and then you'll go back in six weeks and look at the OT report and the speech language and you're seeing a lot of similarities and you're seeing things that are sort of supporting what you do every day (1009: 198-204).

Organizational Philosophy and Transdisciplinary Leadership

Organizational Philosophy

The philosophy here comes from the top down, because leadership, so to speak, sets the tone for the whole place. The leadership here have the philosophy that we are here for a bigger purpose, a greater good (1003: 40-41). And that's what drives this place is what's in the best interests of the clients and the mission to really help these people and to help the community is just really pure (1002: 337-338).

Taking care of people is the bottom line here. If it was for making money the administration sure wouldn't be doing this, they'd be doing something else (1010:73-74). I mean that's really the mission, not to make money (1002: 345-347). It's not a matter of getting rich, it's a matter of just keeping the doors open (1010: 20-21). They make a lot of decisions from their hearts more than if someone else was in charge. Someone else might be making decisions from the bottom line or only the financial picture (1002: 339-340).

Leadership Roles and Style

The clinical director here is a therapist, who is the primary decision-maker and the person who has really emerged as the power and the impetus over the years (1002: 183). But even though that person is the director, they are not direct (1002: 183). I mean, the director can be directive if need be (1005: 60-61), but they are really very good at sharing leadership and decision-making (1008: 176-177).

I think that if you didn't know better, you wouldn't know who your boss was because the director leads in a way that makes you know

that they are not above you and that also makes me feel like I am part of something bigger really (1003: 45-49). I mean, even if you ask the administrators, they will tell you that communication leads the team (1005: 1/8/2010 personal communication). So I suppose while it is from the top down, you need to look what you have at the top. (1010: 250).

Roles

I think that the director's role is pretty much a facilitator and spending a lot of time facilitating communication amongst us. That role is about building and generating of a very positive environment where everybody is sharing and doing together (1005: 55-68).

I suppose we shouldn't forget that we do have different departments and we have department heads here, too. And for some people they are their own department! (1006: 440-441). So there is kind of a communication hierarchy here if there is a need to talk about a clinical or administrative protocol that impacts all those departmental components. So the director may then go to the department heads around what needs to happen in some hierarchy as well (1006: 440-445). But it's not the same as a traditional hierarchy sort of thing (1003: 280-284).

I mean, if there is some protocol that we're looking at, or we can't come to consensus about a time-sensitive matter, the leadership will make a final decision. People will give input and defer to the director's judgment when it's called for (1006: 408-410). Otherwise, if it's not a time sensitive thing, we'll usually just keep talking about it until we come to consensus (1005: 1/28/1013 3pm) or majority rules. And even after all of that, people can certainly object to certain things as well (1006: 408-411).

Flexibility and Family

When the administrators came to work here they took a big pay cut. So it's not a big salary sort of place (1009: 345). And the administrators believe that the people here buy into the philosophy and the financial situation but they like the flexibility for family things that you don't have in the traditional model (1010: 53-54). So we can put family first here if need be, you know? If an emergency comes up somebody will cover and, you know, make sure that it's

that you don't feel guilty (1004: 2-3)! Family is recognized and honored (1011:35-26).

So the administration lets us pretty much set our own schedule (1010: 55), and I think the flexibility is really actually conducive to transdisciplinarity. We can have kind of, I guess, breaks to have a little breathing room to be fresh with our patients. So your job can kind of be flexible around your life and your schedule and all that, but yet also taking into account our patient's needs (1007: 43-53). They let people work when they want to work. If they need more people then they get more people instead of saying, "Okay you can no longer work 3 days a week, I need you 5." So they're good about that (1010: 48-51).

And I think that's helpful. I think that if you want to do something else. Like I can go do whatever else I want as long as I keep my schedule. So the administration doesn't keep me from doing anything and I think that's true of all of us. If you want to do this but then you decide you want to also have a job somewhere else, go ahead and move your days to Thursday. So it's very flexible in that sense (1009: 345-348).

Compassion, Safety and Professional Regard

I think that what is different here is that in any another setting they would fire people over and over again because they are having personal challenges (1011: 4-8). But the director has such compassion, foresight and creativity. As all of our supervisor, the director will totally have our back and be very accepting if we screw something up. So there is also that element of feeling safe here that also comes from there (1012: 134-136). It's an interesting balance because I feel very independent here in terms of like, I don't feel like anybody is looking over my shoulder or like I have to be careful that I do things right all the time so to speak (1003: 57-58).

They doesn't just put minors in the minors and majors in the majors just because certain, there's certain things about your personality that's going to make you different than somebody else. If it doesn't affect your job, they're like, "Just go with it" (1010: 224-228). They believe that if you hire professional people, they know what they need to do. They just need an environment that supports and facilitates them doing the very best they can (1009: 61-63). If the administrators know that if they are hard-assed it would

not go over well at all. I mean, that would be bad. They are not that kind people as managers. They believe that if you're doing your job they just leave you alone (1010: 224).

So I think that that's a component of the maturity of our staff here and also our administration's philosophy of people being really good at what they do. People are really good at what they do. We may all chide each other a little bit and we need to share other personality or work styles but at the end of the day, we're able to move forward with us as a staff and around what we need to do (1006:134-138).

Receptivity and Responsiveness

The Director is very open to new ideas when people do it in a constructive way! They love it! They call it 'great thinking'! If someone hates something and it's small and changing it is going to be positive for everyone, all they have to do is change it! Change things around! Do what you have to do! The director just puts it back on us and tells us to just get it done the way we think it should be done. Leadership here is very different that way (1010: 232-240).

And they take very seriously what they hear from the patients and that's their feedback. And I feel like they have made changes and adjustments regularly based on what they are hearing from the people they treat (1003: 27-30).

Availability and Accessibility

And I can walk across the hall to my clinic director and say, "I need to talk to you about so-and-so, and I need to talk to you now." Depending upon their schedule and your schedule and that, but it's an important thing, "I've got to talk with you in the next two hours before such and such happens," you know? I can go into her office and say, "I really have got to talk to you about so-and-so and we've got to figure out a plan and take care of that in a couple hours" (1006: 375-381). The director has, for the most part, an open door policy but is a very busy person as well because that person also shifts into case-management when they carry a caseload (1006: 73-76).

Preservation of Power, Program and Philosophical Integrity

Basically, if someone comes here with a different agenda, or if it looks like a one-man show, it just doesn't work. And you can tell pretty quickly, within a couple of months. If you've got an ego it shows. We don't want people here with a different agenda and whose egos overrun what you're trying to do as a program (1010: 207-216). People just don't fit in if they just think that they know how to run things better. They think, "We need to do it this way. You people aren't doing it right! I know better, blah, blah, blah...." It's horrible! You can't have that in any business, especially not in a team-based rehab environment. We just don't have time for that (1010: 232-240).

For the most part, we don't hire people who are like that. Our director is pretty good at finding those, not hiring those people to begin with. Or if somebody doesn't fit in with what we want to do, or they don't have the same mindset, it's "Bye-bye" when you quit (1010: 206-216). And they either quit themselves, kind of weed themselves out, (1002: 286-287), or we get rid of them (1010: 210-211). It's pretty natural attrition when that happens (1014: 306). Either way, they don't stay very long because we don't want anybody in here that doesn't buy into what we're doing (1010: 210-211).

The Transdisciplinary Work Environment

Required Attributes for Transdisciplinary Team Membership

I think that people are here because they want to be here. We don't all make the income here. Most of us could make money elsewhere, make much more money elsewhere. I mean, the money is adequate. But it really has to do with the work. And for a number of people it has to do with their colleagues as well as the clients and the real reason we're here for folks (1006: 519-524). I think that we believe in the program and we are true caregivers. We're not here for the paycheck (1010: 204). We are all here because we care passionately about the work that we do (1012: 123-124).

If you are going to work here you have to be flexible, open and compassionate. You have to be able to laugh at yourself and laugh with others. You cannot have an ego involved and you have to be honest. You have to be (1012: 297-299). And there has to be some a part of you that's in it for the greater good (1009: 301-302) and that

you're just going to be one piece of this (1003: 63). I don't really know that you can learn to leave your ego behind. I mean, I don't know though. Maybe you could if you work with the team for a while (1014: 304-305).

We are not the type of people who feel like we know more than anybody else, or the type of people whose identity is tied to their profession (1013: 125-126). I'd never use my degrees to impress anyone, except when you're at a conference because you have to impress the outside world. Out there it's always kind of like, "You guys in your field don't really know what you're talking about," so you have to justify yourself with your credentials (1013: 125-127).

We are people first, right from the beginning (1014: 93-94). I've never heard anyone on our team say, "I'm the physical therapist Martha, or I'm the physician, Dr. Jones." It's always, "Hi, I'm Martha, the physical therapist that you'll be working with today." It's always our name first. People here are not their own entity that you can't possibly really touch. People here are real. It's so amazing. I think everyone here comes from that kind of humanity perspective (1012: 132-133, 143-151).

I'm not like some people out there who are sensitive about redundant titles or certifications from a long time ago. And finally let those go. My concern is over more what's going on with the client and what we need to make sure that client and families can come here and be focused on what's going on with their therapy (1006: 94-100). We are all very client-centered and I feel like we're always thinking client first (1009: 104-105).

And I think that we are all quite independent people, and I think the independence is important because you've gotta be pretty strong. You've gotta be pretty strong to work in a setting where you've got a lot of people with a lot of knowledge and are able to speak their mind, particularly in a staff meetings, that sort of thing. You have to be able to have a dialogue and still be comfortable in your own skin (1006: 219-223).

I also think that the members of the team have well-rounded lives because they value what they're doing outside of here as much as what they're doing at the clinic. So that when they're not here, they have other very fulfilling things, very important things they're doing (1011: 138-141). They have back-up systems outside of the workplace (1011: 62). When you hear, and a lot of it is together,

like, “We’ll go and have a beer,” or, “We’ll meet.” So there’s a social support within and there’s social support outside. I sort of feel like they have a lot of buffers (1009: 324-326).

And I think that some of the people here are unusual in that sense, in that they don’t get down. Like, I’ve seen a lot of people who have above-average resiliency. So I think that there are a lot of people who you would put in them anywhere and they would be happy. They’re just good people (1009: 314-317).

Interpersonal Relationships and the Maintenance of Social Harmony

Mutual Trust and Support

This is a very safe place, a really safe place. I think that safety is a really important piece (1006: 451-452). And I think that everyone on the staff would say that they feel safe here (1012: 120). It’s not intimidating, it’s not scary (1003: 37-38)! So we’re not very, I don’t know what the right word is. Guarded. We’re not very guarded about our shortcomings, not like it is elsewhere (1009: 70-71).

Here I can say, like, “Oh my god! I can’t believe that I just said that! I’m really sorry! I’m such a dork,” because we’re all just human beings. I think that we all feel safe because we all trust that we’re all here for the same reason (1012: 120-123). It takes time to reach that comfort level where you can bring things up in front of everybody and not just say behind doors (1002: 272-274). It takes a while until you’re like, “What am I doing wrong,” in front of everybody (1001: 272-274).

Self-Disclosure

Here, if there are things that are dramatic going on in our lives we want it to be common knowledge among the staff. It’s not like I’m just going to tell one or two people if it’s something that’s going to affect my life pretty broadly and could possibly affect my work relationships with clients or the way that I interact with them. I want the rest of the staff to be aware and to let me know if something’s going on that maybe I’m not aware of. “I’m off this week. How this inward stuff is expressing itself? I’d like feedback” (1004: 18-28).

I think that we tend to do that last bit a little more within our departments than with the whole team (1004: 18-28). I am sure that

there are things about each one of us that all of us don't know. That's just the nature of being human (1004: 11-12). And it's just nice to know that when you're going through a struggle, I personally don't need to know but I can at least give you a hug and say "I hope you're having a good day" (1012: 178-80).

Compassion

I do think that people are very forgiving, too. If you need to take two weeks, we'll cover. I mean, that's an emphasis here. And I think the right people end up there who sort of cover for each other (1009: 329-332). I think that when someone knows that you are going through something or you are just going through a day when you're just not as energetic or your preoccupied or whatever, then there can be a concession. And you don't necessarily have to ask but there is an understanding. And that just helps us all to feel supported (1012: 174-177).

Reciprocity

I would never hesitate to call somebody and say, "Do you mind going into my office? Or can you cover for me?" They are all so supportive (1009: 320-322, 330). But I've never heard any resentment being voiced or through body language or anything because you know that they will do the same thing for you. When the tables are switched, they will (1004: 35-37). I've even seen people actually give up their admin time to help somebody and just say, "Well, it's the best thing to do right now. So maybe we'll just make an exchange down the road." I've never seen that before. And they do that, and they have done that for me (1009: 82-85). But I've never asked anyone for anything that they wouldn't do in return (1009: 157).

Accountability

But that doesn't mean that there isn't accountability. Even though none of us ever insult each other or say, "Why didn't you do that?" I very rarely ever feel that way. But there's accountability because we're all talking and working together. If somebody says, "Well, I haven't really worked on that," and then if I say, "That was in supposed to be part of the assessment like we had talked about. Why didn't you work on it?" You just, you just can't really skate on it in that sense either when it's a team. Because we can

all say, “I’m working on my piece, why are you not working on your piece” (1009: 387-392)?

I think that’s the reason for the lack of burnout here and the reasons why we like each other so much. No one feels like they have to clean up after anyone. And I think here, it’s nice that nobody feels like, “Oh, why am I having to clean up for blah, blah, blah” (1009: 434-442).

Interpersonal Relationships and Longevity

There are a lot of settings I’ve worked in where people come and go and come and go. And if you don’t have, I think, at least a core group of people that stay for a period of time then you don’t have that kind history that we do here. And I think the history with the staff that has been incorporated over all the years has added onto the depth of this place (1006: 545-547).

I think that we have just learned to trust that whatever we say is not going to go anywhere else. It’s nothing like, you know, somebody starts and then within the first month the new person would know everything about everything and everybody. Trusting relationships develop over time (1004: 4-9).

The Inexplicable Nature of Transdisciplinary Team Relationships

For people that are attracted to the clinic, I think that social harmony is like a big piece of their lives and I think that it is respected more here (1009: 326-329). Even after people have been here for months and years, I continue to shake my head and be shocked that there are no politics, and no employees having tiffs between one another. There is no need for hard feelings or problems or any controversy. You just work together and do what you can to help patients (1003: 42-43). I don’t get a sense that there’s a lot of people that go around undermining other team members or it doesn’t happen. It doesn’t happen (1014: 242-243).

It’s been very hard to find a word that really fits what it feels like to be a member of this team (1014: 10/7/1011, team retreat). I think it just feels good here. It just feels right. It feels very much like a family here (1003: 36-37), at least for some people. There is a mixture on how people feel about it. I don’t think we try to mold anybody else like us. There’s a lot of similarity here and a lot of diversity here (1004: 125-126). So like, some people may tend to

think of the group as a more of a 'professional family' (1009: 50) or a 'fami-we' (1014: 10/7/1011, team retreat). I get the family analogy but I also get that some team members are best friends and have worked together at the clinic for quite a while but still think of the group as more of a very cohesive team than a family (1009: 50-52).

Someone recently told me that they think that there are just some people on the team who are more 'prone' to developing personal relationships with their work colleagues than others. Like maybe full-timers versus part-timers. Not that that person doesn't think that personal connections here aren't important. That would make the team feel too segmented, you know? There would be too much separation between people (1008: 225-226).

Of course there are some of the staff that feel like there is an inner circle of people that are sort of a 'family' but then there are the 'others'. But even in that situation, they really feel like the people in their own department work so physically close together, like at arm's length away from each other for 8 hours a day, that they have that feeling of personal closeness. Not in the sense that they would want to spend their weekends together or anything, but they feel if they had a problem and really needed help, they could call one of their colleagues for something if they needed to (1002: 306-313). For some of us, some people just don't have family in the area at all, so the people they work with in their department are the closest thing to family that they have (1002: 306-313).

So people may have different ways of viewing the team, but overall, everybody really truly cares about each other, you know? It's not just a job. It's that everybody really, really connects and cares and that kind of thing. And it develops over time (1004: 4-6). So it's about our shared history, the longevity, the respect, the caring, the flexibility and the fact that everyone always carries their own load (1004: 1-3).

And I really, and I tell people this and I know it sounds cheesy, but it's really the people here. So I don't know how you would, how you could hire an OT and a PT and a speech therapist and a social worker and a neuropsychologist and a doctor. It could all far apart horribly (1009: 282-285).

Preserving Social Harmony

Of course, there have been some other personalities that haven't fit very well, like people who are prone to bringing drama into the workplace with them. So if they are bringing a lot of drama, like gossiping about everybody and you are the only one gossiping, when you have this whole group of rather cool-headed team working sort of people (1002: 288-294). And we did have that going on in one of our departments and I think it probably spilled over to into the rest of us. And, I mean, you don't have to be an earth person, but this person didn't have a caring spirit about them. They seemed to present things in kind of a cold way. Negativity breeds negativity. Anxiety breeds anxiety (1004: 81-87).

And if you're not the sort of person that can sort of let go of some of that stuff you maybe did where you worked before and sort of "Oh wow! This is great," and develop a new way of doing things or again, you just probably won't stay very long (1002: 295-297). We don't need this. We'll work overtime if we need to rather than take somebody on that is going to muddy the waters. Some people just seem to have a negative bent to them and they'll find fault with something as opposed to looking for the good in a person. Just about everybody here is a glass half-full person. I don't think that there's anybody on our team that is half-empty (1004: 87-91).

And if you're coming in here pretty impressed with yourself, you don't want to interact with other disciplines (1014: 306-308), or you give off an attitude that you're your own entity or not a team player, it's not going to be a part of the puzzle that's going to work (1004: 47-49). But if you're coming in with an attitude more like, "I've got a lot of knowledge I can share with you guys and learn more as I go along", then you're going to be successful (1010: 207-216).

Meaningful Work

So I really do feel in my heart that this is probably the best place for people to come (1002: 85). And I just know that this is going to be so good for them. That they are going to get taken such good care of (1002: 378-380). At the end of the day, you're going to see real outcomes in people. People's lives are really changed. I don't honestly know if everyone, not every type of person could do this full-time. Sometimes it's frustrating, not the clinic, but we just,

we have such a disparity in people who come in (1009: 305-309). This kind of therapy is not as easy. It's not (1012: 262-263)

And all those people that I get to the point of them taking charge and becoming self-motivating, that's the reason I'm a therapist. That's what I live for. That's when the tears just flow. Or, more of the gooseflesh up your spine and down your arms, you know? I tear up and I think "Ohhhh, they're going to make it! They're going to make it! Okay, they're making it. They're going to make it." I don't think we tear up. Ours pour down our faces. Yes they do (3002: 18-24).

Orientation Toward Health

This is a neat atmosphere that you don't get in the real world in general (1003: 52-53). I just feel like, "Wow, this is a place that's really doing good in the world." And no matter what your job is, it feel like your part of this thing that is really good (1002: 358-360). Working here definitely fills a need for me in terms of being part of something bigger (1009: 311-312). It has to do with the clients, with our colleagues, with the clients and the real reason we're here as folks (1006: 523-524).

But it's kind of hard to describe the milieu here because the therapists benefit from each other. I think it's just the support and being recognized and valued. And everyone loves the milieu and contributes to that, to this atmospheric thing (1011: 66-67). I feel like I am so fortunate to have found the clinic. It feels like a little gem that I just found (1002: 333-334). Personally, I love it here! I really do love it! (1009: 26) I

Motivation

I think the respect that we have for our clients and their systems, I think the respect we have for the staff, and the expertise here is really pretty exciting. I mean even after all these years, I mean the staff that we have here is very, very good. And part of that has to do with hiring, so our administration is very careful about selection with the experience of the individual but also their personality so that they will fit into our system here. I think, also, the expertise and the effort that the staff has made in their career to get to this place, to be here, is a motivating factor as well (1006: 211-217).

And so I think the energy that goes on here and the fact that staff, in their own coping styles, with the support of their peers here, continue, I think, to be engaged in what's going on. I think most of us like to come to work. Some days are better than others. But we are interested in the next client and we are interested in moving forward with even the difficult clients. We are we interested in figuring out another way. We are excited sometimes because we've come up with something that is just so out of left field. Or have simplified and downsized and that has worked. And I think the challenges continue to keep all of us younger in our profession.

It can be very invigorating here and it can be frustrating. But I think at the end of the day the staff has enough respect for themselves and the other staff members that we just carry on to the next case and the next and the next (1006: 232-235). But, I think the efforts from people are, there's still energy, there's still interest. In some work settings I have worked in, the people have dragged themselves to work and dragged themselves home. And I think that people are here because they want to be here (1006: 517-520). Most of us are part-time, but there are people that wish they could work here full-time because they are so happy and so fulfilled working here (1001: 279-280).

I almost get spoiled working here because the therapists are so good and they have that understanding and you don't have to take the time to do as much background education here because they've got such strong knowledge of their own (1001: 136-142).

Longevity

I think it's also a rare opportunity to really work in a place where people have each other's backs and are helpful and enjoy each other. I've been happy to work there for as long as I have. I wouldn't have if I wasn't happy (1009: 38-40). We stay. Ins and outs, ups and downs, we are committed (1011: 67-68). It's not like we all enjoy talking on the phone all day or writing up reports all the time. But there are a lot of things I like about working here. There's so many levels (1002: 332-333). Like the flex time is really great, and people love the flex time here (1011: 138-140).

So I think those are some of the reasons why a lot of the team have been here for so long. They still have energy. There's still interested. I think it's, rehab in general, is a very invigorating atmosphere to work in. I don't think any of us are bored. And I

think all of us are running as fast as we can most days as well (1006: 401-403). Never a dull moment (1007: 29-30).

Loyalty

I think at the end of the day, we all view the clinic as a greater entity. We don't bash on the clinic. But there's just a feeling here that even if you don't like something, you know that what the clinic is doing is good. We all believe that you don't bash on the clinic because the goal is the right goal. Sometimes there are missteps and that's OK and that's not true of a lot of places. I think you just, you have the people that work there and then you have a greater good there and so nobody's mad at the clinic (1009: 332-340). And we all share this common vision, a common view, and I think the philosophy here really is a shared philosophy from the staff's perspective (1006:385-387).

Personal Transformation

I think that what's been so great is that the team could absolutely transform me into somebody that could function here with all the disciplines. All of the team through all the years have helped me become who I am. Because of the kind of people here, they have helped me whether it's advice or just thoughts or just support and I'm so grateful (1011: 159-164) .

Socializing New Team Members

Personal Safety

I think that I was, initially, really intimidated because they have such great experience here that I didn't feel like I measured up as a therapist. But that's the other piece is that they are really supportive and they, you know, every time I would say something, I would get a little bit more confidence because I would get such great feedback from all the different disciplines. "Oh that's a great idea. That's a perspective I didn't have because I don't have your expertise or I don't have your specialty" (1001: 74-79). But I was so nervous anytime I had to speak I would get hot flashes! But then I got to a comfort level where I could talk in front of the whole group or bring something up if I thought I was doing something wrong instead of staying behind closed doors (1001: 267-274). But when you have that interaction with the whole team along with the

therapeutic piece with the clients it helps you grow in ways that you wouldn't anywhere else (1001: 181-183).

So I think you have to learn that communication is everything here. You have to communicate with all the team and they have to communicate with me. And I think that's what was originally so hard for me. It was one of the hard things about working here (1011: 165-167). The communication piece it's just, it's just, as you come in the door as a new staff member, you're just going to be meshed in it (1006: 340-341). Communication is inherent (1007: 301). I mean it just, it's the expectation. It's the plan. "This is how things proceed" (1006: 341). But for the most part, I mean if a staff member is newer or perhaps a little shyer in their personality they may not be as vocal. But for most of us we are pretty vocal and most of us get more vocal the longer we are here (1006: 449).

Communication Systems

You also have access here. The phone system that we have here, in talking about communication, is perhaps different than many healthcare settings of this era. But the voicemail system here works for us. It works for a clinic that is this size and is easily managed once you kind of learn some of the techniques that you need to use (1006: 342-345).

And it's very interesting when we get a new staff member. I remember two people in particular, they're like, "Well can't I just e-mail you and we can...." "Well, emailing is fine, but have you heard about the voicemail?" And so it almost seems archaic, but it started even way back when. So when you have something on your mind, and I mean I'll just dial up so-and-so, put in their number leave a message (1007: 301-311).

Role Orientation

When I first started here I didn't know anything about what the other team members did. I had to read about what occupational therapists did and what speech language did. I had no idea. And part of my training was that I had to sit in on sessions. And that person was like, "That's ridiculous!" And then I went, "I had no idea that's what you did" (1009: 199-204).

When a new staff member comes some people will meet with them and say, you know, "This is my role. This is what goes on," and

give them some parameters on how to contact them, or use them and what we can do as a team. We explain the different aspects of our discipline and all those other sorts of things, like what I hope I can do to be an advantage. And I'll also say, "Hey, we've got this piece going on here and I want to make sure that you're aware of these things." And then part of the process is to really look at the history of this place (1006: 553-557).

And then, after you've worked here for a while, we have people meet with the Director so they can of pitch hit when the Director is away. We just kind of talk about things together like when the clients are first coming into the center and what they need in terms of therapy, you know? So it's kind of learning how the Director thinks (1002: 152-154).

Transdisciplinary Gaze: Zooming Out

When I first started here, I was just trying to do things in line with the other therapists. I think it took at least a year to really understand what it means to be a therapist. Specifically, I think, when you go into a field you focus so long and your schooling is so focused on a disorder and how you fix it but the therapist aspect, that empathy piece doesn't come into play.

I think it's the last piece to develop, that counsellor role that you have to take up in helping the clients cope with living with whatever it is they are living with. I think that's the piece, finally being a therapist, that's the piece that starts to develop. When you work here, you begin to understand it and it does shape how you do treatment. So rather than having the person imitate a movement or something, like those pieces of it, when you're doing that you're not understanding or taking into account the person's experience and what they are actually dealing with (1001: 51-54).

I think that how I've learned was seeing how the other therapists bring the therapist role to the table first and then support it with their skills. That was learning for me. So I think the reason that piece developed in me as a professional is because I work here. I don't think it would have developed to the extent that it is if I had just stayed in a traditional setting (1001: 63-66).

Professional Boundaries, Communication and Knowledge Integration

Professional Boundaries

Personal Attributes Required for Cross-Disciplinary Knowledge Integration

I think that the number one thing here would be a core of people from all disciplines who are committed to this process of sharing our knowledge and our connectedness with the people who come to us (1005: 348-350). Everyone here is willing to move outside the box and do stuff different (1003: 235-238). We are just trying to be creative and do what is best for the client (1008: 142).

But the thing that you'll find here is that we don't have boundaries. And generally that's not a good thing because we're always talking about you need to set boundaries with people. But that's because we're not territorial (1004: 113-116). It's a blurring of professional lines in a healthy way (1012: 143).

I think that the other thing that really separates us is that the goal is for this patient or this client to achieve as much as they can achieve. And we will all do whatever we can to help them and it doesn't matter. So it's not like, "Oh my god, the physical therapist just asked them about their home" It's not like that. Or, "Oh my god, the physical therapist dared to ask them about some activity! That's my job. It's a speech job" (1012: 138-142). And I cannot have my feelings hurt by that if that's my territory and you do that, even if it's a size-y thing, you know? That's my territory if you do that (1004: 110-112).

It's like, somebody will bring something up and I may address it in three or four sentences and then say, "But that's really OT's area, so let's talk to x about that. This is something x can help you with" (1004: 116-121). I'm not going to go into it from a counselling perspective because that's not my job and that's way out of my scope of expertise (1012: 110-112). Or you may do some swallowing therapy but not too much because we have two other therapists here who really specialize in that (1007: 35-36).

So I think there's so much specific skills in some of the domains that like I couldn't do anything with physical therapy or speech things, but the other therapists will come and talk and say, "What would be a good way to assess this?" So it's more just like

brainstorming kind of ideas. There's a lot of brainstorming between the disciplines (1009: 54-60). And since we have many people that also may have some involved mental health components, we have that blending happening that I mentioned before. And then we talk about how we can move about a particular treatment component forward that may be overlapping (1006: 257-259). So there is also a crossing over of the skill sets that embeds it more (1011: 156-157).

So I think that when you're working as a team, your boundaries get a little looser and maybe you go along with something you wouldn't as an individual but it was best for the team and the client (1009: 292-294). And honestly, having been here, I just don't know how you can do that work without mixing it together. It's that building on one another that impacts the therapy we do and the therapy we do impacts that. So it builds on itself (1003: 89-90).

Preservation of Cross-Disciplinary Knowledge Integration

We have people that have interviewed here that haven't worked out. We started telling them, "Oh yeah, some of the cognitive rehab will be done by OT, some by speech, some by psychology depending in the needs." And they called back later that afternoon and told us, "I don't want to interview anymore because cognitive rehabilitation is owned by speech and language therapy and I can't believe that you would be letting other people do that." And we felt that was good because somebody was recognizing what we do (1014: 244-245).

Impact of Cross-Disciplinary Knowledge Integration

I think at a philosophical level there is an understanding of what each other does per discipline. It is. And not just by words. It is knowing that if I've done a shared session with another discipline I know exactly what they are looking for, what they are thinking, where they are coming from. So there is that philosophical understanding and sharing of our information across our therapy specialties (1005: 130-138). I feel so part of the team. I don't feel alone at all and when I am working with a client, I feel like I am working with a team all the time (1003: 59-61). That gives me a perspective on the client that I, you wouldn't have in a traditional practice (1003: 95-96).

Some of the disciplines do tend to be more clinical and non-outside-the-box thinkers. Their discipline is much more practical, real-life oriented. So it helps us. They help round us out and think about ways to work with this person in the real life and these stickler problems that they have and how to get around that (1007: 287-292). So I've tried to learn from the people that were therapists who are working outside of my realm to try and figure out what was going on with the client (1014: 195-197).

And when you're getting enmeshed in a situation that's so difficult and so complicated with clients sometimes you do get the blinders on and you're just looking at your discipline. But the opportunity here is to look at the bigger picture and to see if there isn't a different way (1006: 421-424). So if you're a counsellor, you're the mental, emotional angle, but I just, and I'm guessing you would get this from all of the therapists too that there is just so much mind/body connection and there is so much about rehab that is psychological, that is mental (1003: 271-275). We have that blending happening (1006: 249).

Understanding and Managing Complexity

I would say probably clients that are seen with multi-disciplines, that indeed are more complicated in their psycho-social needs, are families that are in distress and, again, are particularly challenging for our staff (1006: 64-66). And when you're dealing with a complex client the key is to just start talking (1005: 194).

We don't kind of trash basket people like when nobody wants them. At the clinic if there is a complicated case they'll say, "Yeah, let me look at that. Let me see if I can try and figure out. I'll take your assessment and I'll take this person and I'm going to try and figure it out" (1009: 417-419). That's why I like this kind of work because I feel like an investigator. OK, send me this person. What's going on? Why are there so many problems? So we can kind of tease things out a lot of times (1013: 98-102).

And it oftentimes it's those complex cases where everybody is just grinding away, grinding away, grinding away, and difficult client, difficult family, difficulty diagnosis. I mean it can be very invigorating, it can be frustrating, but I think at the end of the day the staff has enough respect for themselves and the other staff members that we just carry on to the next case or the next case or the next case (1006: 227-234). And here are a lot of complicated

cases that we will talk about again, and again, and again, and again as necessary (1006: 286).

Sometimes we table things also. We may just all be exhausted with a particular case, let's talk about what we can today; let's make a decision about what we can do with this part and let's put them back on the list again in another week and let's think about some other ways. And in the meantime, let's have two of you try this, that or the other thing and then come back (1006: 424-428).

So if a therapist feels like they are struggling with their progress and they can't understand why, someone will go in and we will work together to figure out what other sorts of emotional or social kinds of aspects are interfering with progress. I am very aware of the fact that the client's doing PT and OT and all the different therapies and that it is a process of helping them get better and move on (1003: 59-63).

I guess you could say that when we're working with clients it's really an interface of us collectively, as well as individually bringing what we have to the lives of these people, so that they can move forward and heal, and be back to life as they have known it before as close as possible (1005: 57-59). And that has just been developed over a process of time (1005: 154-155). Umm and I'm just one piece of that (1003: 63).

Team Communication Patterns

So there are a lot of opportunities for people to have a dialogue with the team and listen to other staff members because there's always more out there, there's always another thought, there's always another way to do something. On occasion people can certainly get sidetracked, but we still can get back to the main issue of why are we here, what are we doing, and how can we best manage this very, and it's oftentimes that complex case (1006: 224-226). So the opportunity to have access to other staff is a huge, huge issue (1006: 252-253). And the therapists are amazing about talking to each other (1009: 80-81), especially when we have cases that are really challenging.

The staff are continually checking with each other. You know, "What's happening? What are you doing? What are you seeing?" Sometimes that's by voicemail, sometimes it's person-to-person and then we have our designated meetings times (1005: 196-199).

And there are also a lot of mini-meetings that go on for people also to look at another way to do something aside from our gatherings that we have (1006: 250-252). And we'll all huddle and say, "What do you think about this," or, "There's a new idea about that," you know? There are just so many little conversations that go on and build into everything (1011: 82-83).

We have a sign-up sheet in the chart room for the weekly staff meetings. So if I just had a difficult visit and, "This is what I think we need to do but I need to talk to you all further about it," signing up is setting the stage for that. So we can go quickly into the chart room and write down so-and-so's name and then talk about them at the meeting. It's a pretty easy, fast simple process (1006: 369-373). Most people have a pretty good handle on what is going on with all of the clients and what they're doing so we don't oftentimes have to have really elongated discussions (1006: 131-133).

We also have our own voicemail box to leave messages for different staff. So when you have something on your mind or you just had an idea on how to address the patient's 'whatever', or remind another staff to do something I can just dial up that person. And I don't mean to make it sound like we're in our little box and we're not going to go out and talk to the other person (1007: 301-311), there's a lot of individual contact too. You've probably seen staff grabbing staff outside of the restroom, down the hall, in the chart room, or under the tree outside. Whatever we need to do to get around some of those details and get them taken care of. That next step that needs to take place. Are we still moving the client forward? Is there something else that needs to take place? Are we getting stuck in what we're doing? (1006: 238-243).

The Client's Voice

And we also have the playback of the client that is, again, in distress in some way, shape or form going through whatever they're going through and sometimes there's push-back around those changes that may need to happen and the emotional side of what's going on, the psychological things that are going on. Or sometimes we have pure communications around, "Did you speak to so-and-so's wife? Is she on board about this, that and the other thing" (1006: 245-258)?

Transdisciplinary Therapy, Roles and Practices

Factors that Facilitate Transdisciplinary Therapy

Organizational Support Structures

In addition to the philosophical understanding and sharing of our information across our therapy specialties, functionally, there is the opportunity in the setting to treat together. The scheduling can happen and there is permission. There is a way to make that go. That doesn't happen in a usual therapy realm. I don't even know how the system could deal with that. We have to make that happen. It is hard; it's swimming upstream; we have to make that happen (1005: 137-141).

Professional Competency

But I think that's kind of the secret and the key to this place is that we're all really good and really skilled in our individual areas, but even before that because we've got so many staff members who have 20, 30 years of experience under their belt and they've seen the ins and outs of the therapeutic process. They know all these different pieces. And I think that therapists bring that to the table first and then support it with their skills (1001: 66-70).

And I think that when we can be flexible in their roles I think that kind of adds, that's fun! It kind of adds a little color, a diversity to what we do, right (1008: 96-100)? I mean, I'm not going to go into something from another disciplinary perspective because that's not my job and that's way out of my scope of expertise, but I don't think anyone on our staff is afraid of getting their hands dirty (1012: 103-114). I guess I may be comfortable in my ways, but maybe I do step out of the box more here (1008: 102-104).

Support Roles

There are other things involved here (1006: 550-551) and a lot of support roles that multi-task. I mean, there's just all this other stuff. And the front desk staff, the records people, the billing people they're seen as much as a part of the team as the therapists. I don't think there is any differentiation in terms of hierarchy. And I think that really contributes to the whole feel of us working together as a team kind of aspect. That's all a big piece, a big part of it, too, to include them (1003: 279-284).

The staff does a lot of connectors here depending on what is needed. We may go in and out of all kinds of different things. We check in and out. We might connect staff with the client, with the family depending on what's going on with the treatment plan. We may be very engaged with a client, client system or in the background orchestrating a variety of things that may need to happen. So it could be active kinds of things or peripheral kinds of things.

We may be band-aiding some things along the way. Sometimes there more things we can control than what our staff can control. Sometimes we're on the phone all day long making sure that so-and-so has thought about this and that. And we'll go ahead and take care of this so that it will save a staff member time because they're seeing people back-to-back. Our schedule is much more fluid so we can go back and forth between what goes on in a much easier fashion.

We have the opportunity to fit in many places and that allows an opportunity to hear lots of information and things that need to be acted on aside from the staff always being vigilant. So we interplay with some of those things, although staff still has responsibility, each one of them, to do many things. But sometimes we'll field phone calls from staff and say "Can you help me with this," or "We talked about this, could you clarify," or "Do you have another thought," and then you just kind of move through that. Or we may be contacting the referring organization on behalf of a therapist (1006: 4-14, 152-155).

We also have people who can step in and do some general counselling if something is going on in the family system if the counsellors here are busy doing more in-depth coping work. And we make sure that we're catching the client at that point in time if they're in some sort of a crisis situation. Perhaps their marriage is falling apart, kids are leaving or the family's not able to tolerate what's going on with the change in the individual as they're moving forward in their recovery (1006: 34-38).

But because we're smaller, we don't have that additional staff that you might have in a big hospital, so the staff has to follow up. They have to make a lot of phone calls with the client's family and the rehab specialists involved with the driving program has to call the about licenses themselves. And it's not easy when staff is

seeing clients back-to-back, to have the time to be able to make those connectors, to write letters, to do whatever they need to do to make sure things are faxed. The fact that our clinic is smaller, that we have a campus here, I think lends itself to all those other needs (1006: 353-365).

Duration of Therapy

I also think that the involvement with them is at a different level because clients come here and spend the day or a big part of the day here. I do my hour of therapy, but then I am going to see them in the waiting room as they are getting ready to other therapy and I can ask them about that and how was, are they tired and how is that? Whereas if I happen to be working with a client in private practice who is doing PT across town for something else, I may or may not be aware that they are doing PT. I certainly wouldn't ask them in the midst of it. I would not be involved in the rest of their, their daily activities and treatments and those kinds of thing (1003: 73-84).

Client-Centered Therapy

Modified Evidence-Based Practice

I think the idea that the client is a whole person and a real person is a big part of how we do business here so to speak. And I think I see that here more than I have ever seen anywhere is they are not just a number, they are not just a patient, they are not just a disease or an injury, but they are a human being who then is seeking treatment (1003: 124-122). From early on we couldn't just say, "Have him come in here and just do this little rote thing every time." It has to be related to the world (1007: 181-183). There isn't that cookie cutter approach here. There isn't that cook book sort of approach. We don't have a standardized plan. Thank God! That would not be our model (3002: 267-271). The purpose of what we're doing is to help the person and to help them achieve a greater degree of independence or better life quality or whatever it might be outside of therapy (1001: 7-9).

Therapists very much put the client first (1009: 142-243) and I guess that's what I think client-centered is. It's going out of things that are comfortable because that's what the client needs. It's easier to do your regimen for everybody. It's just easier because you just do

the same thing for every person. But the fact that therapists will flex for every client that comes in is amazing (1009: 165-167).

We're not like an ortho clinic where there is a protocol for your knee replacement. Like, "This is what you do," and then you go home and do it (1012: 261-262). So I feel like every therapist has a standard protocol, standardized care plans related to the diagnostic component (1006: 295-296; 1009: 143). But a standardized 'approach' hasn't been something that's come up in the vocabulary. Well, I mean the therapists have it and they would like to do it, but they also realize it's a different population (1009: 143-144). There are different neuro diagnoses we see and there's a big cross-section of different kinds of cases (1007: 33-34) so there are a variety of progressions and interventions that can make a difference (1006-181-183, 188).

The work that we do here is very unusual that the work isn't just cut and dry. Like the particular injury or the particular illness where there is a cookie cutter solution to it. Occasionally somebody will come in and they just have a bad foot or something and they really, that's really all they need and all they want is a little physical therapy to take care of it. But I think in general, it is bigger than that. It is more about treating the whole patient and treating them as human beings (1012: 197-200).

And so sometimes in order to treat something in the best way for that person, because it may not be that we are going to resolve it completely, is to ask, "So to what degree are we going to resolve it? What's the ultimate goal and are there other avenues to reach that goal if we can't actually cure the illness or fix the injury?" So I think that is the biggest way that we can help people find their way through their problems into the future in a way that is satisfying for them, but there's not just one way to do that (1003: 156-152).

So I feel like all of the therapists will very much modify that for the person more than I've seen anywhere. They really work with them (1006: 295). Not one person has the same situation or problems they are bringing. One stroke is not the same as all other strokes. There are so many other dynamics certainly in areas like therapy and counselling and there is always the ability to try to customize what you are doing with clients (1008: 125-126; 3002: 281).

Like in one of our cases, one of the therapists decided, you know, "I need to back off a little bit. I need to take my physical stuff to the background and let counselling come to the forefront and work more on PTSD and some emotional and behavioral things and get that started." And then the therapist scooted back and when it was time increased their frequency. So you adjust the doctor's orders, you make sure we're still following a plan legitimately, but it's better for the person (1005: 200-205).

So we do have adhere to standards, keep abreast of the literature and we do have to follow best practice guidelines and research but it's just that everybody's different so we bend the goals and objectives to meet the client's needs (1007: 33-42). There is also kind of theoretical orientation in some areas that goes across all kinds of presenting problems, too. Like cognitive-behavioral is very skills-oriented. Some of it is educational as well. But it's skills-based training that almost everybody can benefit from some exposure to (1008: 52-54).

And there are lot of theoretical theories that use the team aspect, like reflecting teams. So I think this kind of practice fits well with drawing on theories like marriage and family therapy, systems theory and even coaching theory if you're a counsellor. But things aren't exactly like 'this' or 'that' particular situation, so there is also a lot of making it up as you go along (1007: 111-115).

And I also think that the client's personality piece, how they got there and the diagnostic component, both of those avenues are important. The percentage would really be up to the therapist and how they felt that needed to move forward as well as the client because the treatment plans are ongoingly discussed with the client as well as the family members depending on how involved they are or not (1006: 297-303).

In the end, I think that the challenge of rehab is really continuing to look at how to do things better. How to make the changes. How to stay focused. How to still use the basics (1006: 515-516).

Client-Centered Co-Treatments

Co-treatments are so viable and we've come a long way in combining those in lots of different passions, very different passions than the traditional that you would see in, perhaps a hospital setting (1006:206-208). Developing new co-treatments has

been awesome. It's like, "Let's do a joint session! How can we make this even better than just the two individual parts" (1013: 150-151).

How we co-treat depends on the client. There are sort of two pieces to it. One is in the room where a PT might be talking through an exercise and then a counsellor might step in and start talking about or dwell on some of the strengths that the client had in his or her job. You know, "How did you do this when you were there? How did you feel about that? What did you do when you were there?" So we will tag team kind of, sort of work together for some success in that (1003: 99-109).

For example, sometimes an OT will say, "I'm noticing some vestibular issues with this person who has a head injury and I really would like to see if we can take that into more of a doing realm and get a little more active with that." So they will meet up with the PT, they will schedule to have a shared session. They will take an existing schedule and remodel it so that they can get together and see the person at the same time (1005: 130-137, 157-169).

People used to come to the table and say "I'm doing this type of therapy and it's so obvious that this person isn't ready. They can't do this yet because, emotionally, they're so wrapped up in what happened and how their life has changed that they can't. So we need counselling. We need you to help me with that." Or, if they can't get in right now with the counsellor, "What you suggest I could do in my sessions to allow the, then, to be able to partake of the therapy that's going on" (1005: 200-205).

So if someone is having trouble after a stroke, counselling might get involved in the PT office to bring in the counsellors desensitization language conversation they had with the client as kind of a supportive piece. So we apply some of the conversation that the client and the counsellor had about maybe walking anxiety into a kind of real life situation. It's important to do that so the PTs will recognize and use the language that the therapist may have been using with the client. Kind of have a construct or a mind-set that both therapies are working at the same time (1008: 106-114).

In one of the cases, one of the therapists decided, "I need to back off a little bit. I need to take my physical stuff to the background and let counselling come to the forefront and work more on PTSD

and some emotional and behavioral things and get that started.” And then the therapist scooted back and when it was time, increased their frequency. So you adjust the doctor’s orders, you make sure we’re still following a plan legitimately, but it’s better for the person (1005: 200-205).

And the other thing that’s nice is when they come back with the other therapist in the room the next week or whatever, the therapist can say, “So when we were working on the treadmill and you were struggling with this? Let’s talk about that a little bit.” You just can’t really do that without being there. I can just say, “So how’s the treadmill going?” But that’s just their subjective report of that as opposed to, you know, I saw it. I know what was going on (1003: 99-109).

And I think it’s unique here, like maybe bringing one of the counsellors into a physical therapy session or whatever. I’ve never seen that before, those two things coming together. It’s a co-treatment which I think is really neat (1002: 75-78). Or a model we have developed is for what we call an hour and a half merge. So you have 30 minutes of the person individually seeing one therapist, then the middle thirty minutes is with two therapists with them sharing, and then the last is the other therapist. So it is this kind of shared process. But we have to work really hard to make that happen. It happens. We do it. It’s just that I think everybody feels like you get more benefit out of that than by not (1005: 130-137, 157-169).

Group Therapy

I think another angle is groups. I know for example that the hospital on their rehab unit, they have a music combined PT group. And I think that’s about as far as it goes. We have been so good and so creative in our out-of-the-box thinking, that we have been able to develop groups for small amounts of people. Literally sometimes three people, that’s our rule. Three people can be a group, plus the staff. And it can be anything from an OT and a counsellor having a group with women on women’s assertiveness issues and how after chronic illness or injury, how you pull back into that in your life.

Then we meet together once a week. And they have homework and they have agendas. It’s a working group. And this is not an insight-based psychotherapy setting, this is a doing and reflecting,

“Let me tell you what works for me.” So they are supportive of each other and some accountability. So everyone is sharing, “This is what I would like to accomplish.”

And we have had OT and PT working together on sort of a commit-to-be-fit process. So people 6 to 8 people will get together in a group and share across types of diseases or injuries in terms of what makes it work for them. And they look at nutrition, look at time management, stress management, look at abilities, and set your goals and decide what it is you want to accomplish in the week and holding each other accountable so that the therapists are there to facilitate and guide and structure and provide resources as we need to (1005: 307-333).

So the groups start spontaneously. That’s exactly what happens. We determine what, based on our people that are in the program. And we will be talking and that’s why the therapists have to be talking because you don’t know each other’s patients. So, “Let’s go and see who else we can get to join us.” It’s not there in the traditional model that I know of (1005: 335-338).

Understandable and Meaningful Outcomes

There are real life problems and real life situations that they are dealing with and learning from, kind of simultaneously, that they are doing in therapy (1001: 191-193). You are hoping for people to improve and get better and stronger and take on more stress (1008: 49-50). And while the clinic can’t completely fix your problems, they can teach you how to function with what you have now (1002: 109-113). We do what we can to make this meaningful for them and to show them some gains and move them along, so we do quite a bit of brainstorming around that (1007: 2441-243).

After we have our first session, I have a debrief session with them. And we go over in detail what that means and what the results represent and how we get to those and what that means for them. I’ll tell them the reason they are being recommended for therapy. The goal of it is that they get it and this is absolutely related to life (1009: 235-245; 1007: 283). And we use language for a 10th grader and up. We very much sort of make it for the lay person. And we’ve done this for so long because it just stemmed from the foundational leadership (1009: 242-243).

And so they may have felt like they're having all of these horrible problems and then I'll show them instead of this global, "I'm falling apart," you tell them that this is real. "Do you understand how this can't be because you can't do it," and they get it. We'll often talk about if you can change some specific things in your day that hits home to a lot when they see. And when you show them you can actually fix that. You could fix this whole problem with giving yourself a little more time I think it's very tangible to them. So part of it for me is like, "I don't have time to do this every week," so it's about making them see why therapy's needed. And I think for a lot of them it's an impetus when I explain that, "You could get this better." I think they would feel stupid not doing therapy if they could get better. So for me it's sort of two-fold. That it helps them I think the moment they leave, but then, more importantly, it gets them invested in why the therapy is so important for them (1009: 257-280).

I think where we excel at is enhancing the confidence and ability of the client and their family to identify and maximize their strengths, resiliencies and resources. When a person has a pull towards illness they have so many overwhelming things but we have got them facing the right direction. You've pulled him back. They may not be moving very much but they're re-oriented towards health (3002: 118-119).

Our goals for the client are about empowerment and growth, client-centered growth (3002: 448, 450). So I think that here their improvement is more, they own the process, and they are much more ready to return to life than we ever left them in the past (1005: 112-113). So when an adult who always stood up to dress and put their pants on and they couldn't do that and now they can. And they feel more like themselves and they care and they are safe and they are independent, you know? "I can do this the way I used to" (1012: 217-230). So it's like, "How can we help with this" (1012: 219-220).

Therapeutic Relationships

Power Sharing

I think if I was going to tell a client what we are all about I would probably say, "We are going to partner with you. Our main goal is to be helpful and to help you function better in the world in a variety of avenues. We are going to look at you in a holistic way.

That means with sensitivity to a variety of dynamics and pressures that a person has and also in a terms of the functioning of the mind and brain together. So that will involve therapies that integrate the brain, body and mind” (1008: 188-198).

*But I think the thing has to be emphasized is we provide the opportunity for a person to be a member of the transdisciplinary team. Some people will not do that because they don’t have the ability to do so. Some people will not do that because of various aspects of their personality which either prevents them from interacting in that way, or sets it up so they don’t want to be that kind of person, so. But the **important** thing is we give people when we would do a de-brief or give them a patient handbook, we’ve always said, “You’re a member of the rehab team. You’re a part of that.” So it’s kind of like, the opportunity’s there but some people either may choose not to be part of it or they may have some aspect of their past history or the culture or whatever or their generation or whatever or something that prevents them from interacting in that way (3002: 197-207).*

We’re not here to rescue folks. We certainly can do a little magic here and there to perhaps reduce the stress level, but the bigger theme is that, indeed, they got into that situation because of this, that or the other thing. How can we even it out for them so that they can go through their recovery (1006 126-130)?

The Client’s Role

I think when they first come in we’re driving the bus because we’re doing the assessing, we’re teasing out their strengths and weaknesses, and then we as the therapists are developing that initial treatment plan (1007: 126-128). Or in co-therapy, both therapists would work to come up with the plan (1005: 180-181). But based on our first meeting this is my take on what, in my professional judgment, what we need to addressing your therapy to make you better (1007: 136-139).

And so once we develop that, we sit down with the client and we go over the results of their testing, where their strengths and weaknesses were. And then we show them the treatment plan which includes their long-term goals and short-term objectives as well as their frequency of therapy and how long they’ll be coming, the duration of therapy (1007: 126-134).

One thing I try to tell them, “We as your therapists, have all this experience in devising treatment plans,” and I said, “That’s what we have done. We’ve devised your treatment plan and I’ve put my or our input on what we think.” But I say, “You are the CEO of your treatment plan. So, you let me know if there’s something I’m not addressing that should be, or something that you quite frankly don’t want to address.” I think that’s the term that we started using years ago. The client is the CEO of the treatment team. So we try to get that to them (3002: 256-264).

And those are the terms that I use. I say, “So I want to make sure I’m covering your needs, what we need to focus on and this is changeable” (1007: 136-137). So the treatment plan is something they can then grab and they can generate what they need to be able to do better on their own because of the scaffolding that we provide (1005: 205). And they need to own it. That’s a term we float around a lot (1005: 205-206).

And most important of all, they need to tell me if what I suggest works. If it doesn’t work, why? You can always say, “I hate it.” Hopefully you’re gonna say it before I give you a sheet because I don’t wanna waste your time that way. And I say to them, “There are reasons why we don’t do things. We don’t like them, we don’t know how, or we don’t have the tools. Those are the reasons.” So I said to them, “If you don’t do something that I’ve asked you to do, let’s figure out why. Maybe I gave you something completely inappropriate for you and your lifestyle,” and I can take that (1012: 286-295).

On occasion I’ve tried to push somebody to be part of the team and decision-making and it just doesn’t happen (3002: 224-225). We’ve all been there and that’s kind of really painful but that’s part of your job and you’ve just got to do that (3002: 226- 228) But sometimes I just didn’t know where the stopping point was, but they let you know (3002: 229-230).

And I think that the therapists know better than to stick to their guns in terms of using a standardized approach. They’re amazing in that sense that the therapists, the folks with whom they build rapport and build a connection. And there are some that I’m thinking, “They’re never coming back,” and then they fall in love with this therapist and they’re like “You’re helping me,” and they come back. And that part’s amazing to me (1009: 172-177).

Accountability

I think, I think that we really do tell people when they come in and we talk about what we did in last session or whatever, and I always say to people, “ your job is to come in for the scheduled appointments, cancel within 24 hours notice when you can’t be here” (1012: 286-288). And, like I mentioned before, we fill out little sheets every week about, “This is what I’m doing with this person,” or even to know this person no-showed. Those things are very helpful to know because I’ve had clients who lie to me. And then I pull out this sheet and I say, “That’s amazing, because you no-showed here and you no-showed here.” And it puts some accountability and I think on a lot of people who have been in the traditional system, nobody keeps tabs on you. So, I think it’s good and bad for the clients. But in general it’s good. I mean I think they don’t like necessarily knowing we’re all talking about you if they’re messing with us (1009: 374-382).

Providing Feedback

The only things that I hear complaints about are like therapists not returning phone calls quick enough because they think they should just be able to pick up the phone. But I don’t think I’ve ever heard a complaint about the actual care they received in terms of, “This person treated me really bad and now I am worse” kind of a thing. It is kind of more like, “My appointment got changed and nobody told me.” But then the kind of stuff you hear about might depend on what department you work in (1002: 245-253). But we do get on our feedback surveys that people feel like we are communicating. They feel like we are sharing information amongst each other (1005: 153-154).

Disciplinary Boundaries and Role Diversity

Professional Boundaries

I think our relationships with clients is a little more relaxed than you might find, in a different setting. I don’t know exactly what it is. But, we do get to know the whole person. Kind of, how they were before and what’s brought them to this place and stuff like that (1004: 147-148,150-153).

I mean, you’re never friends with your clients. My clients are not going to be my new best friends, and we’re not going to hang out.

But, I might say, “Why don’t we get together over coffee after you’re discharged and if there’s any loose ends we can tie them up” (1004: 128-132) or we might take them out to celebrate a birthday if they are ready for discharge. And we’ve all given people rides places. It doesn’t happen other places (1004: 128-132).

While I do think that professional boundaries are important, I also think that it is important that my clients know that I’m a human being. My recipes don’t always turn out well. I’m not always on time for things, and I think those kinds of things. And because they see those things in us, we’re giving them permission to not be perfect. I think that helps too. I don’t think we know everything that is a benefit or a barrier to them but I think that we know more than most places (1012: 90-94).

So while it’s still professional, I think we all wax and wane in reference to where we need to draw the line with our clients. I think we have worked very hard to make a friendly atmosphere here. I think the distance that most professionals have with their clients, their patients, I think is different here (1006: 527-530), you know? I think our relationship with them is a little more relaxed than you might find at another therapists office (1004: 147-148).

Therapy Advocates: Counsellors in Disguise

Well the one thing that we did that I think is, I love the idea, we’re still working on utilizing it. The counselling staff worked together with the Director to come up with something we call therapy advocate. It was something that we made up that works great (1003:185-186, 202).

So we would come to staff meetings fairly regularly, struggling with a client who could really use counselling, but is very resistant to counselling. So if they ever do decide that maybe counselling would be okay, they know they have connected to somebody. Or a client who is doing okay, doesn’t necessarily need counselling, but they have a lot going on here and they are a variety of things with different disciplines (1003: 181-184).

And so we will assign a therapy advocate to a client and that counsellor would set up a session as a therapy advocate and meet with them as opposed to a counselling intake delving into, “Okay, are they depressed?” They get to know them and talk to them about what therapies they are doing here and how they feel things

are going and what are their struggles with those particular therapies. And then they will try and go and sit in on one of each of the therapies and kind of observe how that is going. And then maybe a month later, check in with them again and say, "Okay, how is that going? How do you feel? What is your relationship? Do you like your OT? Is that a good fit for you? Personality-wise, is that working" (1003: 181-199)?

So this is a different role to go in and meet the client and be chatty that counselling title (1006: 171-172). And so having a sense that, "Yeah, if we could just have them open to the possibility then let's see this." And the trial oftentimes is a good way for people to feel a little more comfortable in going there (1006: 286-288).

Or if a client isn't comfortable telling something to the speech therapist for whatever reason, he could come to the therapy advocate to help facilitate that conversation. So there is that role and it works the other way too. If the client says, "Boy, you know, I just feel like I'm not getting such and such," because that would really be of the OT and not the speech therapist. "Let's get you in step with some occupational therapy." So you can play that role.

And there have been people too where just through those 2, 3, 4 meetings now they know the counsellor and they're talking to their PT and she is like, "You know, that really would be something the counsellor could help you. And the therapy advocate is also a counsellor." And then that's a nice easy transition because they already, it's not this new patient and they have to tell their whole story again and all that. We don't have the same duplication of services here that burns patients out. We also talk, we fill out little sheets of paper every week about this is what I'm doing with this person. And that's been very helpful to know this is what's happening.

And so it is just a little bit of a different focus, but again the goal is to help them be more efficient and more productive in their therapy (1003: 180-216). And we are trying to bring people and desensitize them to the whole conversation of psychological-emotional issues that is impacting their rehab or the neurological pieces of it. It does work (1008: 97-99).

I mean, you do have some who they don't really need or want things like counselling therapy and they never do evolve to that (1003: 204-205). We have many clients still are very concerned

about having that in their record that I've seen a mental health counsellor, or a licensed professional counsellor or a marriage and family therapist. They don't want that label. Or, perhaps, older clients oftentimes just don't want to have a thing to do with a mental health therapist. And so some of it can be just old myths, some of it can be, perhaps, some past history that may have been difficult. And so, we're just trying to come up with some other ways. And again I think part of the motivation of the staff is being quite creative. There's many, many ways to drag a horse to water. At least we'll try it. We try those and most of the time they work (1006: 274-281).

The Transdisciplinary Gaze: Meeting the Client-in-Context

When clients first come to the clinic, when people are needing therapies and we're deciding who they are going to be seeing, often times it is just based on what therapists has openings. But sometimes it's like, kind of a personality thing. Like we'll talk to somebody and be thinking, "I think this person would go really well with so-and-so." Sometimes it's only based on brief telephone conversation and who knows how accurate it is, but we all do that (1002: 273-281).

So I think people here listen really well to their patients. Therapists to get to know them whether it is physical therapy, occupational therapy, not just in, you know, counselling is kind of obvious. We get to know your background and we get to know who you are because that helps us treat your emotional world. I think everybody here gets to know their patients and listens to them and learns who they are because I think that affects the kind of treatment that they are going to receive depending on what their goals are and what they really want from the treatment no matter what that is (1003: 376-380).

I think the idea that the client is a whole person and a real person is a big part of how we do business here so to speak. And I think I see that here more than I have ever seen anywhere is they are not just a number, they are not just a patient, they are not just a disease or an injury, but they are a human being who then is seeking treatment (1003: 124-122). So, like, even the front desk staff talk to these people on the phone, kind of a little brief connection with then, you know? They really feel for the people that will tell their stories (1002: 376-378).

Social Environment

We also go to clients homes. And when I go to somebody's home, and again, not that you HAVE to go to the home because I've said to people, "Bring me pictures." When you go to someone's home you get to know what interests them. You get to know what their passions are. You get to know how they do things or why they do things that you would never get to know in a clinic (1012: 273-284).

I think in that because we go to their home, I always tell them "Don't send your kids off. Have them be there. I wanna be able to meet your kids and if your spouse can be there that's great, too." So I think in that respect we can and very often we become much more intimately involved with our clients than most places. And so I think that they generally feel much more comfortable sharing things with us than they would in a lot of other settings (1012: 90-94).

And sometimes if people have personal issues, I might tell them, "You know, I'm helping you to deal with all aspects of your daily life and things like intimacy is part of that. So if that's an issue, as another human being, as an important event in your life that impacts everything that you do then whatever you want to share with me will help us move forward" (1012: 103-114).

Cultural Beliefs and Social Support Systems

I think just the nature of what we do is more than just physical actions. Like the act of it's the act of eating meals with other people. Connecting with people over food is such a huge part of our culture that when somebody has difficulty and they start to isolate and they lose that part of their life or say they are on a feeding tube and they can't eat meals anymore. And family is just naturally a part of that.

Usually, the spouse is the one also preparing the food, preparing the meals. We do a lot of education on what types of food to be providing and how to prepare and how to thicken liquids if thickened liquids are needed and that kind of thing. So in that realm, that's why family is naturally a part of it. Also, we teach them what to be watching for in terms of difficulty and how to prevent difficulty and that kind of thing (1001: 237-246).

Cultural and Societal Beliefs

Our clients are fighting this cultural belief that they grew up with and many of them grew up in homes where, “It doesn’t matter, you do it. This is what you’re supposed to do.” So they’re fighting all of this and yet they can’t get over the fatigue and they don’t understand it (1012: 252-253). And I think it is a challenge because I don’t think the world understands really that this always takes a lot longer when you’re dealing with the brain (1012: 229-230).

So we always tell clients that therapy takes longer because it’s your brain because clients don’t get it. They expect things that they’ve heard or read or just from life in general that, “I should be better right away and when I’m not I feel discouraged.” I always say to them, “If you broke your leg the doctor would immobilize your leg in a cast for 12 weeks or 24 weeks and you wouldn’t use that leg. We can’t do that with your brain. Your brain has been injured and it’s constantly working. We have to give it that time and a temporary cast, which is sleeping” (1012: 217-235).

Financial Circumstances and Access to Health Care

People are investing time and money in therapies. A lot of people are taking off of work to be here, you know? They’ve got mounting bills already and some of them don’t have extended health coverage for alternative therapies or therapy from allied health people like physiotherapists or chiropractors. So they end up having to pay a percentage or all of the cost for each and every therapy they are doing. So when they are making this big investment in this therapy that they are not even sure what it is, so we want them to feel that that recommendation for therapy come from people with 20+ years of experience (1002: 192-200).

So the client’s financial circumstances are taken into consideration when we’re planning therapy (1003: 170). Do they have the finances to by the food that they need so they can make the meals we make here (1012: 234)? And if the people are worried about money or food or need a place to live or if they got laid off, or whatever the case may be. There may be some things that we can do to make that more palatable while they’re trying to carry on in their situation here. I mean, Transportation is a huge issue. It can be very minor to many people, but it can be a major issue if you don’t have gas money or if your car breaks down. Or if you have an

older person and three appointments a wee, as in three days of appointments to make a difference in your rehab (1006: 105-111)."

Navigating Strained Relationships

There are sometimes the therapists have to sit down with the other team members and say, "I hit a wall. What do you think?" And so if somebody's having a hard time with a client, we will be respectful. We're pretty respectful about saying, "I don't want to have this meeting with this person. I don't think it'll go over well coming from me. Do you want to bring it up?" And it's not one person gets, slammed with everything. It's really because I feel like, "Wow, this person likes you and they don't like me so I think it would come about better." It's just a lot more of that than everybody trying to do the things that would probably not be best for the client (1009: 62-69).

The Therapeutic Social Environment

When clients come here, I think it's a little bit of that family atmosphere like they belong here. This is their place that they are coming to get better and I think they take ownership in that and so some patients come here and spend the day or a big part of the day and they are doing their different things and they are coming and going (1003: 73-76).

I think that this place is really special that way. Patients feel like they belong here and this is their place as much as it is, it's not just some place they come to get treatment. And so they are so many patients who stick around and do volunteer work after the fact and be involved here in different ways, even beyond their treatment. Some people are so passionate about the work that was done here, that they've connected and involved ever since. I don't think that would happen in a hospital rehabilitation. I think there are different factors right. I think that the whole personality of this place lends itself to that. But I also think that, my guess is, the bigger you get the harder it is to end of those kinds of connections. It's probably a combination of things (1003: 22-34).

I don't think the boundaries are not as strict here between patients. I mean, of course I don't talk to one patient about another one or anything like that, but I mean they build relationships in the waiting room (1004: 144-148). People come in and they say, "Hi"

and they, you know, there's a lot of people will say they're just, they really come here because they're comfortable there. And they'll come half an hour before their appointment and say, "Hi" and chit-chat with staff and with each other (1009: 397-300).

Overdependence on the Clinic

Does the whole team together provide more benefit than just 2 or 3 team members individually? I think so. I think it's unsaid that maybe that feeds back to some of the clients who become over dependent it feels kind of like a family. And there is a lot of roles. It is not just the relationship with just one person, it's kind of the relationship with the whole center (1008: 219-222).

The atmosphere that's been created here for the clients does feel homey, relaxed and non-clinical for the clients. It's clinical behind the scenes of course (1011: 64-65). And I guess I would say there is a sense of belonging that is such an important piece of all of our emotional/psychological development. There is a sense of belonging and safety here. And that becomes engraved in identity as well, "This is what I do. This is my role in life, being the patient and needing a helper." You know, thinking about one in particular, I haven't treated but we have talked about before, that he is I don't know all the details, but he is basically through his rehab but hasn't been able to jump off and have and create a social life or a family life very much on his own. So I get a sense of that this sort of fills that sort of need for him (1008: 200-206).

For some people, I don't know if it's fear of, "Okay, if I'm going to be discharged that means I am losing this tie. I have to then live my life without the support of therapy." So I think it's more of like a scary thing for them to think that they won't have this support. But I also think it's also a sign with some people like, "Oh, I'm at the end of the road now and I'm not where I want to be but I've done all I can so now I need to go on." And I think it's that piece of, "Now I need to go on and live my life." I think its fear, I really do (1007: 227-233).

The Family in Transition

Transition Support: System Navigation

After hospital discharge, our social workers, case managers or care coordinators are there in the fringe and the horizon kind of

staying in touch and checking with them to see how they are doing (1005: 271-272). They will come out of the trauma center or the hospital like a Rehab Hospital and you have a 24/7 supervision for the patient and they don't know what to do. There's even people who lose their jobs because they have to say with their injured person. So they come out of that timeframe which is not very long anymore, maybe 6 weeks. It used to be months. It used to be, you know, a coma of 2 weeks would be a 3 month stay, not necessarily (1005: 244-256)

We make sure that people understand how to get into the system, who to call, what to do when they're involved in that system so that we can have a positive outcome. And some of these situations are such that we are beginning the planting of seeds because, for some things, it takes months, and months, and months. But we can give them a good plan on what they need to do. We can intervene somewhere along the ways to make sure that they're moving forward 'cause these things are very frustrating. But then it's an issue of making sure that they've got the plan in mind, the tools that they need, and then also how they then move from there (1006: 133-140).

Therapeutic Relationships and the Role of Family

Our relationships with families are going to vary some depending on the patient and how much they're open to that. My sense is a certain history and background and future goals and family I think is huge. We do a lot of getting to know either family or friends or whoever the significant others are for those people. Those people, the significant others, are invited to be a part of the therapies and to give their input and those kinds of things which I think all allow us to know the person you know otherwise (1003: 144-149).

One of the best things we do is our team meetings with patients and where we're always talking in between and on voicemail and connecting as a team. But there is really something really powerful I think about pulling the family and the client and all of the therapists together into one room and talking about what progress has been made. "What are our goals? How does the client feel like things are going?" Having that interaction. It's usually after therapy has started. It's usually like a progress report sort of thing. There is feedback to client and family about where they are, where the team wants them to be. But, that's not to say that new insights and new directions come out of those

meetings. I mean, because it's collaborative. It's asking the client for feedback (1003: 241-247).

And it is hard to do very often because it is expensive to do, to be able to pay all the therapists for that hour and to take the time to do that (1003: 241-247). When I first started here there was a lot more opportunity to do team meetings. We would get with the client every so often, we'd get with the family and the client and all the therapists and we'd do a review. But I think partially that is economically driven there is not a lot of reimbursement for that. So we don't do it as often. It still happens, particularly with complicated clients (1008: 149-153).

So I think that significant others are their support system, their life. They help us in knowing who they are in their life as a human being. But there are some patients that don't allow that (1003: 151-152).

The Family in Recovery

Re-establishing Self

Some of those folks right away need to do some counselling because they are kind of falling apart. Most of the time they are pretty guarded. They've learned how to survive in this crisis and they are functioning on adrenaline. Families need us to step in after hospital discharge and be the guidance for them. They need us to be, in some sense, where the person can be safe while they spend some time regrouping. They have to get their lives and jobs and get groceries and get everything back together. They are going to have to let down and that's usually when it happens, they kind of start to let go of stuff and need to think about what they need to do for themselves.

So many times they just need, we find initially they need a couple of weeks of not doing a whole lot. The person is here with us a lot and they're kind of getting reestablished and doing their own thing, so we are staying in close touch with them as much as we can. We tend to have weekly or couple of time weekly meetings at that point with the patient, the family members to educate them, support them in what we are doing.

Then we kind of get down to business when they are settled and the person is settled and things are going better then we kind of get

going on things bring them in because then they have more energy and more capacity to be available. They have to recover as well. So we're sensitive to all of that. I think it is a transition (1005: 256-269).

Injury, Enmeshment and Dependence

Us, a larger group, kind of understand that clients live in families and that's a big part of it. Particularly there is an emerging dependence happening because of an emerging disability, then there is that whole dependence. So, there is kind of the biased to bring families in (1008: 61-68).

The struggles are that the young injured people, say brain injuries, who don't have a place to go other than living with their parent. And they are not ready, and they probably never will be ready, to live independently. And those families either don't have the financial resources or don't make the choice for them to live in a group home or a setting of greater support, and then the family stays very meshed. But what usually happens is that they have no other place to go. And they cannot afford for them to be in any other kind of setting so it's difficult (1005: 291-299).

And it also depends where people are in their developmental stage. Some of the more difficult clients with the difficult families are young adults who are injured or ill. That's a very difficult time. Where is that family going go in the next 10 years with this? Kids don't launch. That's a pretty difficult client set (1008: 214-217).

The Family's Role in Rehabilitation Therapy

The family role? It's so individualized. Our preference is always to include the client and/or family member. We may have caregivers, like if somebody's got Alzheimer's and is in a position at this point in time where it's difficult for them to process information that is of a technical nature. We may be trying to navigate on behalf of the client or the caregiver is really taking the lead, trying to make those things happen. Then we may be working more with the caregiver or the significant other or the spouse or whatever else to try and make that happen. And it may not be as pertinent or as imperative to include the client if we've got that situation, if we've got some cognitive impairment (1006: 50-66).

We really want to bring family as much as possible. Just recognizing that sometimes the impact of a chronic illness or injury is not just the client, it's the whole system that gets affected. So we have a biased to try to do that. And it can be a challenge with some families to get involved or not. Some don't want to be involved or they have an assumption that they shouldn't be involved because it's the client that needs the treatment. So it can vary.

Therapy Homework

If we send homework home with them the client may often just complete it independently, but maybe have some questions and have a family member help them or the family member may, may in some cases, be the responsible party. "You need to get your homework done!" And to me, if the client she can't remember things, they can't be responsible for bringing homework. So a husband may be needed to be the go-to person for that. So, yeah, so they have take a big part of that. So I will bring them in and show them, "Okay, here's what they're doing today." So it really does take training the family for that, for using the tool that the client needs to use (1007: 187-212).

Letting Go

Some family members would like to sit in on almost every session, which sometimes we don't think that's always good. We try to wean them out of that to where they prefer to sit in the waiting room. But then I have them come in afterwards and give them a summary of what we've done. And maybe not every session, but maybe every other. There's no set ... it's just like every client's so different. I think their family involvement is different. So, it does vary (1007: 183-190).

But I think sometimes they don't initially, neither the client nor the family member knows, what is this therapy all about. So it's, "Let me sit in." But I think that in gaining independence with their skills and things they're trying to learn to do that eventually, I do want to fade that in, fade that out. And then just have it be more of a report. Or, reporting, "Here's what we did and here's what I'd like you to follow through with" (1003: 214-225).

I don't know if I'd be so strong as to say family over involvement is detrimental. It can be detrimental if it's just too much of a

dependency. Like if a parent is sitting in on every single session and it was fine, but then, I mean all the therapists, you start getting this, it's not scientific or anything, it's more of a gut feeling like, "We need this person to be, you know, start being more independent. And she can write down what we did in therapy and then share that with you."

I think in the hospital they families have to 'do for' their loved one because they're so ill and so impaired. And I think this transition time helps them to see moving toward normal, moving toward a sense of, "Yes, the person, the patient, the client is taking on more for themselves and you can let go a little bit," and that's very hard. That's a very hard thing for people to do. They are so used to being 'the everything'; the person that does the physical, that does the emotional support and they can start to back off.

They see us taking on more of those roles and linking them in as we need to and the person begins to have more ability. And you literally you have to have that discussion. "You know, Joe can do more of this self-care and you don't need to be there for every minute. It's okay. It's okay to go in the kitchen and clean up your kitchen for awhile and let him go ahead and finish his care in the bathroom. Let him get dressed. You don't have to there every minute" (1005: 279-289).

Caregiver Respite

I think for some families it's a stress relief to not have to be connected. They have free time. They don't have a lot of free time. If you are dealing with someone in a family who is very injured and becomes more dependent that role strained changes. The more confident non-effected family member is often taking over a variety of roles that they never had to do. So it's kind of a welcome break to take care of other business if they can drop off their effected person for a period of 3 hours. So I think that is some of it. Definitely, that is just that other side of that coin.

And if it's a family member that's part of that I think it comes from several people. If I feel and report that I'm part of the team that means I'm part of the solution or the outcome. And that means I have to participate. For lots of reasons that can be really scary. I think some cases there is so much fear, particularly from a parent, and so much exhaustion and just multiple layers of things that. And sometimes it's kind of like you just do whatever you need them

to do to him and we'll come pick him up. And I think people need some people need to start there and some parents become really different over time (3002: 210-219).

Enmeshment, Overdependence and Return to the Clinic

I think the overdependence is a little more challenging because that is sometimes difficult to reverse. But often we can make progress if we have enough time with clients to help them understand as they see rehab, rehab is trying to make people stronger, better, more independent. So I think they get the message. I guess I have to fall on the side that, of that it is eventually helpful. That independence/separation is eventually helpful (1008: 71-81).

But sometimes the family stays very meshed. They kind of get into just habits, you know? Like if the parents are retired and at home, it's easier for them to just do it for them rather than to have them do it. Sometimes they have to come back here to readdressing those skills so they are able to take on and do more (1005: 291-299). So they will be admitted and then do some work here to try to bring him or her to a better, different level, higher level of ability, and then discharged. And that can be on a continuum and 2 years can become 6, 8 years (1005: 291-311).

And they always appreciate the opportunity for the person, the patient, to be back in here. To do some more work about it. It's individual. But what usually happens, and it's so difficult, what has happened is over the years we see them number of times (1005: 291-311).

Program Discharge: Community Reintegration and Ongoing Support

Philosophical Orientation and Discharge

We have always said we are community-minded. We are really community reentry focused (1005: 116-117). Our goal is community reintegration (1001: 190). And that is more than just that word, that's the stuff that I am talking about. You've got to be willing to send your people and you got to be willing to let them go do home visits if you need to (1005: 116-119). Clients are already in the community and they have a life going on that is very active (1001: 191). We believe that it is best to have clients live in their

community and make it a functional situation for them, their neighbors and their family (1006: 314-315).

The main reason the clinic has evolved over time is because it is meeting needs of the community. We have a very special niche that is very different from outpatient services. There are many wonderful outpatient services out there, but this is a very different environment, a different goals, different plans, different treatments in many ways (1006: 539-542).

In terms of the administrators, they have to be willing to pay your staff and to go outside the boundaries and you have to have staff that are willing. There's a willingness to do that. They have to bring their suits, they have to go to the pool and after they have to fix their hair. And I mean whatever they are going to do, that is a big addition on top of just the usual session. So it does take higher levels of commitment, it takes a willingness of the administration and the program to support the financial of that (1005: 126-128)

Ongoing Care Coordination Roles

Case managers and care coordinators may follow the client and family through the entire time they're here, including discharge planning, making sure that we have arrangements for the next step, whatever that might be and/or they may just be doing some peripheral sort of things making sure that staff is indeed coordinating these types of things (1005: 22-25). Some of that may have to do with the community services that the client is needing at that point in time (1006: 35-36).

We have reasonably good working relationships with governmental and local organizations, faith-based organizations and social service organizations in the community. So we are often called on for questions about a program or, again, the process of navigating, "How do you get into that system? How do you get whatever you need?" We're advocating for the client on behalf of, really, their needs and making sure that we then have an outcome that is as positive as possible (1006: 78-81).

And in doing that, we can be hawkish with certain agencies if we have to be and we can be gentle on the other hand we need to get something procured in a different fashion. But that's what it's all

about. It's all about maximizing the benefits for the identified client and family (1006: 116-118).

Client and Family Education

We also have our own educational events and seminars that we have here, making sure that people have, again, some more exposure to what's going on and getting them more comfortable. Also, with our setting, particularly when we have our forums here, that can make a big difference for folks in their comfort level and getting a better handle on what's going on in rehab (1006: 320-324).

Intersectoral Collaboration

Access to Community-based Resources

The other piece is the educational piece; to plant those seeds. There's stuff going on all the time in this community as there are other communities and for you to make those choices about whether or not you're going to continue to educate yourself and get more information and make some other choices about your lifestyle. If you're a smoker or a non-smoker, all sorts of things that can impact what's going on with your rehab and your rehab goes on even after you leave our doors. And oftentimes some of those sorts of things that can make a difference. If we've got somebody with an Alzheimer's or dementia, we get them involved with the Alzheimer's Association. We do a lot of that sort of stuff (1006: 329-336)

And we have a lot of the connectors with other organizations as we're making sure that the client and family are aware that there are some brain injury conferences going on that they could be included in. That MS society is having another lecture. That we've got docs coming from programs that work to empower people to make sustainable changes through healthier lifestyles that will be talking about this, that or the other thing (1006: 324-328).

Educating and Training Community Partners

And we've done workshops here where school personnel have come in to learn about mostly traumatic brain injury because the kids usually have that diagnosis (1007: 117-119). And there have

been some great things done with the OTs and the PTs as well as the speech therapists out in the community with some special forums (1006: 317-318). We train a lot of people in the community (1009: 358-359).

A good example of that is inter-community is with the university. One is having individual students that are in and out of here helping us with our therapy process and we supervise them. No cost to the person and student gains. It's all a big win (1005: 81-83).

Work and School Reintegration

We've come up with some really great ideas for functional tasks that clients can do that are meaningful for clients. It's like a project and each therapy has its own part in the project (1007: 243-245). We're in such close contact with each other, meaning PT and OT and counselling and speech, that when we're looking at somebody going back to their job or going back to school, OT will assess the needs at the worksite and another therapist will become more in tune with what they need (1007: 85-87).

So we look at the skills and the things that they need for the worksite. OT will communicate with the boss or the supervisor and then we look at certain skills. If somebody needs to do a lot of multi-tasking, OT and speech might set up a certain scenario where they might be sitting at the desk working on something. We'll give them a worksheet, we'll call them on the phone or we'll interrupt. So we'll set up some parallel situations that they might come in contact with (1007: 87-95).

And if the client has a really unique job, we'll do a phone conference with the counsellor and OT and speech as well as the patient and his or her boss. And then the boss will give a mock situation for a customer situation that was going to be coming in. So our patient had to talk about how they would handle this in initial interview. So we try to really make it realistic in this regard (1007: 97-102).

And sometimes what we give them doesn't work. A client might say, "No, what I really need is how do I take all think information from people?" So then we bring in some different things like graphs and organizers. And the then client will go, "No, no. That's not what I need at all." So in one situation it all boiled

down to that it was more auditorially getting the information. It wasn't about written language at all. It was more about how could they take on all this information. So it was really interesting, you know? It's a good example of trying to meet their needs and listening and having the client be the CEO of their therapy team" (1007: 156-161).

So in doing work readiness it will be graduated things to get them to a level where they can physically, cognitively, emotionally be ready to go. And then going to the work site and actually evaluating with them what their job requires. And then OT analyzes and breaks those tasks down and looks at the components. Do they have fine motor issues with managing paper or files, or organizing things versus keyboard or visual processing? Then there will be a set of tasks and therapy exercises addressing those things. So they will work on that stuff on the side, getting ready to go back. Or if they are there part-time, the goal would be to increase the hours. So generally increasing their abilities while you increase the hours at work (1005: 183-192). Or if they are a paraplegic, it might be that they need help with being able to drive (1010: 11-12).

Transdisciplinary Physicians: Roles and Leadership Practices

Physician Authority and Jurisdiction

In a traditional setting the physicians are a little more in charge (1015: 188). So administratively the doctors are more figure-heads than what the traditional role of a medical director in a leadership position might be. The physicians here are available for medical consultations although they certainly do provide leadership from a medical perspective, (1002: 217-219; 1006: 500). And I mean, the doctors themselves have said that what you really want in this type of setting is for the therapists to be making the decisions (1015: 116-117), but there will always be that layer, because they are our doctors and we know we have to work under the orders of the physicians (1005: 278-281).

And to be an accredited facility, you are required to have a medical director. You have to meet certain criteria (1002: 211-214). And the doctors are the only ones who can authorize a treatment plan here. So they are there to cover the legal things. And somebody has to authorize so they have to have the power to

authorize a treatment plan and nobody else associated with the program can write prescriptions (1015: 110-113).

Medical Gaze and Transdisciplinary Practice

We don't do as much diagnosis at the clinic (1009: 215) so the direction, I think, is a little different (1006: 482-483). The purpose of what we're doing is to help the person and to help them achieve a greater degree of independence or better life quality or whatever it might be outside of therapy (1001: 7-9).

And because physicians are not here all the time they don't really change how we function in the therapy treatment process. I think staff just kind of carries on which I think that adds to the independence that we have (1006: 483-486). The pattern of work is different and in some ways there is more freedom because the staff is able to just carry on without having to go up through that additional layer, that overlay of having a physician here all the time. I don't know if freedom is the right word. Maybe it's more around flexibility (1006: 492-495)?

So even though the physicians don't really change how we function the therapy treatment process, we all look to them and they can effect change by their information or decision-making from a medical perspective. So if we are relying on imaging or on meds and the results of those things to give us information for therapy we have to look to the physicians for some interpretations. We have to look to them for guidance about those things (1005: 384-386). And that's good stuff (1005: 388).

Of course there are time when they just come in and do the neurology piece (1003: 126-127), but sometimes we need them to take the difficult cases and try to help solve a relative impasse that has occurred. And that impasse might occur in relation to say, discharge from the program, or a shift in the program, you know? (1015: 183-184).

Physician Attributes and Interpersonal Team Relationships

Humility, Equality and Mutual Regard

The doctors that work here work with us quite a bit and they have an understanding of rehab and all those pieces (1008: 172-174). They are very busy, and very knowledgeable. They are good

educators and they have tremendous experience and exposure. (1006: 474-475). And the education the physicians provide when they're talking about a particular circumstance, I mean, they've been very helpful (1006: 473-475). I would like to have more of that (1005: 378-390; 1014:: 123-125).

And in terms of what we do, I think they do believe it's really important and they do respect that. Of course, I think there may be someone who feels like the physicians treat us with respect, but that they still think of themselves as 'the doctors' (1013: 187-188).

But I think they are the type of doctors whose style isn't related to their title, it's just their style (1006: 501). If they do change when they come here, I'd say they are much more relaxed and at ease than they are in the hospital, probably because they're dealing with issues that are very different, not as acute (1005: 392-396). I think their style is also...I mean they listen to the staff as well (1006: 501).

So I think they fit in (1008: 174). And I think that even though their role is different, they don't see themselves as outsiders. It's that their role is more integrated into the system (1015: 69-70; 192-193). But I do think that a physician has to be the right type of person to work with us (1013: 188-193). Like, you have to be ok with the team making the decision to invite you meeting and fill you in with where the team thinks the situation needs to go (1015: 185-188). There are times they come in and just say, "This is what it is," you know? And then it's like, "No, it isn't." People will say that right back to them, too. Yeah. And they're okay with that (1013: 191-193).

So when you bring new physicians into the clinic there may be some power struggles (1008: 174). We have had a couple of docs that we **just** couldn't work with. They wanted to run everything (1005: 1/28/2013 3pm). I think that we're all, most of us, are of the personal opinion that we are lucky we don't have doctors like in the traditional model (1014: 165-166).

Transdisciplinary Physicians and Complex Problem Solving

The doctors amaze me at how willing they are to just sit and brainstorm and talk about, you know, if I come in and say, "Gosh I'm struggling with this client," and maybe it's something that really takes some talking through and figuring out and I need to

know, okay, “How much of this is psychological versus physical” (1003: 229-234). Or, “Does this medication make a difference on what’s going on with this, that” (1006: 457-458). When they are talking with us, they are...just on a different level (1005: 394).

Or the therapists may be treating this element over here but this person has a bipolar disorder underlying or maybe overlying everything that is going on (1005: 373-389). And when I need an opinion they are so willing to be a part of that conversation and that kind of thing (1003: 232-233).

Limited Access: Physicians as a Scarce Resource

Unfortunately we’re not always able to have physicians here physically as often as we would want (1006: 463-464). I wish that we had more access. I wish we had a physician on site just to have more information and knowledge at the ready. We get it now, but we have to wait sometimes. We have to wait until we have access (1005: 366-369). I mean if there’s a purely physician-related question then yeah you get on the phone and you have them paged and you get those things taken care of (1006: 473-474). But we have to make sure we’re corraling our questions for when they are here. So we can get them on the phone and ask a question, but it is always very limited and just by phone (1005: 369-371). When we have do have access when they are onsite and we can just dialogue with the physicians, and we can also dialogue with other physicians that are involved with the clients too as necessary (1006: 496-498).

‘A’ and ‘not A’: The Traditional-Transdisciplinary Practice Flip-Flop

It is hard to work between two places, to go back and forth between, and to have more than one job (1001: 276-277). In kind of a rehab model versus, I don’t know, a medical model of outpatient therapy (1008: 25-26). But working here has definitely impacted my practice at other facilities. I think that I co-treat a little bit more than some of the other therapists in that system. And I end up co-treating a lot just to see why the other therapist might be saying this person is crazy (1001: 120-123).

And I’ve seen people as outpatients in another job where they didn’t want to continue with home health and they wanted to stay with me. So they did outpatient with me instead. Like, I saw someone who I discharged. So we developed a system that will

influence her functional abilities in her home environment. So for her, she's got a couple of different diagnoses and so with the interventions that I developed she can use those in functional situations. She hated therapy until she worked with me which, I don't know what I've done, but she likes me so she is going to continue with me on an outpatient basis (1001: 226-231).

Regionalization and Assimilation of Private Outpatient Clinics

Biomedical Perspective

From a hospital systems perspective, I think there is a place for a transdisciplinary rehabilitation to stay philosophically intact if it is in a larger hospital system. You could easily bring in the same kind of concept that you have at the clinic and just bring them into the group and their part of the services. You do neuropsych evaluations and then appropriate to the treatment plan and you still bring in the other member of the team as long as things are done within the pod of the larger entity. The system has already done that with the stroke program and with trauma for example (1015: 226-236).

So I could even see the clinic become integrated into the system, especially if the overall financial responsibility is in a region for people getting better from traumatic brain injury from the point of when they arrive on the trauma service to when they have they are released from the system in some way. If all of that is under one prevue, then having one program that is effective at a certain stage in the process becomes useful. So I think they can be transdisciplinary integrated (1015: 248-252). And it would solve some of the funding issues associated with smaller private clinics in the region (1015: 223-224).

If the clinic became part of the larger system, could a transdisciplinary program maintain its philosophy and practice as an oddball if all of the other outpatient facilities are about standardized care and oriented towards physical outcomes? That's a good question. But I'm not really sure who you could ask about at a more senior administrative level (1015: field notes). I mean, it all comes down to money. At some point we will have an integrated, accountable system and then for things that get authorized, physicians can control our expenditures and we can say, "I don't know about that procedure for that 'thing'. That's costing too much" (1015: 253-264).

I think if the larger hospital system was to ever seriously looking at integrating us in it, we'd have to sit down and talk about whether or not we could make it work and still keep the integrity of the program (1010: 113-114). If we did ever go that direction, we would have to hope that it's in a way that we can keep the integrity of what we do and the structure of what we do and make it work within their system. But I don't see that happening any time soon anyways (1010: 103-105).

Private Business Perspective

To keep the doors open we have to look at different revenue streams. Any kind of revenue stream. And the Director's been great at that (1010: 114). Like, "I think we need this driving program," so the director gets that all set up and that's bringing in revenue. And then the Director thought, "We need to change our name because our name isn't all that we do" (1010: 119-123). The Director realized that so we spent like 6 months with the staff having meetings and talking about what our name should be and throwing stuff up and throwing stuff out. And the Director listens to all suggestions. Because of the Director, the name changed and at that point that made us survive (1010: 125-127).

And then the Director thought, "I think we need to do this memory clinic thing." And so we set that up and talked to the docs about so we get more memory clinic referrals now. Think about the aging population and the baby boomers, you know? And that's, there's a lot of problems with memory and so we get a ton of that now. That saved us again. Oh, and we also have a driving program because of the Director putting it into effect, learning it and figuring it out and mastering it and doing that and so they refer us for that (1010: 12-15). I mean all those little things keep us going. And now we're going to need to, we need to figure out a way to make our physical therapy department better (1010: 119-123, 125-133).

The Director just knows what she's doing and is just very good at recognizing what the community needs and how that will fit into that and how we can take care of that based on neuro. Just having researchers come in is creative! And our staffing is phenomenal. It was wonderful. I'd say we got zero to 2% of kickback or problems with people when the Director comes up with a plan that would help us. The director makes it pretty easy for everybody by, first of all, identifying the people that are going to do it. Like we had someone who had her own little business, and came to us and

said, *"I can't do business by myself. Can I just work for you?"* And the Director said, *"Bingo! You'd better believe it"* (1010: 190-202).

If I all of a sudden they won the Powerball, here's what would happen. We would build a monster, wonderful facility. We'd make it not-for-profit. We would say all people are going to be taken care of. We'd set it up, however we could to be able to do that, so that if you don't have money we'll still see you. And we would take care of people instead of having to worry. I mean we'd still use their extended benefits, but we'd figure out ways to make it so that nobody, there was nobody, there was not a person that didn't get what they needed from our disciplines (1010: 88-94).

We joke about getting these homes/apartments over here and helping people transition to their own lives and have some kind of community-based, a halfway house, something like that. We could help people function more independently because that's a very difficult transition into their homes. So that would be something we would talk about (1008: 208-212)