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Multiple balances in workplace dialogue: experiences of an intervention in health care

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Abstract

Purpose – This paper aims to illuminate and analyse the participants' experiences of the influences of a dialogue intervention. Cooperation and coordination in health care require planning of dialogically oriented communication to prevent stress and ill health and to promote health, well-being, learning and efficiency in the organisation.

Design/methodology/approach – An intervention method based on dialogue theory, with Socratic provocations and concrete workplace examples enhanced authenticity of conversations. A qualitative study, using qualitative content analysis, entailed interviews with 24 nurses, assistant nurses and paramedics, strategically selected from 156 intervention participants.

Findings – Two themes emerged, dialogue-learning processes and dialogue-promoting communicative actions. The first includes risk-taking to overcome resistance and fear of dialogue, expressing openly thoughts and feelings on concrete issues and taboo subjects, listening to and reflecting on one's own and others' perspectives and problematising norms and values. The second comprises voicing opinions, and regarding one's own limits; requesting support and room for manoeuvre; and restraining negative emotions and comments in the interest of well-being. Findings depict strengthened awareness and readiness regarding dialogue and multiple balancing of dialogue at work.

Research limitations/implications – This study implies further observing and examining of communicative patterns during workplace dialogue.

Practical implications – A useful approach to communication development for occupational health and personnel in health care and other workplace contexts.

Originality/value – Previously, arenas have been created for dialogue, but close-process studies of dialogue in health-care work are scarce. This study provides insights into how workplace communication can develop towards dialogue.

Keywords Health care, Employee behaviour, Workplace learning, Occupational health, Employees communications, Interpersonal communications

Paper type Research paper

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Introduction

Cooperation and coordination in the health-care sector require professionals to be able to communicate with and continuously learn from each other and to be given opportunities to do so. The reform of public sector organisations that took place in the Nordic countries during the 1990s (the "New Public Management" reforms) incorporated rationalisation, standardisation, decentralisation of responsibility and, simultaneously, clearer distribution of work between the various occupational categories. This augments the requirements placed on health-care personnel (Pollitt and Sorin, 2011), as standardising work tasks in health care is difficult, and many decisions must be made on the spot, which increases the need for communication within the organisation (Vigoda, 2002). Communication within health-care organisations, however, suffers from too little space, from gaps in trust and from rigid boundaries between various parts of the system and between the professions (Mintzberg and Glouberman, 2001b; Abbot, 1988). Deficient coordination can, besides quality problems and inefficiency, cause stress and mental ill health (Kira, 2003).

Cooperation, coordination and learning in health-care work therefore take place within and by means of communication, and especially interpersonal verbal communication, which includes dialogue as a special form of communication characterised by a mutual, genuine exchange of thoughts and experiences between two or more interlocutors. The dialogically oriented form of communication at work is positively valued, but, in reality, often absent (Grill *et al.*, 2011; Deetz, 1992; Linell, 2009). Potential obstacles to such communication include a range of factors, for example, superficiality, routine, locked positions, one-way communication, power asymmetry, insufficient reflection, a shortage of spatial arenas, tactical monitoring of special interests, uncertainty concerning the consequences of openness, stress and the inertness of established patterns (Wikström *et al.*, 2004; Wilhelmson, 1998; Argyris, 1993; Nytrö *et al.*, 2000). Communication runs the risk of being neglected because demands to "produce" health care are acute and high (Skagert *et al.*, 2008; Wikström *et al.*, 2004). Due to these obstacles, structural prerequisites for and the ability to engage in dialogic communication need to be created (Ekvall, 1996; Nytrö *et al.*, 2000) and maintained or recreated as a part of ongoing learning (Ellström, 2006).

Psychosocial work environment, mental health and well-being of staff are also affected by communication. Well-functioning communication may, in itself, promote well-being as a means of making reality meaningful, understandable and manageable. This brings a sense of coherence in orientation to life (Lindström and Eriksson, 2005).

Previous research has investigated how different arenas can be set up for dialogue in groups (Gustavsen, 1992; Wilhelmson, 1998; Hyde and Bineham, 2000), examined conversation and dialogue by observation of groups set up at workplaces, led by dialogue facilitators (Kristiansen and Bloch-Poulsen, 2000), and suggested that groups could be trained to increase their use of dialogue and enhance their *dialogue competence* (Wilhelmson and Döös, 2002).

In this study, it is argued that workmates can be trained in the use of dialogue as part of a learning process in an intervention that takes place in an arena with competent dialogue trainers and a safe group context. The dialogue training intervention consisted of, first, a strictly structured framework. Second, consensus was meant to be avoided by means of provocative communication components. Third, there was focus, not on group processes but on developing participants' individual abilities to engage in dialogue.

Fourth, the intervention was placed in a special context, namely, the health-care environment, where professionals from several categories work together in teams, but hierarchical power and professional boundaries aggravate communication and cooperation. Hence, this intervention to promote workplace dialogue seemed optimally motivated and had not previously been thoroughly described and studied.

The aim of this study was to illuminate and analyse the participants' experiences of the influences of a dialogue intervention.

Theoretical framework

This study is based on dialogue theories and a socio-cultural learning perspective. Dialogue takes place when interlocutors are speaking unfeignedly, listening, respecting and suspending (awaiting the other) in an interpersonal communication. The concept of dialogue originates from the Greek "dialogos", that is "meaning floating through" (Isaacs, 1999), and refers here mainly to two orientations of dialogue theory, related to Buber's (1970) and Bakhtin's (1981) views. Buber describes dialogue as in essence an encounter, a meeting with the other face-to-face, which involves remaining in the position of tension created by standing one's ground while, at the same time, being open to seeing things from the other person's viewpoint. Enhanced understanding and acceptance of the other is the aim. Interlocutors are supposed to be honest and authentic, and dialogue is distinct from the more conflict-imbued concepts of debate and discussion – which designate more of a battle which you try to win, using arguments (Isaacs, 1999). For Bakhtin as well, dialogue is characterised by openness and mutuality in the communicative interchange, but his perspective accentuates the intermittent and continually changing character of the relation. Thus, the understanding of the other includes seeing differences, dissensus and even conflicts as a positive energy. Dialogue is unpredictable, depends on timing, relationships and contexts, and always runs the risk of breaking down (Kristiansen and Bloch-Poulsen, 2000). Dialogue has little space in organisations, as organisations focus on results and efficiency, whereas dialogue does not focus on immediate results in the usual sense, but on increased employee participation and autonomy, which could actually clash with productivity (Schein, 2009). Dialogue focusses on listening, reflection and redefinition, rather than on efficiency. Dialogue involves continuous learning, in that it always questions assumptions, even those most fundamental to an organisation (Linell, 2009). Modern bureaucracies, including the hierarchically structured health-care organisations, are organised to prevent them from becoming destabilised. Nonetheless, the organisation is always a place where conflicts between different discourses, that is conversation cultures, are ongoing (Mumby, 2005). Tacit assumptions (Schein, 2009) that individuals make about how the world is constructed, and socio-cultural conditions – such as the organisational culture – restrict what workgroups are permitted to talk, and even think, about. To identify and, to a certain extent, overcome these restrictions, a provocative *Socratic* method of conversation can be used, involving bringing the accepted norms of the group to a head to question them (Sullivan *et al.*, 2009). Another cornerstone in arranging for dialogue is the concept of the secure container, that is, an emotionally safe conversation environment (Bion, 1962), guided by a so-called facilitator (Isaacs, 1999). *Dialogue competence* (Wilhelmson and Döös, 2002) is a concept which has a differentiating and an integrating quality – both deriving from listening attentively to the other. The differentiating quality means that one has the ability to recognise and also

tolerate that the view of one's conversation partner is different from or actually in opposition to one's own, and still have a dialogue. The integrating quality means to be interested in and also take parts of the other person's viewpoint into one's own world view.

Socio-cultural learning theory (Vygotskij, 1934/1966) is the other perspective used in this study, treating how learners in the learning process are affected by the socio-cultural setting. Cultural practices, time and situatedness (Säljö, 2009) – where words and other interpersonal communication convey the meaning for the individual – are dependent on the social context in which they are performed. Learning from workplace dialogue, like other forms of learning, is supposed to be best achieved by practising – through response from, and interaction with, others, that is, action comes before insight (Engquist, 1996). Individuals are seen as the learning entities, but to be successful, supervision by someone who is more competent and experienced in the field is essential (Vygotskij, 1934/1966).

The dialogue intervention

For the elaboration of the intervention, practical methods from management psychology, based on the studies of Isaacs (1999) and Schein (1999), were used. The individual learning of dialogue was in focus, although it had to be practised with others. A container, a setting as secure and as free as possible from power asymmetry and other possible sources of anxiety, was achieved through a framework of intervention rules concerning procedure and dialogue, and the guidance of a psychologically skilled and experienced facilitator acting as dialogue trainer. To further support the container function, no feedback between participants was allowed – as feedback does not focus on relationships but rather on performance, and could therefore result in defensive routines (Argyris, 1985). The role of the facilitator was to hold the conversation on a constructive level by countering factors that undermine dialogue, and to introduce concepts and clarify topics of conversation, through commentaries on the communication process: the so-called pedagogic initiatives. A parlour game was used as one of the tools designed to bring up authentic and concrete examples of personal experiences in day-to-day work situations. The game used cards printed with statements about workplace conditions that addressed seven thematic areas, namely, communication, culture, change, quality, cooperation, employeeship and leadership. Rules for dialogue also pertained to this game: being respectful, open and direct; using "I" messages; not putting pressure on anyone; not using irony; listening attentively; and avoiding manipulation. The intervention alternated between two parts, the first being the dialogic, where the group members took turns as dialogue leaders, following procedure and dialogue rules. The second, educational, part – the pedagogic initiatives – gave the dialogue trainer an opportunity to comment making clarifications and generalisations on relevant topics, stage confrontations, carry out provocations and present psychological theories on communication and cooperation. The intervention covered two full days and was conducted in groups of eight participants with a two-month interval. The same composition of the group was retained for both training days. Ward managers were present as observers and "secretaries" only, and were not allowed to speak.

Coercion and prescription bring two paradoxes into the framework of this intervention. One paradox is manifest in coercion (because the manager had decided participation in the intervention was mandatory) – versus trust (because the unfolding

of dialogue is dependent on trust). The other paradox is that of authoritative prescription versus freedom: the dialogue trainer who prescribes the rules for conducting the dialogue is also supposed to facilitate free and open conversations. To address these two paradoxes – the coercive situation, and the prescriptions and authority of the trainer – a "carnivalesque" atmosphere was sought (Sullivan *et al.*, 2009). That is, a playful, unpretentious atmosphere, in which the leader – in this case, the trainer – lets go of the role of authority and joins in the play, intermittently reassuming her authority. In maintaining a dynamic power situation, her position was not made permanent or reified (Hyde and Bineham, 2000).

Methods

Setting and design

This study was approved by the Research Ethics Committee of the Medical Faculty of the University of Gothenburg in Sweden (reference no. 514-08), and was conducted in eight hospital wards at four different hospitals in small, medium-sized and large cities in western Sweden, specialising in orthopaedics, medicine, psychiatry, paramedicine and intensive care. The explorative and descriptive design allowed for close examination of individual descriptions, in order to discover diverse and specific realities of those involved, providing opportunities for comparison.

Study participants

Intervention participants comprised 156 employees: nurses ($n = 84$), assistant nurses ($n = 50$), administrative personnel ($n = 6$) and paramedic staff ($n = 16$). In total, 26 study participants (of whom two declined to be interviewed) were strategically chosen for interviews, representing each training ward and with maximal variation regarding the degrees to which they experienced the dialogue intervention positively, based on a survey (Appendix, Eklöf *et al.*, 2011). Interviews were conducted with 12 registered nurses, 7 assistant nurses and 5 paramedics. Twenty-two were women and two men, ages were 31-60 years and three of them were interviewed by phone.

Data production

Interviewees were contacted by phone and invited to participate. Written information then was sent about the aim of the study that participation was voluntary, interviews would be recorded but treated as confidential and that they were free to terminate the interviews at any time. Interviews were conducted by the main researcher (CG), in university or hospital administration buildings 6-12 months after the end of the intervention. Interviews lasted 60-90 minutes, were recorded and transcribed verbatim, focussed on issues concerning the participants' description and experiences of the dialogue intervention and were as reflective and detailed as possible.

Data analysis

A qualitative content analysis approach was used (Graneheim and Lundman, 2004), without predetermined categories or themes. Interviews were read and re-read a couple of times with the aim of gaining an overall picture of the material collected, searching for units of meaning relating to the aim, which were then condensed and coded. Categories were subsequently generated. The analysis constantly moved between the original texts and the various levels of abstraction to ensure that no data were excluded and that categories were mutually exclusive at a manifest level. The final step in the analysis was

to find out the thread of the underlying meaning of the categories, e.g. the latent level (Graneheim and Lundman, 2004). The authors – a psychotherapist, a pedagogue, an economist and a physician – participated in the entire process of analysis.

Findings

Two themes emerged (Table I): dialogue-learning processes, illuminating different aspects of the processes that developed during the intervention period and dialogue-promoting communicative actions, illuminating communicative actions which were either used or avoided in order to promote dialogue.

Dialogue-learning processes

Risk-taking – to overcome resistance and fear of dialogue. Participants described different ways in which resistance to dialogue was experienced; for instance, by

Table I.
Themes, categories and codes illuminating how health-care workers experienced the dialogue intervention

Codes	Categories	Themes
Talking derogatively about the intervention	Risk-taking – to overcome resistance and fear	Dialogue-learning processes
Afraid of speaking at meetings		
Reluctant attitude changed		
Challenging to participate		
Good to be encouraged		
Expressing own thoughts	Expressing openly, thoughts and feelings – on concrete issues and taboo subjects	
Experiencing concrete examples as pressuring		
Being able to tell each other		
Addressing small everyday incidents		
Learning to listen actively	Listening and reflecting – on one's own and others' perspectives	
Being forced to wait		
Acknowledging others' experiences		
Greater understanding		
Becoming aware of teasing		
Feeling uncomfortable		
Awareness of strength of norms and values	Problematising – norms and values	
Questioning unwritten rules and slandering habits		
Querying power positions		
Paying attention to norm conflicts		
Confrontational communication	Voicing – opinions and regarding one's own limits	Dialogue-promoting communicative actions
More directness and honesty		
Setting one's own limits		
Defying power relationships		
Making requests from managers, concerning support, wishes and needs	Requesting – support and room for manoeuvre	
Asking for help from colleagues		
Asking for own increased responsibility		
Less ill-humoured communicating	Restraining – negative emotions and comments, in the interest of well-being	
Restraining insults		
Decline of negative talks		
Clearing up misunderstandings		

referring derogatorily to the practising of dialogue, claiming that there was no need, as staff already communicated well and that the idea of practising was "stupid". Others claimed that the dialogue intervention was useless, as doctors did not take part, did not function naturally or lead to any solutions to problems. According to interviewees, it was particularly those colleagues who had made these types of remarks who themselves had difficulties in communicating. Resistance and reluctance subsequently changed for some of them and could be overcome:

> I noted that my colleague who thought that the whole thing was stupid softened over time, and the second time we played she spoke almost as much as all the others' (Interview 5).

Participants described frustrating obstacles to workplace dialogue, like workmates being afraid of speaking at meetings, even if only to agree. There was fear that if sensitive issues were to be addressed, one could end up saying something that conflicted with conversational norms, or conflicts could arise, as in one workgroup that defined itself as normally "one big family". However, in the intervention, people took the risk of talking to each other, and said it was good to be encouraged even if they found it challenging to participate. The moderate amount of strain was perceived as necessary and beneficial.

Openly expressing thoughts and feelings – on concrete issues and taboo subjects. Statements appearing on the parlour-game cards and used in the intervention were said to be helpful for identifying and expressing openly one's thoughts and feelings on concrete issues. As a result, the typically reticent participants did talk more and express their thoughts using concrete examples. "I think it was good that they stepped forward and were forced to say something for three minutes. I am very happy about this" (13). Concerning the use of a parlour game in the intervention, some participants said they found this unnecessary, while others saw parallels with child therapies that provide self-insight through games.

The dialogue rules and the assignment to find concrete examples in the talks were described by some as difficult, pressuring or provoking. Experiences were that when the topics of conversation and dialogue were "hot", the involvement and engagement on their part became strong and more controversial. On the other hand, participants said that a basis for productive communication and openness was established, thanks to the accepting environment, creating new channels for dialogue. Workmates were able to tell each other about differences in their work methods and practices, and declared that having shown each other their true faces, they now had more of a sense of belonging to the group, as well as a greater ability to be honest in the future.

Hidden disagreements between colleagues and taboo subjects were brought to the surface – like exclusion of workmates – and complaints made behind their backs about colleagues being too slow. Even if reported as being pressuring, this was considered in the end to be salutary. Those who felt shy or unsure of themselves commented that they appreciated having the opportunity, and being specifically helped, to talk. The quiet ones were forced to speak and the talkative ones to listen: "[…] here you had no choice, you were forced to talk and listen. So that even the shyest souls could step forward a little" (Interview 6). Being open was said to be a huge step and got participants thinking about how they were being perceived. To not address major conflicts, but small, everyday incidents that affected everyone was described as providing a condition for dialogue.

Listening and reflecting – on one's own and others' perspectives. Participants reported that they had learned to listen actively to each other and to reflect on their own perspectives and those of others during the intervention. To be forced to wait, and postpone thinking about how to reply, facilitated listening to others' experiences – sometimes confirming, sometimes contradicting their own. Reflections after considering concrete examples were cited as contributing to greater understanding of others' habits, views of the same events, work methods and how different work positions caused occupational boundaries. Additionally, new perspectives on communication at work, including talking behind each other's backs and using irony with the aim of teasing, were highlighted and sometimes described as uncomfortable, as participants became aware that this teasing could be based more on criticism than they had previously thought. That not everyone finds it easy to deal with irony was surprising to some "Perhaps they simply had not reflected on it. Sunlight was shed on this topic" (Interview 3).

Problematising – norms and values. Interviewees reported that they became aware of norms and values that characterise everyday actions and learned to better appreciate their strength. This enabled them to problematise and question unwritten rules and norms. Allowing power relationships to have an impact on their ability to talk freely and articulate reservations was probed and queried. An assistant nurse gave one example, where she said she should have opposed the anaesthesiologist who decided to give the patient less pain relief due to the ward being short-staffed during the weekend. Newly hired colleagues broached issues of which the others in the group were unaware or unwilling to speak, like the norm of just waiting for help and not asking for it, related to the norm that work colleagues "should see" that help is needed.

Talking behind each other's backs was another norm that participants problematised. It became clear that different and conflicting norms applied to this type of behaviour; not everyone found it offending. Participants also found that some conflicts about norms and values were actually related to their private lives, like keeping up a healthy lifestyle, which some workmates felt pressure to adhere to:

> At our workplace there is a lot of talk about having a healthy lifestyle, like – "You should exercise" and 'Smoking is so terribly disgusting.' The norm of rather smug virtuousness is pretty strong (Interview 7).

Dialogue-promoting communicative actions

Voicing – opinions and regarding one's own limits. In connection with the dialogue intervention, participants more often dared to give voice to their opinions, be more direct and honest – especially face to face, address their criticism to the relevant person, and speak at workplace meetings. They conceived that setting their own limits in interactions at work were competencies they developed. Consequently, confrontational communication instead of suppressed opinions was said to occur, for instance, in relation to physicians and between assistant nurses and nurses. Constructive confrontations were conceived as good for quality of care; for example, when defying power relationships, and when clarifying on a joint responsibility for a patient and when views differed on whether to let the patient remain in bed all day, even for toilet needs and mealtimes. Other examples of setting limits were in the form of speaking up about not wanting to be disturbed during an ongoing patient meeting behind closed doors or

declining to help a colleague: "Being able to refuse and say – 'No, I don't have the time right now, but maybe later'" (16).

Requesting – support and room for manoeuvre. Participants also mentioned how, since the intervention, they more easily made requests to managers and expressed their own wishes and needs, by requesting more support in discussing how holidays should be allocated or saying they needed more appreciation in a period of frequent overtime, as well as asking colleagues for help more often.

One nurse reported improvement in her cooperative relationship with an assistant nurse, who now dared to ask for more tasks and responsibility to be assigned to her:

> "She said to me: 'You go and get the medicine for the patient, and I will do the rest. We were supposed to practise dialogue, so I'm saying it now'" (Interview 9).

Restraining negative emotions and comments – in the interest of well-being. Prior to the dialogue intervention, some staff had engaged in insults – for example, referring to colleagues as slow or lazy – and generally used jargon affected by anger and offensive to those subjected to it. They were now more able to speak with a certain level of restraint, and insults were reported to be less common, as staff now helped each other to put an end to them. More considerate communication prevailed after, and was sometimes ascribed to, the dialogue intervention. Negative "corridor talk" about colleagues was said to have declined, and the communication environment seemed calmer and nicer. To be able to talk freely and make their concerns known without being attacked was described as extremely pleasant. People cleared up misunderstandings that might have appeared minor, but when they were eliminated, feelings of safety and relief increased. The atmosphere in the workgroup was described as happier and easier with a new communicative freedom. It was reported as also affecting the patients positively, improving quality of care and giving greater scope for developing and redesigning practical care procedures, even across occupational boundaries. Staff had become more attentive and avoided irony, as it can lead to misunderstandings, especially for persons whose native language is not Swedish and who cannot always understand the nuances of the language. "You can end up thinking, 'Now I said something that this person might have misinterpreted', which makes you stop and think" (17).

Discussion

When illuminating the experiences of the influences of the dialogue intervention, four dialogue-learning processes and three dialogue-promoting communicative actions developed.

Expressing and problematising brought dialogue awareness

Entering into dialogue learning at work was taking a risk and triggered resistance in participants in this study, which can be understood, as dealing with perceptions by others that are incompatible with one's own value system is often experienced as painful learning. This causes unease and a dissonance within the individual as is theorised by Alexander *et al.* (2009). Additionally, a feeling of threat to one's identity was found when arranging for dialogue, in case studies by Hyde and Bineham (2000) and Sullivan *et al.* (2009). In this study, tools containing consensus requirements emerged, like idealisations and silence. Silence at workplace meetings, for instance, served as a centralising force, to uphold norms and reduced fear of disorder. Attaining consensus –

where everyone agrees on an issue or opinion – can have a strong attraction, and can therefore be a pitfall and hamper learning when aiming to have a dialogue. When participants, however, took the risk, or sometimes felt forced to deal with conflicting perceptions, norms like the habit of using irony at work, which was actually defended by some, could be problematised. This habit is discussed in organisational communication research (Sullivan *et al.*, 2009), as exactly the form of resistance used towards superiors, in confronting power in organisations, which could explain why irony can be experienced as normal and even as necessary at work. Also some of the resistance to dialogue can be attributed both to the coercion aspect of the method, and to other formal and informal power relationships that existed in the intervention setting and implied a "command", vandalising genuine dialogue as Bokeno (2007) pushes forward. When resistance was triggered, this could however be understood not only as an obstacle but also as an asset for dialogue, signalling that conflicting norms had been uncovered, sometimes by the Socratic provocations, which could open up for so-called developmental learning possibilities (Ellström, 2006). When disorienting dilemmas and cognitive conflicts thus were created, there was a simultaneous fear of change and wish to change. From reported experiences of the interviewed participants, we infer that the strength of their engagement provided courage to overcome their fears of openly expressing their thoughts and feelings – due also to contextual and individual dialogue-promoting conditions like trusting relationships, friendly work environments and individual self-esteem (Linell, 2009; Grill *et al.*, 2011). Dealing with concrete work issues has been found in this study to be an important factor for engagement. The matter of engagement has been explored by Wikström (2000), who found a so-called "mutual task engagement" to intensify endeavours to dialogue. That is, dialogue needs to concern the fundamental life conditions and value bases of the interlocutors, which Matusov (2011) designates as a matter of "ontological engagement". The concrete, engaging issues however led to conflicts, when commitment became strong. Thus, rather than bringing up major conflicts, dealing with minor conflicts concerning small daily events seemed productive. The greater the sense of involvement, the harder it is to continue to listen to each other and dialogue, instead of immediately initiating a discussion or debate. The tensional relationship that exists between emotional intensity and emotional safety was one of several delicate balancing acts in learning of workplace dialogue.

The problematisations of norms and values in this study brought communication closures to the surface. To remedy such closures and facilitate cooperation between different parts of the health-care system, Mintzberg and Glouberman (2001) has suggested standardisation of values in health-care systems. While of course necessary when it comes to rules for conduct, standardisation of values, however, runs the risk of opening up for superficial consensus and insincere communication (Deetz and Simpson, 2004). As shown in the current study, by refraining from pursuing standardisation, but rather allowing resistance and dissidence real dialogue between distinct parts could instead be created, as stated also by Gabriel and Willman (2005).

Therefore, initial resistance and fear diminished for some participants. Awareness of dialogue character and preconditions, as well as of the necessary balancing of dialogue, evolved during the processes. Taken together, this can be analysed as a *dialogue awareness*.

Ability to confront and dialogue readiness

In the dialogue-promoting actions theme of this study, two types of communicative experiences can be interpreted as affording participants more scope for control of their work situation. Not only requests for support and help from colleagues but also the limiting, boundary-setting refusals to help colleagues – were actually said to not often be realised before the intervention. To keep control of work demands has been shown by Karasek and Theorell (1990) to be beneficial for health. When analysing not only these requesting and limiting actions but also the communicative confrontations on health-care issues in voicing, and the restraining of negative emotions and comments, a *readiness* for *dialogue* emerged. Dialogue readiness can be explained as the extent to which the individuals involved are able and willing to use dialogue.

Multiple balancing acts

Dialogue awareness and dialogue readiness, together pointed towards fostering a *dialogue competence* (Wilhelmson and Döös, 2002). Human processes are not linear, however, and having competence is one thing, but striving for dialogue at work was found to entail continuous and multiple balances. In the analysis of the findings, *multiple balancing acts* are discerned within both themes – in the sense not of keeping things in a steady balance but of a dynamic and demanding tightrope walk. In the learning processes, this came across in participants' experiences of oscillating between hesitating to *take the risk* to engage in dialogue and working up the courage to express, openly, fluctuating processes which could be denoted as balancing. These balancing acts could also be distinguished when choices were made between making the effort or not – to voice and limit, request and restrain oneself. Moreover, balancing acts in this study imply an answer to how the paradoxes of coercion and prescription mentioned in the introduction could be dealt with. On the part of the trainer, a careful balancing of authority was necessary. Balancing took place by the Socratic provocations used in the intervention method helping to bring up the engaging issues. These provocations implied that trainers balanced when putting pressure – but a moderate one – on participants. Balancing was also called for from the participants, as being open about personal perspectives on work issues potentially risks being misused by a manager.

Improved health and cooperation

In both themes, indications could be found that the intervention promoted well-being and more cooperation. When there was open expression, a free and accepting atmosphere was reported. The setting of personal limits to poor treatment as well as requesting and restraining seems to have led to a better work atmosphere, as well as furthering care quality by more dialogue and cooperation at work, even across the occupational boundaries found by Abbot (1988) to be a problem when several professions are working together.

Methods discussion

One of the four participants in the analysis (CG, E-CL, EW and GA), the interviewer had a vested interest in the dialogue intervention, which could have contributed to a bias. The strategic selection, designed to find respondents with experiences and perceptions of the dialogue training as diverse as possible, should have balanced some of the risk of too positive a bias. Moreover, to strengthen credibility (Graneheim and Lundman, 2004), the research process was described in detail, there

was a rich variation of meaning units from the interviews, and researchers were experienced in analysing and interpreting qualitative data. Two remarks should be made regarding implementation of the intervention. One is the reason to omit doctors from the intervention, which has to do with earlier research findings of power relations creating difficulties for dialogue. The other concerns the sensitive fact that this training method has a potential for repressive abuse, which is an ethical issue that must be carefully considered.

Concluding remarks

Participants' experiences of the dialogue intervention seem to have deepened understanding and strengthened awareness and readiness regarding dialogue, and to have influenced workplace communication towards dialogue development. However, the process was found to entail multiple balances, necessitating great caution and care when arranging for dialogue at work.

In future studies, the behavioural pattern during a workplace dialogue intervention could be examined even more closely, for instance, by observation. In the service of leadership development the method's characteristics deserve in-depth study via interviews.

Practical implications are that this approach could be helpful in improving workplace communication in health care and other workplace contexts.

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Appendix

Jobs in categories	Self-reported learning on dialogue from dialogue training Learnt about dialogue and use this at work	Learnt about dialogue but is not applicable at work	Learnt virtually nothing	In total
Registered nurses				
N	45	8	24	77
%	58	10	31	100
Assistant nurses				
N	27	5	13	45
%	60	11	29	100
Paramedical staff				
N	12	0	2	14
%	86	0	14	100
Managers and section leaders				
N	7	0	0	7
%	100	0	0	100
Administrative personnel				
N	4	0	1	5
%	80	0	20	100
Other				
N	1	0	0	1
%	100	0	0	100
In total				
N	96	13	40	149
%	64	9	27	100

Source: Translated from Swedish, Table 13 in Eklöf *et al.* (2011)

Table AI. Self-reported learning on dialogue from dialogue training, per job type and in total

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