



Text in an Evaluative Context

Writing for Dialogue

TINEKE A. ABMA

Institute for Health Care Policy and Management, Faculty of Medicine and Health Services, Erasmus University, Rotterdam

Written texts are an important medium for evaluators to communicate their findings. Evaluation reports take many forms and functions, commonly having the character of a scientific text. An objective and factual description informs readers about the activities and outcomes of the program and its underlying mechanisms. In this article I suggest that a scientific text can be useful when an evaluation aims to determine the worth of a program. However, if the goal of evaluation is to promote a dialogue among those who have an interest in the evaluated program a different kind of text is required. In my attempt to identify an appropriate text for such a purpose I describe and apply the notions of texts developed by postmodern writers—self-reflexivity, polyvocality and multiplicity—in an evaluative context. The potential of this kind of text is illustrated and critically examined by the responsive evaluation of a Palliative Care project.

Introducing the Article's Question

For several years, a growing interest in palliative care and palliative care for terminal cancer patients has developed among those who work in the Dutch health care sector. Many initiatives have been recorded, varying from special units within hospitals and nursing-homes to hospices and mobile teams (Francke et al., 1997). Just before the elections, the minister of health announced that resources were available for the development of five centres of excellence in the palliative field.

Palliative (versus curative) care is intended for patients who cannot be cured. Saunders (1984), commonly acknowledged as the founding father of palliative care, described the goal of palliative care as: 'A patient should be enabled to live until he dies'. Traditionally, medical treatment aims to prolong the life of a patient. This implies that the role of health professionals stops when a patient cannot be cured. Palliative care, on the other hand, acknowledges that health professionals still have something to offer in a situation where the patient sooner or later will die. Pain treatment is, for example, an important component to improve or to maintain the quality of life. In the terminal phase, spiritual assistance is also considered to be of

great importance. Many experts emphasize that palliation requires a multidisciplinary approach and a holistic attitude in which the patient is considered as a whole person. The education and practice of health professionals are, however, still dominated by the principles of curative care. This not only results in a lack of knowledge about palliative care, but also means that students and health professionals do not acquire holistic attitudes.

The discrepancy between the increasing need for palliative care and the traditional practice of health professionals was also recognized by the nursing-director of the Slingeland hospital, a middle-sized, general hospital in the eastern part of the Netherlands. In his words: 'About 60 percent of the cancer patients cannot be cured. Right now we can offer these patients very little'. In the fall of 1996 he initiated a project to improve the palliative, oncological care in the surroundings of the hospital. In collaboration with the regional general practitioners association, the regional home care organization and the regional cancer institute, a multidisciplinary consultation team was formed. The team is composed of an oncologist, an oncology nurse from the hospital, a general practitioner and a nurse from home care organization. They are assisted by an oncology nurse and by a chaired coordinator from the regional cancer institute. The initial idea was that medical specialists, nurses and general practitioners could consult the team if they had questions about the care of terminal cancer patients. When this did not work as expected, the team decided to organize lectures, courses and case meetings to communicate the required attitude and insights, for example, how to treat pain.

Our involvement in the Palliative Care project began in the winter of 1996. At that time, a colleague and I met several times with the initiator of the project and the chairperson from the consultation team to talk about the project and the goals of the evaluation. They expected that an evaluation would provide the team with useful information about the project and that regular feedback might lead to eventual modification and improvement of the services provided by the team. A responsive approach to evaluation triggered their imagination. According to this approach, we are living in a postmodern, plural society (Abma, 1996, 1997a; Guba and Lincoln, 1989). Differences between individuals have become more central and consensus about policy goals is no longer given. Instead of assuming consensus, a responsive approach takes *plurality* as a point of departure to facilitate a *dialogue* between those with an interest in the evaluated program. Criteria are not derived from the goals or intentions of the client or policy-maker, but from the various, and sometimes conflicting, values and meanings of a great many individuals with an interest in the evaluated program.

Officially, the evaluation started in February 1997. During the year that followed several activities were carried out (see appendix for an overview of the activities). The findings of the evaluation were presented in two evaluation reports which served as vehicles to stimulate a dialogue about palliative care with the consultation team.

A conventional evaluation report did not seem appropriate to promote such a dialogue. Although evaluation reports take different forms, the text often has the character of an objective and factual account about the activities and outcomes of the evaluated program. Such a text may be suitable for evaluations that try to determine

Evaluation 4(4)

the worth of a program; it does not enable and invite readers to form their own judgements and conclusions. In our attempt to find a kind of text that would facilitate a dialogue we took our inspiration from the textual experiments of postmodern writers. Despite individual differences, their texts are typically self-reflexive, polyvocal and multi-interpretable. Postmodern writers understand themselves reflexively as persons writing from particular positions at specific times. The experiences of those who figure in the text are presented in their own voice and language. The variety of voices is woven into one text, but the relative independence of the voices is maintained. This enables readers to experience the narrated events from a multiplicity of perspectives.

In the remainder of this article, I further clarify these notions and illustrate how we applied them in our evaluation reports. Subsequently, I describe how we structured the dialogues, who participated in them and what the participants discussed. In order to give readers a fuller understanding of the particular context in which the notions of a postmodern text were applied and the kind of the dialogue that was organized, I will first situate the evaluation and define the term dialogue.

Situating the Evaluation and Defining the Term Dialogue

We used a responsive approach to the evaluation of the Palliative Care project. In a responsive approach, human beings (including evaluators) are active interpreters of their world. Interpretation brings different experiences, biographies and socializations into play. These different social, temporal and historical contexts equip different interpreters with different experiential resources. Given the different constituencies to which nurses, doctors, patients and managers belong, we assumed that the Palliative Care project would have diverse, sometimes conflicting, meanings for different individuals. Instead of gathering facts about the activities and outcomes of the project, we were interested in the different meanings the project had for those with an interest in it. We took these differences as the starting-point for a dialogue and we acted as facilitators and mediators (rather than experts or judges).

Dialogue: Characteristics, Aims and Content

Evaluation to Promote Dialogue Many readers will no doubt have been attracted to this article because of the appearance of the term *dialogue*. Guba and Lincoln's (1989) invocation of a 'dialogical paradigm' has alerted many evaluators to the possibilities inherent in the development of a more democratic approach to evaluation. Dialogue may provide an alternative to more autocratic approaches to evaluation, but what kind of dialogue, about what and with what aims or intentions?

A dialogue can be compared with an 'academic marketplace of ideas' where 'stakeholders' discuss 'claims, concerns and issues' (Guba and Lincoln, 1989). This kind of dialogue is dominated by an argumentative rationality. Arguments refer to opinions and persuasions. An argumentative debate has a competitive element; it is about criticizing and defending. The aim is to persuade the other party of the righteousness of one's own standpoints; an argumentative debate creates winners and losers (van Maanen, 1988). One may also understand dialogue as an open conversation.

In an open conversation participants share lived experiences. The term lived experiences does not refer to events, but rather to the way these events are experienced. What is of interest is not what happens but people's images, feelings, sentiments, desires, thoughts and meanings. An open conversation is structured by a narrative rationality. Whereas an argumentative debate aims to reach a final conclusion and judgement, the purpose of a conversation is to enhance the mutual understanding among participants and to define actions for the future.

Substantial topics in a dialogue as conversation are not pre-ordained, but gradually emerge during the process. In this case, we wanted to promote a dialogue about the meaning of palliative care and the consultation team. During the process, several themes and subthemes were recurring. Communication (between health professionals, between health professionals and the consultation team, between health professionals and patients and between health professionals and informal caregivers) appeared to be a central theme; among the subthemes were organizational constraints in the hospital and the organizational changes within the home care organization, the wish of patients to die at home, the overburdening of informal caregivers and the need to pay attention to all the facets of the patient's life.

Back to the Beginning We started our evaluation with a series of interviews with a number of people who had an interest in the evaluated project, including nurses, medical specialists, general practitioners, patients, relatives of patients who died and members of the team. In order to gain a broad spectrum of the values and meanings, the selection of respondents was based on the principle of variety. Respondents were not selected in advance of the evaluation, but during the process of data gathering. In order to do this, we followed the tactical device of Guba and Lincoln (1989): at the end of each interview we asked the name of a respondent whom we might also want to interview because this person would shed further light on the matter. Instead of a conventional qualitative 'question-and-answer' interview, our interviews had the character of a 'natural' conversation. We asked open-ended questions, such as 'What do you do when a terminal cancer patient enters your ward?' and 'What happened when the project started?' and we tried to listen with a minimum of interruption and to use silences as occasions for the respondent to speak.

The analysis of the oral stories was structured by the implied meanings and actions. The following intermezzo gives an impression how this process worked in the analysis of three stories concerning the Palliative Care project. Let us consider the stories of Yolanda, Angela and Mr Stobork.

Intermezzo: An Analysis of the Stories of Yolanda, Angela and Mr Stobork

Yolanda is a nurse who works in the outpatient chemotherapy clinic where many incurable cases of cancer are treated. The patients stay in the oncology or lung ward of the hospital, or at home, and only come to the clinic to receive their medication in the form of chemotherapy. When asked, Yolanda suggested that we might want to speak with her colleague, Angela, in order to get a better understanding of the communication with the nurses of the oncology or lung ward. Yolanda also urged us to talk to their

Evaluation 4(4)

patients. She was very curious to learn how they experience palliative care: 'We never receive complaints, but that doesn't mean the care is optimal'. In response to our question of who might be willing to help us, she named Mr Stobork, a middle-aged man who had stopped working when the oncologist diagnosed cancer in his large intestine.

Since the cancer was diagnosed Mr Stobork has been operated on twice. At the time, he was staying at home with his wife, but regularly attended the hospital to see his medical specialists and to get his medicine. During the interview he told us that the cures are very intensive: 'One of them consisted of 27 treatments. Everyday I took a taxi to go to the hospital. 27 times (sigh) the cures are tiring and I am glad when I have two weeks off'. Mr Stobork has to visit the hospital quite often and he is sometimes confused about the appointments. During the interview, he showed us a card on which the appointments are written down in the order of when they were made; the dates are mixed up and if we asked when the next visit was Mr Stobork had trouble finding it. Another practical matter that bothered him were the costs for the taxi. These are covered by his insurance company, but he has to pay them in advance and send the bills to the company.

The treatment Mr Stobork receives is tiring and has negative side-effects: 'My skin has become brittle. That's the effect of the medicine. I also get diarrhoea'. This means that he has to clean his stoma more often and this takes a lot of time. It also affects his social life: 'Social contacts are becoming more difficult. That's part of it'. Mr Stobork compared the medicine with 'poison'. It is not only devastating for himself, but it is also dangerous for the nurses: 'The nurses have to protect themselves against the poison by wearing green hospital gowns, masks and gloves. That's why I call them poison sisters'. The medicine may have negative side-effects, but in the eyes of Mr Stobork he has no choice. This is the only kind of medicine available. He accepts the situation as long as he can enjoy walking with his dog, cycling and working in the garden: 'These are my hobbies and so long as I am busy with them I am fine'.

Mr Stobork continues his story with an account of what happens when he visits the outpatient chemotherapy clinic. He goes to the room where he gets his treatment and stays there for a few hours. He compares the room with a 'doctor's waiting room': 'Nobody says anything. You chat a bit, and now and then you make a joke. The nurses sometimes come in to check if everything is going alright and then they disappear again. It's okay. I feel how I feel and nobody can change that. I certainly do not want to tell my story over and over again'. While Mr Stobork is satisfied about the psychological support, he is critical about the technical skills of the nurses. He told us the following: 'The first hour I lie on a bed. I am given a yellow fluid and salt suspension. After an hour they inject the poison. But first of all they have to find a vein. They have to be careful, because the poison has to go into the vein and not under the skin. Quite often the nurses have trouble finding the right vein and they take me somewhere else in the hospital'.

What is the message of the story told by Mr Stobork? Mr Stobork says that he is satisfied about the psychological support, but then says that the social support could be improved. He is also critical about the technical skills of the nurses. We thought that he

wanted to stress that his illness encompasses his whole being and that nurses could improve their palliative care if they paid attention to all facets of his life (physical, social, psychological, spiritual and financial) and this structured our composition of Mr Stobork's story.

In response to the question of what happens when a terminal cancer patient enters the clinic, Yolanda told us that when the patient stays on one of the clinical wards she will visit the patient to get acquainted with them. Information about the treatment will be given by the nurses from the clinical ward. The communication with the patient does not always run smoothly. When asked to give an example, Yolanda remembered a situation where she felt ignorant about the patient she visited: 'I thought "Oh, I really miss some relevant information"'. That I find not very professional'. Yolanda said she did not receive enough information from the clinical ward nurses. In general, she thinks the communication with other wards is far from optimal. This is especially true when it concerns patients who stay. Compared with the lung ward, oral communication on the oncology ward has less priority and the written reports which the outpatient chemotherapy clinic receives are often inadequate. She also finds it more difficult to ask for information because she does not know the nurses on the oncology ward. Although Yolanda acknowledges this is partly her own fault, her story implies that she needs the help of others to improve the situation: 'There is much to gain. With more collaboration you would observe things earlier and continuity would also be improved'.

We interpreted Yolanda's story as a call to take action to improve communication between the clinical wards and the outpatient chemotherapy clinic. Angela's story does not imply such actions. She told us that when she lacks information she takes the initiative to sit down and talk about the patient with one of the nurses. In addition, she will read the nurses' report about the patient. Angela has not experienced the kind of situation Yolanda talks about and seems quite satisfied with the current state of affairs. Her story implies that it is one's own responsibility to communicate with the nurses from other wards.

Yolanda continues her story with an account of what happens when a patient actually comes to get a treatment. She tells us she will assess whether the patient can handle the situation himself or whether he needs a psychologist. According to Yolanda, nurses have an important observer role as far as psychological care is concerned. She will also give psychological support herself if needed, but experiences several constraints in doing so. Sometimes the patient might not want to talk. There are also organizational constraints, such as the lack of time and discontinuity: 'We work with many part-timers and on a combined ward. We shift everyday, so patients do not always see the same nurses'. Another problem is the lack of privacy. Angela recognized this problem too and explained that the room where patients receive therapy is not very appropriate for intensive conversations. Other patients will hear what is being said and that inhibits her from probing too deeply: 'You don't want to burden the neighbouring patient'.

In our eyes this part of their stories is directed at the management of the hospital. The nurses' stories imply that actions should be taken to improve the basic conditions that are required to give psychological support.

Evaluation 4(4)

Mr Stobork, Yolanda and Angela told us their stories. Our analysis of their accounts shows that the evaluations of the palliative care practice on the outpatient chemotherapy clinic and implied actions diverge. Mr Stobork's story implies that the practice of palliative care can be improved if nurses pay more attention to all facets of the lives of patients. Yolanda's story implies that actions should be taken to improve the communication between nurses from the clinical wards and the outward chemotherapy clinic and the conditions required to give psychological support. More generally, she urges her colleagues to talk openly about their work; to discuss the actual effects of their behaviour and to search deliberately for the opinions of patients. Her colleague Angela is much more reluctant to encourage actions to change the practice in the clinic. Some things might be improved, but fundamental changes are not necessary. In her eyes the practice can be continued.

The above *intermezzo* shows how we analysed the stories of Yolanda, Angela and Mr Stobork. Other interviews were also interpreted by looking at the meanings and performative aspects embedded in the stories. The *intermezzo* heavily emphasizes the evaluator's interpretive role to underscore the fact that we were not just recording the stories. We interpreted them and wrote what the respondents told us. In order to check the credibility of our interpretations and to prevent any harm that may result from the publication of personal stories (such as repercussions and sanctions) we always checked our interpretations with the respondents. They were the ones who were in control of the published version.

Below, we describe how the stories were composed and organized in the intermediary evaluation report.

Reporting Findings in a Self-Reflexive–Polyvocal Text

Our evaluation was intended to facilitate a dialogue among those with an interest in the evaluated project. We doubted whether a conventional report would be appropriate for such an aim and began to search for a different kind of text. Postmodern writers (including scholars and novelists) appeared to be an interesting source of inspiration, because they have goals comparable to those which we formulated for our evaluation. Instead of communicating a clear message, postmodern writers want to invite readers to generate their own interpretations of a situation. There are many examples of newer textual and typographical forms composed by academic scholars (Braidotti, 1994; Derrida, 1991; hooks, 1990; Kristeva, 1986) and novelists (Byatt, 1996; Calvino, 1979/1995; Ekman, 1997; Jamowitz, 1987; Morrison, 1987/1988; Ondaatje, 1992; Rushdie, 1981/1997). Despite the enormous differences between these writers, their texts are characterized by several common notions (Hutcheon, 1988). I will describe and illustrate these notions with examples from two postmodern novels and show how we applied them to our evaluation reports (Abma and Visse, 1997, 1998).

Multiplicity

Commonly evaluators produce reports with a scientific character. In these texts, readers find a presentation of facts in the form of statistical tests, ratios, numbers and

qualitative data. Theories or models provide readers with unitary explanations about the success or failure of the program. Factual accounts about activities and outcomes of a program may be appropriate to inform readers but they do not encourage a dialogue. The abstract, conclusions and recommendations further curtail the interpretation by readers. The text is relatively tight and closed and it does not leave much room for alternative interpretations. It is coherent and compelling and does not invite readers to dispute its message. This is certainly the case if readers are impressed by the scientific status of the evaluation report. The account is then taken for granted. If readers do question the text, the discussion that follows often has the character of an argumentative debate instead of an open conversation.

Postmodern writers do not present one final interpretation, but a variety of meanings. These meanings are conveyed in stories in which people interpret what happens to them and how they experience these events. Every story is a personal account of the reality experienced by the storyteller; different persons will construct different realities given their various backgrounds and experiences. That is the reason why postmodern writers prefer texts that contain a set of stories. Stories are *open*. Events are connected by a plot (versus logic or causality), and although there may be some kind of causality inferred, the nature of the connection between events is left open. Stories have multiple meanings and this creates room for an infinite process of interpretation and negotiation. In order to derive meaning from a narrative text, readers cannot rely solely on the author. They have to work to connect the disparate images in the text. They cannot passively consume the text and let it determine and govern their experience, but are forced explicitly and deliberately to write while reading.

Rushdie's (1981/1997) *Midnight's Children* is a good example of a text with multiple meanings and interpretations. The book is a search of the main character, Saleem Sinai, into his identity. He starts his search with detailed descriptions of his grandparents and their life in Kashmir, his uncles and aunts, his parents and their complex family relations. After many stories dated before Saleem's birth he begins to tell us about his life. We learn that he was born on 18 August 1947 at 24.00 hours, when India celebrated her independence. As midnight's child, he becomes a symbol of the New India. The detailed descriptions of his ordinary life show that dramatic shifts in private and public history are more the outcome of accidental events, like the time of birth and the impulsive act of Saleem's wet-nurse (in the birth-clinic she changes the baby of the rich Sinai family with a baby from a poor family), than of destiny or historical laws. To understand who Saleem is, Rushdie forces his public to read an endless stream of stories. Readers can identify with Padma, Saleem's housekeeper, who feels annoyed. Impatiently, she urges Saleem to go on and to keep it simple, but he sighs that his complicated life cannot be reduced to one continuous storyline. Again and again, at any one time, other things are happening and have to be told in other stories. As such the text may stimulate a dialogue about the meaning of life; as predetermined, as the outcome of rational choices, as a series of coincidences.

The notion of multiplicity spoke to our imagination, because it enables readers to experience a situation from a variety of viewpoints. If a text does not reduce various meanings to one final truth, it will facilitate a dialogue about this multiplicity. In our evaluation report, we showed the multiplicity of meanings enacted in the practice of

Evaluation 4(4)

palliative care. Concretely, this meant that we presented a collection of stories. The composition of these stories was based on the performative analysis as shown in the intermezzo. In order to stress the personal view of each story we gave every storyteller a name.

We did not end the evaluation report with conclusions and recommendations, nor did we include an abstract. The text has a non-linear structure and the plot that connects the stories is recursive (the difficult communication between people). Since we could not include all the stories, we decided to highlight the stories of those who felt marginalized and whose voice was not (yet) heard. The report includes, for example, an extensive and detailed account of the experiences of a cancer patient. Ultimately, we decided that a story would be included in our report based on the extent to which it illustrated a different reality about the practice of palliative care.

In order to avoid the kind of fragmentation that occurs when the selected voices are reported simultaneously, in the intermediary report we ordered the stories for each location. There is a chapter with stories about the oncology ward, the lung ward, the outpatient chemotherapy clinic and two more about the care given in the home. The stories in the separate chapters are relatively independent, but connected by certain themes. The metaphor Kundera (1986/1988: 73) introduces explains what I mean: storylines are like melodic lines in a polyphony that are bound together but still keep their independence. The theme, for example, that connects the stories in the chapter about the oncology ward is the problematic communication between the professional nurses and a highly skilled lay person who takes care of his wife with cancer. Two nurses explain what happened in this particular case and why a conflict did arise. According to the first, the husband was too exacting. The other one explained that the nurses were not paying enough attention to the needs of his wife, and that they should be more caring. As such, the chapter reveals a range of arguments for and against actions to prevent these conflicts. In the final report, the stories were organized thematically, with communication as a central and recurring theme.

Polyvocality

Commonly evaluation reports are written in a scientific jargon of a certain discipline. Not all lived experiences can, however, be adequately translated into scientific jargon and this implies that certain experiences are neglected if one sticks to the dominant scientific discourse. Women, children and artists are particularly vulnerable in this regard. In their attempt to include 'silenced voices', postmodern writers have experimented with 'polyvocal' texts. Such a text contains a variety of languages, jargons, dialects and discourses (Bakhtin, 1953/1981).

Babel Tower (Byatt, 1996) is an excellent example of a polyvocal text. The title is a metaphor for the confusion of tongues and the idle hope of finding one universal language to overcome mis-communication between people. The book is a rich collection of discourses; of the lingua franca spoken in the courtroom, the fantastic language of the fairytale *Babel Tower*, the official language of the Steerfolk commission, the literary and poetic languages of inserted fragments from novels and poems, a variety of scientific jargons of experts engaged in the trial of the book *Babel Tower* and the journalistic language of those who interview the falsely accused author

of *Babel Tower*. The conflict between discourses is a central theme in Byatt's novel. She shows, for example, that in order to divorce her husband, Frederica has to translate her story into the juridical language of the courtroom. She is afraid that the judge will not hear her because 'The things she knows she cannot say and the things she says are not descriptions of what she thinks was and has happened or is happening' (Byatt, 1996: 517). Frederica has to translate her experiences into the dominant, and masculine, language of the courtroom and she fears the outcome. How can she win the case if there are no words for her experiences?

Babel Tower not only presents a variety of discourses, but also contains a variety of genres: personal letters, fairytales, children's stories, juridical letters and accounts, prose, newspaper articles, and fragments from diaries and poems. Each genre has its own particularities and possibilities. A poem, for example, is very appropriate to express the unique and ambiguous experiences of one person. A fairytale, on the other hand, very clearly states what is morally right and wrong in a certain culture. The genres are typographically distinguished from each other; for each genre another typeface, font, etc., is used. The variety of genres and typographies is not only aesthetically pleasing. Assuming that content and form are closely connected it also enables readers to experience certain events in terms of a variety of voices and languages.

We found the notion of a polyvocal text particularly interesting, because it unsettles the 'real'; a 'carnival' of voices shows readers that there is not one truth or story, but many truths and many stories. Furthermore, it enables an author to include 'silenced voices' without the pretension that people can 'speak for themselves'. According to postmodern writers, this romantic idea is an illusion, because the writer still fashions the final account and has the last word. We can become spokespersons for (silenced) others, but we cannot communicate exactly what they want to say. We can only interpret their speech by saying what we think they mean. The polyvocal text abandons the ambition of speaking on behalf of the other, but it does make readers aware that there are different languages and discourses being spoken within one and the same linguistic tradition, and as such it enables readers to live through the particular reality of many different people.

The notion of polyvocality was applied as follows: we included the professional jargons spoken by the health professionals and management, but also the 'plain talk' used by patients. Whereas Angela, for example, speaks of medicine in terms of 'anti cancer drugs', Mr Stobork talks about 'poison'. The words they use convey different realities. We have deliberately chosen to use the grim term 'poison' in our report, because it aptly reflects the meaning the medicine has for Mr Stobork. Instead of the neutral professional term, it has an emotional connotation. It refers to danger and expresses Mr Stobork's feelings about the treatment and his life-threatening disease. Besides the different professional jargons and 'plain talk', we also used a combination of 'Algemeen Beschaafd Nederlands' [General Civilized Dutch] and the regional dialect spoken in this part of the country.

To underline the diversity and distinctiveness of various experiences and knowledge we used different typographies (typefaces, fonts, sizes). In the final report, we also used various genres, because different genres can highlight different experiences and

Evaluation 4(4)

knowledge; journalistic impressions are, for example, appropriate to describe events, prose to represent experiences and conversations, poems to express personal experiences and letters to share intimate confessions.

Self-Reflexivity

Evaluation reports are usually characterized by an exact, precise, no-nonsense, literal terminology. This does not imply that evaluators make no use of metaphors and rhetorical tactics. They do, but in a very subtle way (Gergen, 1994). The author is absent in the text and passively observes what happens ('the data spoke', 'this study demonstrates', etc.). Experimental presence is often achieved during the initial pages of the report by the use of personal pronouns ('I intended to' or 'We were concerned with') or equivocal possessives ('my initial idea' or 'our hypothesis'). Later, the author shifts from the first-person to the third-person and impersonal pronouns. Affective descriptions (emotions, desires, values or motives) of the evaluator are suppressed in the main text. The pretended objectivity of a scientific report makes it difficult to discuss the findings; these are not just subjective impressions, but facts discovered by a neutral observer.

Postmodern writers believe that we are not passive discoverers of truth, but active constructors of reality. To make readers aware of their personal influence, some use personalizing descriptors. In *Midnight's Children*, Rushdie (1981/1997) uses other means to make readers aware of the manipulation by the author. He introduces, for example, his housekeeper Padma to make his audience aware of the fact that his story is a personal account influenced by the questions raised in conversations with an intimate other. At the end of the book, he confronts readers with the question how to end his autobiography. He discusses several options; to end happily with his wet-nurse caressing his son or with the magic of midnight's children, or with questions or dreams. He decides to write the future as he wrote the past, without final interpretations. Irony is another important weapon to make readers aware of the fallible interpretations by the author. The stories Saleem tells may be convincing, but we should not forget that they are constructions. Indirectly, Rushdie says: 'Do not completely believe Saleem, he does not even believe himself'. This is his way to remain open for other, perhaps more appropriate, explanations to make sense of his life.

The notion of self-reflexivity spoke to our imagination, because it dethrones the author(ity) of the evaluator as 'the one who knows' and as such creates room for a dialogue. Our evaluation report is written in the first person. We used, for example, words like 'our view' and 'we feel'. We showed that our report is influenced by our personal biography and persuasions. Not only did we assert who we are, but we also attempted to draw connections between our personal experiences and the evaluated project. This does not require a full-length autobiography, but it does require a keen understanding of what aspects of the self are the most important filters through which one perceives the world, and more particularly, the topic being evaluated. My colleague described, for example, how her experiences with alternative medical treatments made her more sensitive to the often negative responses given to patients who want such treatments. I wrote that my former education and training as a nurse made me aware of the hierarchic relation between nurses and doctors and that I still feel sympathy for this

underestimated profession. This partly explains why we paid so much attention to the experiences of nurses in our evaluation; it makes their work visible.

Commonly, evaluation reports have the character of a factual and objective account. These texts reproduce the dominant values in science: objectivity, truth and progress. A factual and objective account is usable when the goal of evaluation is to judge whether the project has succeeded or failed, but this kind of text is not appropriate to stimulate a dialogue. We assumed that a self-reflexive and polyvocal text would be more appropriate for such an aim.

Examining the Potential for Promoting Dialogue

Our intermediary evaluation report evoked several conversations among those with an interest in the evaluated project. Some of these conversations occurred more or less spontaneously, others were organized and structured by us. In this section, I will present some of these conversations and critically examine the potential of a self-reflexive and polyvocal text for promoting dialogue.

Spontaneous Dialogues

In order to check the credibility of our findings and to keep respondents involved in the evaluation process, we asked them whether they recognized themselves in our interpretations. To do this, we gave everyone a copy of the chapter that recorded their story. Yolanda and Angela, for example, received a chapter with both their stories and the one of Mr Stobork. After they had read the chapter, they decided to share it with their colleagues in the clinic and this evoked a conversation among the nurses about the quality of care given in the clinic. We have not directly recorded this discussion, but we have a record of the conversation between Yolanda (Y), Angela (A) and my colleague, Merel (M):

M: You both wanted to talk about our interpretation of your interview, because you did not recognize yourselves in it. Is that right?

Y: Yeah. When I had read the text, I felt very angry. My initial response was heavily influenced by the reaction of my colleagues. I showed them the chapter.

M: How did they respond to it?

Y: They interpreted my story not as I had intended it and I feared that my point would also be misunderstood by outsiders.

A: The chapter presents a very negative image of our ward. Mr Stobork's story is, for example, very unusual. I have asked several patients, but they do not recognize the experiences of Mr Stobork. The report is also very critical about the communication with the nurses of other wards and the psycho-social aspects of our care.

The above fragment shows that the draft of our intermediary report not only evoked a conversation among the nurses, but that patients were also included in the dialogue about the palliative care on the outpatient chemotherapy clinic. The conversation continued as follows:

Evaluation 4(4)

Y: I now realize that I have only told negative stories. I haven't told one positive story, whereas I do like to work on this ward. My account was in that sense one-sided.

M: You're missing the positive things you're experiencing?

A: Yes.

Y: I am very critical. I always ask my colleagues why are we doing this, because I think that we should remain alert and continuously try to improve what we're doing.

M: I see. According to us your story is not a negative story. It says many things that can be improved in the clinic. We respect your critical attitude. It is the attitude required to improve the quality of palliative care. That's the reason why we included it in our draft report, but I understand that you want to place your story more in perspective.

Y: If the chapter becomes more balanced

A: Well, then I might also go along with its publication.

M: In a revised version of the report I will emphasize that the stories you have told are personal accounts and not the one and only truth about the clinic. I shall also include this conversation in the report so that readers can draw their own conclusions.

The chapter Yolanda and Angela received did not present one final interpretation about the quality of the palliative care given on the function ward, but was composed of diverging experiences and multiple perspectives. This enabled Yolanda and Angela to draw their own conclusions. They did not do this on their own, but in conversation with their colleagues and Merel, the evaluator. These conversations did not lead to consensus. They did, however, stimulate the self-reflection and enhance personal understanding. Yolanda, for example, became more aware of her critical attitude and the one-sidedness of her account. She acknowledged that she had not given a fair portrayal of the functioning of the ward and wanted to balance her story in the report, but remained convinced that actions should be taken to improve the communication with the clinical wards and the conditions required for psychological care. Angela also stayed with her original interpretation. Her evaluation of the current practice did not change. Although Yolanda and Angela held on to their evaluations, different insights were much better understood and mutual respect did increase. Among the nurses of the ward the conversation has resulted in a client-satisfaction survey.

Organized Dialogues

Working Conferences Besides the conversations that did occur more or less spontaneously, we organized special meetings in which participants were invited to talk about the meaning of the stories in the evaluation report. For the members of the consultation team, two working conferences were organized. Health professionals were invited to participate in story workshops. Although the content and outline of the working conference and story workshops differed, both had an active character. In order to illuminate the multiple meanings embedded in the stories, participants were encouraged to bring their own experiences into play: to articulate their experiences and

views and to engage in a conversation about different meanings and perspectives. The meetings were very carefully prepared. Let me explain who participated, what was presented to them and how the meetings were structured.

On 2 August 1997 the members of the consultation team met to discuss the draft of our intermediary report. Instead of the usual two hours for the regular meetings, we planned three hours. For the occasion, a quiet room with a round table was chosen and we transformed the space with flowers to stress the 'specialness' of the meeting and to raise the members' expectations.

In order to enable members to prepare themselves, the evaluation report was sent to them two weeks in advance. Enclosed, they found a short description of the goals and an outline of the meeting and also a list of questions that would structure the dialogue. Since we saw the team as a group with an interest in the evaluated project, we first wanted to give them the opportunity to respond to the description of their role and activities. We had tried to stress the team's uniqueness and wanted to know whether we succeeded in this attempt; was the description specific enough? We had tried to write a report that would be useful for the team. The second question we asked was what the stories in the report meant for them; what conclusions did they draw? The third question related to the actions that should be taken in future: what to do next? In response to our second question the following conversation started between the nurse from the oncology ward (N1), the nurse from the home care organization (N2), the chair (C), the oncologist (O), the general practitioner (GP), the client-initiator (I) and one of the evaluators (E):

- N1: I would have liked to know whether what we are doing is worthwhile, if there have been questions for the team, if people have shown an interest and why it doesn't work. Some conclusions and recommendations would have been helpful.
- E: It is interesting to see that respondents acknowledge the relevance of the team, but do not act accordingly.
- O: That relates to the central problem of the whole project, doesn't it? We have good intentions, but the core activity still doesn't work.
- C: And then the question arises whether this is a realistic expectation after half a year. If your expectations are too high you'll get disappointed.
- O: Yes, but I am not disappointed. I just observe something what we all have observed.
- I: Before we know another half year slips by without changes. That should not happen.
- O: No.
- I: If nothing changes, we should confront people with the question why they acknowledge the relevance, but do not act alike. Why the need for support does not come out.
- N2: Perhaps it does, but in a different way?
- O: Everybody seems to be motivated and interested, but we are not overdrowned with questions. We can conclude that our initial idea of the help-desk does not work.

Evaluation 4(4)

GP: One might say something happens, but that it remains invisible.

C: I liked to read that people now start to think about 'What is palliative care?'
One person has another vision of it than the other. I think we may attribute that to the team.

The above text shows that the members of the consultation team tried to formulate conclusions through a dialogue about the outcomes of the project. They did not agree upon the criteria and standards of success, and reached different conclusions. The nurse from the oncology ward and the oncologist stated that the team had not been successful. They measured the outcomes of the project in terms of the amount of questions and consultations that have been given. A comparison between the 'factual' effects and intended goals taught them that the project has failed; they have received almost no questions and given no consultations. In order to modify the project, they were interested in the underlying mechanisms that explain its failure. The initiator and the chair of the team did not question these criteria of success, but argued that the standards and expectations were probably too high. They tried to convince other participants that the project needed more time to become known to health professionals. The nurse from the home care organization questioned whether the amount of questions and consultations were the only indicators for the project's success. She suggested that there might be other effects. The general practitioner also acknowledged that there might be effects that remained invisible. The chair of the team named some of these intangible effects, which the report had made visible for her, like the reflection upon the practice of palliative care by health professionals.

Although the conversation did not lead to consensus it made participants more aware of the different evaluations of the project and enhanced their mutual understanding. Later on, we observed that the conversation had also stimulated reflection about the right evaluation criteria and created some doubts among the members of the team. For example, the oncologist was willing to admit that the growing interest in the quality of the palliative care among nurses in the hospital was a positive effect of the project. Other members also slightly changed their criteria and came to different conclusions after the conversation.

The evaluation did not end here. After the presentation of the intermediary report to the consultation team my colleague organized five story workshops with health professionals in order to widen the dialogue among those with an interest in the Palliative Care project. In addition, some individual interviews were carried out. We presented our interpretations in a final evaluation report and again we organized a working conference with the consultation team. The outline was comparable to the one held in August.

The conversation at the 18 March 1998 working conference focused on the communication between the members within the consultation team. The nurse of the home care organization highlighted the fact that the stories in the report showed professionals had problems in approaching patients as individuals whose illness encompassed all facets of life. She doubted whether the holistic attitude and multi-disciplinary approach were adequately communicated to professionals and related her concern to the clinical meetings and the way the members of the team operated in these

meetings. In her eyes, the medical perspective was dominant in those meetings. She had attempted to draw attention to non-medical aspects, but the nursing perspective received hardly any hearing. She said she felt no support from the team members and this disappointed her. Her openness evoked a conversation about the asymmetrical relationship between doctors and nurses, the communication within the team and ideas to improve clinical meetings.

Story Workshops During the second half year of the evaluation we organized a series of five story workshops. The aim was to stimulate the reflection upon the practice of palliative care and to enhance the mutual understanding between nurses within the hospital, between nurses and doctors and between medical specialists and general practitioners. Historically, the relationships between these groups are asymmetrical and tense. Sharing stories in public is not very common and may evoke feelings of fear and shame, so we did not mix these groups and tried to create a safe and comfortable environment. We did, however, expect that an indirect exchange of stories might enhance the mutual understanding and create good working conditions for the future. With the exception of the medical specialists, people appeared to be willing to participate in these workshops if they did not take too much time. We therefore planned the workshops within regular meetings. The groups that attended the workshops were small given the available amount of time, per session, 1 or 2 hours, six people appeared to be the ideal size.

In the workshops, participants were invited to respond to two stories from the report. We selected six stories that were all convincing because of their realism and covered a variety of storytellers, settings, perspectives and themes. The stories were rewritten and edited so that they could be read within a short time. This was done according to the notions of multiplicity, polyvocality and self-reflexivity. We began each story with a juicy quote that typically reflected the frame of the storyteller, then we problematized our role as narrators of these stories and subsequently told the story. Typographically, the diversity of perspectives was expressed by placing the stories in two vertical columns. Depending on the participants, we presented different story combinations (see appendix for overview of selected stories).

At the meetings we introduced ourselves, explained the goals of the workshop and asked for permission to tape the conversation. Participants agreed when we promised that they would be able to respond to our interpretations before publication. After a short reading pause of 5 minutes, everyone was invited to retell the stories in their own voice. The initial responses reflected what participants found important and formed a good start to illuminate the different meanings embedded in the stories. Subsequently, we would ask several questions such as: what do you recognize and what do you miss in the story; can a different story be told; and what would you suggest to the storyteller? After 1 or 2 hours we would end the workshop.

Within the scope of this article, it is not possible to cover the richness of the data collected during these workshops, but the following fragments may offer glimpses how the dialogue expanded. The pieces are drawn from the workshop with the nurses of the oncology ward. The nurses (1, 2, 3, 4, 5, 6, 7 and the evaluator [E]) were asked to respond to the stories told by Yolanda and Mr Stobork.

Evaluation 4(4)

- N1: I recognize the story of the patient. The card with appointments. I have asked myself before if patients would understand the mess. It is not a very logical order.
- N2: There is a paradox. The nurse says she has an observing role and that she wants to talk. The patient says he joins the small-talk of the nurses. The nurse and patient think very differently.
- N3: He [Mr Stobork] accepts many things as they come.
- N4: I find it a very tragic story. Where is the sick person? He just accepts everything, as if it were easy.
- N2: Perhaps he attempts to protect himself.
- N4: That is possible of course. But he tells everything so passively. Then I wonder Is this palliative care? and What is the quality of life of someone who has no control over his situation?

And in response to the story of Yolanda:

- N5: The nurse asks many questions. She does not have an answer to all the questions. She says for example: 'We think a lot about patients, but what do they actually want?' Nobody has an answer to that question. That intrigues me.
- E: Yes, I know they are wrestling with these matters. Do you find the story of the nurse recognizable?
- N6: Yes, I think that compared with our ward the contacts with patients are shorter in the chemotherapy clinic. And what [are]the privacy concerns, we have more rooms. If someone wants to talk we can bring someone to another room. In the chemotherapy clinic there is not much room to sit and talk quietly. I think the privacy is indeed constraining.
- N7: And I also think that the available time is more constraining. Perhaps we can shift things around much more easy.
- N2: Yes, but you could receive the patient in a separate room and then give the chemotherapy. If patients have questions you could answer these first.
- E: That would be your suggestion to the nurses?
- N2: Yes! I think that in the chemotherapy clinic the patient gets the chemotherapy directly when he or she arrives. Talking and acting cannot be done at the same time. If you have to inject the chemotherapy and have to listen at once. As a patient I would not find this a stimulating situation to talk about my problems or illness. I would not feel encouraged to express what lies in my heart.

Several nurses compare the chemotherapy clinic with their ward. They acknowledge and understand that it is hard to pay attention to psychosocial and other needs of the patients because the situation is in many respects much more constraining. They are, however, also critical and emphasize that the constraints can never serve as an excuse to accept the situation as it is. Some say this in a very polite way: N5, for example, finds it 'intriguing' that the nurses have not yet found an answer to the question of what patients want. N2 expresses herself in a less tactical way. She places herself in the

position of a patient and comes to the conclusion that the situation does not stimulate sharing one's feelings and problems. Her message to the nurses is to reconsider how they work. The stories also stimulate reflection on practice. N1 says, for example, that the card with appointments can be improved. They also start a discussion about the quality of life and how patients can be empowered if they are not in control of their own lives.

Transforming the Practice of Writing

Like all forms of writing, the writing of evaluation reports is a socio-historical construction (Richardson, 1994). Although conventions are mutable, I have no illusions that the notion of a polyvocal and self-reflexive text will be easy to adopt.

First, such a text threatens the role of the evaluator as an emotionally detached expert. In a self-reflexive text, authors present themselves as people who write from a particular location that influences what they observe and tell. Self-reflexive authors are modest in their claims to know. This de-authoring tactic may result in a loss of standing (versus respect) and therefore not be attractive for evaluators. The acknowledgement of the limits of knowledge may evoke also strong reactions from policy-makers and others with an interest in the evaluated project or policy (Abma, 1997b). A manager can no longer hide himself behind facts to legitimate certain decisions and others have to face the ambiguity and responsibility that comes with the sharing of power. Resistance is reduced when people understand why the report has an unconventional character. Even more important is the assistance given to derive meanings from the report. Carefully prepared working conferences and story workshops can be helpful.

A polyvocal and self-reflexive text may also be avoided, because it does not contain an objective and 'realistic' account of the program. Stories are often compared with biased, misleading fictions. I see stories, as well as scientific accounts, as social constructions of 'a' reality that we can never truly represent. That some authors are not willing to admit this does not mean that their accounts are more true. Compared with scientific accounts, stories lack precision, systematics and clarity, but this probably tells us more about the nature of reality than the shortcomings of stories. If our world is not simple and determined by natural laws, but complex and ambiguous then we should not reduce its complexity and messiness to achieve a quasi-security, but should accept the imprecision and ambiguity that is inherent in stories. Moreover, stories provide an insight into the meaning of lived experiences and always contain certain moral endpoints, which lead to certain actions. This implies that stories implicitly contain certain 'prescriptions' and as such they have an undiscovered worth for evaluators (Abma, forthcoming).

There are also developments in the context of evaluation that stimulate the interest for texts which promote dialogue. Given the plurality of our society and the rising scepticism towards experts, policy-makers and managers began to realize that conventional, hierarchic conceptions of programming are no longer effective (Abma, 1997a). When policy-makers have adopted more interactive forms of programming they are often easy to convince that it would be contradictory to evaluate those programs without the active involvement of those with an interest in the evaluated program. Such

responsive and participative forms of evaluation require evaluation reports that facilitate dialogue.

Acknowledgment

This is a revision of a chapter on narrative strategies (Abma, 1996). I would like to thank Jennifer Greene, Alexis Kaminsky, Murray Saunders and Elliot Stern for their encouragement, thought-provoking questions and suggestions. The article is based on the stories of those who had an interest in the evaluated project. I would like to thank all of them. Last and not least I want to acknowledge my colleague, Merel Visse, who has the talent to translate abstract thoughts into practice.

References

- Abma, Tineke A. (1996) *Responsief Evalueren, Discoursen, Controversen en Allianties in het Postmoderne*. Delft: Eburon.
- Abma, Tineke A. (1997a) 'Playing with/in Plurality, Revitalizing Realities and Relationships in Rotterdam', *Evaluation* 5(1): 25–48.
- Abma, Tineke A. (1997b) 'Sharing Power—Facing Ambiguity', in L. Mabry (ed.) *Evaluation and the Post-Modern Dilemma, Advances in Program Evaluation*, Vol. 4. JAI Press.
- Abma, Tineke A. (forthcoming) 'Introduction', in T. A. Abma (ed.) *Telling Tales. On Evaluation and Narrative, Advances in Program Evaluation*, Vol. 6. JAI Press.
- Abma, Tineke A. and Merel Visse (1997) *Responsief Onderzoek naar Transmurale Palliatieve Zorg voor Oncologie Patiënten*. Doetinchem: internal report.
- Abma, Tineke A. and Merel Visse (1998) *Het Gesprek Geopend*. Doetinchem.
- Bakhtin, M. M. (1953/1981) *The Dialogic Imagination*. Austin: University of Texas.
- Braidotti, R. (1994) *Nomadic Subjects. Embodiment and Sexual Difference in Contemporary Feminist Theory*. New York: Columbia University Press.
- Byatt, A. S. (1996) *Babel Tower*. London: Vintage.
- Calvino, Italo (1979/1995) *Als op een Winternacht een Reiziger* [If on a Winter's Night a Traveller]. Amsterdam: Ooievaar Pockethouse.
- Derrida, J. (1991) *A Derrida Reader Between the Blinds*. New York: Harvester.
- Ekman, K. (1997) *Breng Mij Weer tot Leven*. Amsterdam: Bert Bakker.
- Francke, A. L., A. Persoon, D. Temmink and A. Kerkstra (1997) *Palliatieve Zorg in Nederland. Een Inventarisatiestudie naar Palliatieve Zorg, Deskundigheidsbevordering and Zorg voor Zorgenden*. Utrecht: NIVEL.
- Gergen, K. J. (1994) *Realities and Relationships, Soundings in Social Construction*. Cambridge: Harvard University Press.
- Guba, Egon G. and Yvonna S. Lincoln (1989) *Fourth Generation Evaluation*. Beverly Hills, CA: Sage.
- hooks, b. (1990) *Yearning: Race, Gender, and Cultural Politics*. Boston, MA: South End.
- Hutcheon, L. (1988) *A Poetics of Postmodernism, History, Theory, Fiction*. New York: Routledge.
- Jamowitz, T. (1987) *A Cannibal in New York*. New York: Crown Publishers.
- Kristeva, Julia (1986) *The Kristeva Reader*. Oxford: Basil Blackwell.
- Kundera, M. (1986/1988) *The Art of the Novel*. Grove Press.
- Morrison, T. (1987/1988) *Beminde* [Beloved]. Amsterdam: Bert Bakker.
- Ondaatje, M. (1992) *The English Patient*. London: Picador.

- Richardson, L. (1994) 'Writing, A Method of Inquiry', in N. K. Denzin and Y. S. Lincoln (eds) *Handbook of Qualitative Research*, pp. 516–29. Thousand Oaks, CA: Sage.
- Rushdie, S. (1981/1997) *Middernachtskinderen* [Midnight's Children]. Amsterdam: Pandora.
- Saunders (1984) Speech.
- van Maanen, J. (1988) *Tales of the Field: On Writing Ethnography*. Chicago, IL: University of Chicago Press.

Appendix

Overview of the Activities

The evaluation of the project started in February 1997 and ended in April 1998. In this period the following activities were conducted:

Interviewing In total, we conducted approximately 25 interviews with hospital nurses, medical specialists, general practitioners, home care nurses, members of the consultation team, the initiator, a patient and relatives of patients who died. We also spoke informally with many people who were indirectly involved in the evaluated project, for example, with several management assistants in the hospital. The interviews had the character of an informal conversation. Questions were open and structured by the topics brought up by the respondents.

Participating and Observing My colleague had an office in the Slingeland hospital during the year of the evaluation. This enabled her to familiarize herself with the discourses of the nurses and medical specialists. She also attended several meetings where nurses from home care organizations discussed medical–technical problems and followed a general practitioner. Furthermore, she participated in the meetings of the consultation team held twice a month and attended the trip the team made to several hospices in the UK.

Organizing Working Conferences and Story Workshops In the second half year, we organized two working conferences with the consultation team and five story workshops with homogeneously composed groups of (home care) nurses and general practitioners. The findings in the (intermediary) evaluation reports formed the input for these meetings. The meetings aimed to stimulate reflection upon the practice of palliative care and the role of the consultation team, to enhance the mutual understanding between those who belonged to different constituencies and to formulate actions for the future.

Transcribing, Ordering and Analysing The interviews and conversations during the conferences and workshops were tape-recorded and transcribed, ordered and analysed during the process of information gathering and the findings structured its continuation. We focused on the lived experiences and the claims and actions implied in the oral stories and conversations. After every interview and conversation, we asked for feedback from the respondents to check the credibility of our interpretations (member checks) and to keep them involved. The respondents remained in control of the final publication of their stories.

Evaluation 4(4)

Overview of the selected stories presented in the workshops

Storyteller-Setting	Theme	Perspective
1 Nurse—chemotherapy clinic	Holistic approach	Organizational constraints
2 Patient—ibid.	Ibid.	Illness and all facets of life
3 Nurse—oncology ward	Communication layperson	Loss of autonomy
4 Informal caregiver—ibid.	Ibid.	Well-being of wife
5 General practitioner	Communication between professionals	Changes in organization
6 Nurse—lung ward	Hospital—home	Organizational constraints

- Nurses of the oncology ward responded to stories no. 1 and 2.
- Nurses of the chemotherapy clinic responded to stories no. 2 and 6.
- Nurses from the lung ward responded to stories no. 3 and 5.
- Nurses from the home care organization responded to stories no. 5 and 6.
- General practitioners responded to stories no. 5 and 6.

Reporting The client and the consultation team were informed about our findings on a regular basis. In August 1997, we presented an intermediary report. The report had the character of a working document and formed the basis for a dialogue about palliative care and the team. In April 1998, the evaluation was concluded with a final evaluation report and a working conference with the consultation team. The team decided that the final evaluation report should be disseminated among a wider audience of health professionals and organizations within and outside the region to promote an ongoing conversation.

TINEKE A. ABMA, PhD, is member of staff at the Department of Health Policy and Management at the Erasmus University. She teaches organizational studies, strategic decision-making and policy analysis. In her research, she investigates the potential of a responsive approach to evaluation that 'fits' with new kinds of decentralized, bottom-up and interactive styles of social planning in a plural, postmodern society. Currently, she is editing a volume on evaluation and narrative in the series *Advances in Program Evaluation* (JAI Press). Please address correspondence to Department of Health Policy and Management, Erasmus University, Rotterdam, The Netherlands.