COLLABORATION IN REHABILITATION TEAMS

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# TABLE OF CONTENTS

**ABSTRACT** ........................................................................................................................ XI

**CHAPTER 1 INTRODUCTION** ........................................................................................... 1

1.1 MY STARTING POINT ................................................................................................. 1
1.2 RESEARCH TOPIC AND RATIONALE ........................................................................... 4
1.3 RESEARCH GOALS AND QUESTIONS ........................................................................ 8
1.4 CONTEXT AND BOUNDARIES OF THE PROJECT ..................................................... 10
   1.4.1 Rehabilitation ........................................................................................................ 10
   1.4.2 Health care ........................................................................................................... 14
   1.4.3 Organisations as a context for teams .................................................................... 20
   1.4.4 Health care teams ............................................................................................... 22
   1.4.5 Health professions and professional practice ...................................................... 26
1.5 OVERVIEW OF THE RESEARCH STRATEGY ........................................................... 29
1.6 SIGNIFICANCE ........................................................................................................... 30
1.7 STRUCTURE OF THESIS ......................................................................................... 31
1.8 DEFINITION OF KEY TERMS .................................................................................... 31
1.9 CONCLUSION ............................................................................................................. 32

**CHAPTER 2 FRAMING THE COLLABORATIVE CHALLENGES OF THE RESEARCH SPACE** .................................................................................................................... 33

2.1 INTRODUCTION .......................................................................................................... 33
2.2 MEANINGS AND PROVISION OF HEALTH CARE ..................................................... 33
   2.2.1 Purposes of different meanings of health .............................................................. 34
   2.2.2 Different frameworks of health care ...................................................................... 39
   2.2.3 Health professional practice ............................................................................... 42
2.3 THE AUSTRALIAN HEALTH CARE SYSTEM ............................................................ 57
   2.3.1 Organisational and structural factors .................................................................. 57
   2.3.2 Future directions .................................................................................................. 64
2.4 REHABILITATION ........................................................................................................ 65
   2.4.1 Development of rehabilitation ............................................................................ 65
   2.4.2 Conditions requiring rehabilitation ..................................................................... 69
   2.4.3 Rehabilitation teams ........................................................................................... 72
2.5 CONCLUSION ............................................................................................................. 77

**CHAPTER 3 OVERVIEW OF THE RESEARCH STRATEGY** ............................................... 79

3.1 INTRODUCTION .......................................................................................................... 79
3.2 RESEARCH PURPOSE AND RESEARCH QUESTIONS ............................................. 79
3.3 INTERPRETIVE RESEARCH PARADIGM ................................................................... 83
3.4 OVERVIEW OF HERMENEUTICS .............................................................................. 84
   3.4.1 Concepts orienting my understanding of hermeneutics .......................................... 85
   3.4.2 Interpreting texts ................................................................................................... 87
3.5 INTRODUCING STUDIES AND RESEARCH APPROACHES .................................... 88
   3.5.1 Philosophical hermeneutics and Study A ............................................................. 88
   3.5.2 Hermeneutic phenomenology and Study B ......................................................... 89
CHAPTER 5 STUDY A: COLLABORATION IN THE LITERATURE – A
PHILOSOPHICAL HERMENEUTIC INTERPRETATION ......................... 93

4.1 INTRODUCTION TO STUDY A .......................................................... 93
4.2 METHOD FOR STUDY A ................................................................. 94
  4.2.1 Philosophical hermeneutics .................................................. 94
  4.2.2 Analytical tools of philosophical hermeneutics ..................... 94
  4.2.3 Theoretical framework for viewing collaboration ............... 100
  4.2.4 Constructing and dialoguing with text sets ....................... 108
  4.2.5 Presentation of findings ..................................................... 111
4.3 FINDINGS OF STUDY A: PHILOSOPHICAL HERMENEUTICS .......... 112
  4.3.1 Overview of diversity of understandings of collaboration: Text Set 1 ... 113
  4.3.2 Dimensions of collaboration: Text Set 1 ............................. 120
  4.3.3 Collaboration in the health care literature: Text Set 2 .......... 138
  4.3.4 Critical appraisal of Study A ............................................ 177
4.4 CONCLUSION .................................................................................. 182

CHAPTER 5 STUDY B: COLLABORATING IN REHABILITATION TEAMS –
A HERMENEUTIC PHENOMENOLOGICAL EXPLORATION .................. 183

5.1 OVERVIEW OF CHAPTER 5: METHODS AND FINDINGS ............. 183
5.2 OVERVIEW OF PHENOMENOLOGY .............................................. 183
  5.2.1 Phenomenology as a philosophy .................................... 183
  5.2.2 Phenomenology as a research method .............................. 185
5.3 MY STRATEGY FOR UTILISING HERMENEUTIC PHENOMENOLOGY .... 187
  5.3.1 Orienting to the phenomenon ...................................... 187
  5.3.2 Collecting experiential material .................................. 189
  5.3.3 Interpreting meaning structures .................................. 189
  5.3.4 Illuminating the phenomenon .................................. 190
5.4 OVERVIEW OF DATA COLLECTION PROCESSES AND RESEARCH PARTICIPANTS 192
5.5 ETHICAL CONSIDERATIONS ......................................................... 195
  5.5.1 Informed consent and participant recruitment .................. 195
  5.5.2 Ensuring anonymity and confidentiality .......................... 198
  5.5.3 Inadvertent access of health information without patients’ consent .... 199
5.6 SELECTION OF TEAMS AND RECRUITMENT AND PARTICIPANTS .......... 199
  5.6.1 Selection of institutions to recruit participants .............. 199
  5.6.2 Recruitment of participants ....................................... 200
5.7 DATA COLLECTION ........................................................................ 202
  5.7.1 Observation ................................................................. 202
  5.7.2 Semi-structured interviews ....................................... 203
  5.7.3 Field notes ................................................................. 204
  5.7.4 Analytical and procedural journals .............................. 205
  5.7.5 Means of ensuring data quality for observations and interviews...... 206
I, Anne Croker, hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgment is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

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Anne Croker

June 2011

* Subject to confidentiality provision as approved by the University.
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ABSTRACT

Collaboration is inherent in health care systems. Conceptually, collaboration is valued. Yet how well is collaboration enacted and supported and what does collaboration that contributes to patient-centred care look and feel like? Within the wealth of existing information about teamwork and collaboration, I identified the need for research to address the complexities of the phenomenon of collaboration in patient-centred health care, particularly in relation to interactions among health professionals and to the organisational support required to promote effective team collaboration. The aim of this research was to develop a deeper understanding of the nature of collaboration in health care, in particular of how professional team members collaborate in rehabilitation.

Rehabilitation teams were chosen as an appropriate context for this study since (a) such teams highlight the complexity of collaboration due to the range of different disciplines involved, (b) there is a long history of teamwork in rehabilitation, and (c) there is need for patients and carers to participate actively in rehabilitation processes. The latter is of particular relevance given the focus in this research on patient-centred care.

The overall research questions explored in this project were:

What is the nature of collaboration?
How do people experience collaborating in rehabilitation teams?
How does effective collaboration in teams promote patient-centred health care?
What organisational support is required for collaboration to flourish and effectively contribute to patient-centred health care?

The research approaches of philosophical hermeneutics and hermeneutic phenomenology were suitable for investigating the phenomenon as an abstract concept and as a contextualised human experience. Philosophical hermeneutics (Study A) enabled me to develop a deep understanding of the nature of collaboration (the noun) as presented in the literature; hermeneutic phenomenology (Study B) illuminated the experiences of rehabilitation team members collaborating (the verb).

Key dimensions of collaboration and collaborating were identified. Collaboration was seen to involve four key dimensions of place, people, purpose and process, across which ordered and organic modes of collaboration operate. Place refers to the situation of collaboration both in teams with stable membership and in groups with evolving networks. People refers to the team members involved (both as representatives of their
discipline roles and as unique individuals). Purpose refers to the goals or intended outcomes, that can be externally driven and rather more predictable or internally driven and more dynamic. Process refers to ways of communicating and interacting that can be both predetermined, predictable and trainable, as well as chosen and opportunistic, based on evolving relationships and situations.

I interpreted collaborating to involve five **endeavour** dimensions (**engaging** positively with each other’s diversity, **entering** into the form and feel of the team, **establishing** ways of communicating and working together, **envisioning** together patients’ rehabilitation frameworks with others, and **effecting** changes in people and teams) and three meta-behavioural **reviewing** dimensions (**reflexivity** involving critical reflection and development of self in relation to others, **reciprocity** enabling mutuality of health care roles, and **responsiveness** in facilitating situationally appropriate and contextually relevant adjustments to collaboration).

I developed a view of collaboration that was both systematic and organic from these findings of Studies A and B. From this view I developed **The RESPECT Model of Collaboration**, where collaboration is presented as

- **R** Reflexive
- **E** Endeavours (in)
- **S** Supportive
- **P** Practice (for)
- **E** Engaged
- **C** Centred-on-People
- **T** Teamwork.

The title RESPECT reflects the goal and practice of patient-centred care and the dimensions of collaboration and collaborating discussed above. As well as producing The RESPECT Model of Collaboration, which has value for use in practice and education, this research has stimulated a range of questions and recommendations for future research.
CHAPTER 1
INTRODUCTION

“Truth is not found in parts, but in the interconnected totality”
(Skirbekk & Gilje 2001, p.311)

1.1 My starting point

The goal of this research was to examine the way people (mainly professional staff) collaborate to provide patient-centred rehabilitation. The setting is neuromusculo-skeletal rehabilitation in Australia, specifically in one area health service. The choice of collaboration as research topic arose from my fascination with the complexity of people working together in health care. On the surface it might seem obvious that health professionals would work with each other and with patients and carers towards shared goals; shared goals that facilitate integrated and situationally¹ appropriate health care for each particular patient. After all, why would health professionals not work with those involved with their patients’ care, and why would they not include their patients’ perspectives, fears and aspirations in their decision making? It would also appear evident that organisations would support such care. How could organisations not actively seek to facilitate such practice?

The volume of literature on the subject indicates that even with the increasing research, policy support and educational emphasis on interprofessional practice and shared decision making with patients and carers, collaboration remains a challenge for practitioners, managers, policy-makers, educators and those receiving health care. I was curious about what it was about collaboration that rendered it so complex and so elusive.

The choice of rehabilitation teams as the setting for this study of collaboration was motivated by several considerations including: (a) the necessity of the health care system to service the needs of an aging population, with older people commonly requiring rehabilitation services (thus my research would be useful), and (b) the opportunities provided by rehabilitation situations to see teamwork in action (thus I would be likely to access collaboration). I see rehabilitation as ideally a patient-centred, situation.

¹ “Situation” includes the patient’s preferences and life/wellness circumstances, the immediate health care setting, and the broader health care context (e.g. policies, economies and organisational systems).
team-facilitated endeavour undertaken within health care institutions. Rehabilitation commonly involves a range of health professionals (including nurses, doctors, physiotherapists, occupational therapists, speech pathologists, nutritionists, social workers\(^2\) and neuropsychologists).

Teamwork has long been key to providing a range of health care services, including rehabilitation. Throughout my varied experiences as a health professional and community member I have worked in a range of teams. For example, as a health professional I have participated as a physiotherapist in rehabilitation teams and a lactation consultant on advisory committees, while as a community member I have been the president of the board of a large national not-for-profit organisation and held the role of convenor of a local sporting committee. My fascination with teams was heightened by my involvement in a particular health promoting team where I was aware of an almost exhilarating sense of “so-this-is-collaboration!” This was a different experience from that in many other teams I had worked in. I had found a new reference point against which I critiqued my other collaborative experiences and I developed a new respect for what could be achieved through collaboration, as well an awareness of its complexities and challenges.

I began to see collaboration as being more than working mechanistically or overtly cooperating with others (such as might occur when horses pull together to move a cart, or cars are assembled by a team of factory workers). I saw collaborative teamwork as having the potential to encompass the invigorating problem-solving, difference-embracing and barrier-dissolving styles of interaction I had experienced. Collaboration, to me, became a broad term referring to the process of sharing of knowledge, thoughts and perspectives between different people to achieve a common purpose. I saw collaboration as underpinned by effective communication, group facilitation skills and organisational support. I understood collaboration to be a phenomenon with potential to deal with the subtleties, uncertainties and ambiguities of a range of different people working together. The differences that people brought to collaborative situations provided potential for new understandings and new ways of working.

With my heightened interest in teams and evolving interest in collaboration, I became more attuned to the collaboration stories of others, and found they were often tinged

\(^2\) Although I recognise social workers’ broader social care roles, in this thesis I include social workers as professionals contributing to health care.
with frustration and scepticism. I heard that despite the increasing emphasis on collaboration within health care, health professionals often faced challenges in developing and sustaining collaboration, particularly in relation to the people they worked with and the requirements of the organisations they worked within. They were required to comply with regulations, be measurably efficient, maintain a balance between being a member of a particular professional discipline and an interprofessional team, simultaneously work with the different expectations of society, management, professions, patients and carers, and continue to develop their professional practice capabilities. It appeared that some characteristics of health care organisations and the people within them created opportunities for collaborative synergies whereas others created barriers that could impede collaboration.

I brought to this research an awareness of the many contextual influences on the way people work together. For example, I heard from colleagues how time pressures, poor remuneration for team meetings, staff shortages, lack of evidence-based guidelines to inform teamwork, and obstructive workmates could decrease their participation in collaboration. Yet I also heard how opportunities to get to know other health care staff through work-organised sporting matches and social events provided a foundation for establishing relationships in potential/emerging collaborative situations, or a basis for cementing valued relationships in established teams. In relation to time, resources and opportunities for interpersonal interactions, it appeared to me that organisational support and people’s work and life contexts mattered for collaboration.

I was also mindful of what collaboration might mean to different people in their varied roles. The manager of a hospital, who views collaboration in terms of efficiency of services, seeks to assign a dollar value to collaboration. The health professional, who represents a particular discipline and deals with discipline territories and professional boundaries, is also enmeshed within the interpersonal intricacies of collaboration. The educator, who seeks to prepare novice practitioners to deal with the uncertainties of working with others, is also required to evaluate and assess their capabilities for practice in the future. Then, most importantly, I contemplated the people at the centre of the collaborative efforts, the patients and their carers, who can be overwhelmed by the challenges they face with their newly altered bodies and interrupted lives. They are both the focus of the health care team’s collaboration as well as participants in their care.
The nature of rehabilitation requires that patients and carers participate actively in their therapy. Viewing patients’ and carers’ participation as core to collaboration, I recognised and valued the uniqueness of each patient’s situations, aspirations, fears and capabilities. However, although I initiated this research with the view that patients should be key, recognised members of rehabilitation teams, I changed my view as the research began. I realised that without equivalent agency in teams and responsibility for ongoing team development, patients were the focus of the team without being consistently accepted and empowered as team members. The issue of their decision-making role and agency was a variable phenomenon and was parallel to, rather than inherent within team membership. Rather than explicitly portraying their voices, this research uses patients’ and carers’ experiences as a vantage point for viewing and interpreting the (staff) team members’ experiences of collaborating. Other studies are needed to examine more deeply the patient and carer role in collaboration. Thus I brought to this research my fascination with the ways people work together in health care organisations and my interest in contextually relevant and situationally appropriate patient-centred health care. Neither a “one size fits all” nor a “just do it” approach to teams and collaboration can take into account the myriad differences arising from people dealing with specific situations related to particular settings within the broad context of health care. Rather I viewed collaboration as needing to be critically and consciously relevant to the context, setting and situation, to be responsive to people’s current situations and the varied roles they play in health care, and to recognise the uniqueness of the individuals involved.

1.2 Research topic and rationale

This research explores collaboration as a complex and inherent component of professional practice in health care, specifically in rehabilitation teams. Increasingly the image and role of clinicians working independently within their prescribed discipline framework of roles and expertise are modified by an emphasis on collaboration and a blurring of disciplinary boundaries. The impetus for this transition is multifaceted and is commonly linked to:

- fragmentation of health care, as a result of which different health care approaches (such as acute care, rehabilitation and preventive health) have different structures for their delivery (for example varied funding models for
different health professional disciplines, including medical, nursing and allied health staff);

- increased specialisation of staff and services, resulting in patients potentially being treated and cared for by many people representing a range of health professional disciplines (and discipline sub-specialties) throughout the course of their illness (for example, a rehabilitation patient may be assessed and treated by an emergency physician, a neurologist, and a cardiologist before being assessed by a rehabilitation specialist for suitability for rehabilitation involving nurses and a range of allied health professional disciplines);

- an aging population with co-morbidities, in which people require treatment for a number of co-existing and interrelated health problems, many of which are beyond the scope of one particular health professional discipline;

- economic rationalisation which seeks to avoid duplication of services or errors through lack of communication.

Health care policies and directions commonly call for increased collaboration among health professionals. For example, a key principle of a health service performance management recommendation for the New South Wales Department of Health encouraged “collaboration and communication to aid the exchange of information and better coordinate all aspects of service delivery” (Keating, Cox, & Krieger 2008, p.7). However, although it is a core component of many current health-care directions, collaboration is not necessarily easy or straightforward to implement.

My starting point for exploring collaboration is my stance that the complexity of the phenomenon of collaboration precludes an easy grasp of its entirety and depth. Despite the increasing amount of research into teams and collaboration, research has tended to inform understanding of particular aspects of collaboration without synthesis into a meaningful whole understanding. Research focusing on collaboration between or within specific professional disciplines (e.g. Garber, Madigan, Click et al. 2009; Wertheimer, Roebuck-Spencer, Constantinidou et al. 2008) is not necessarily meaningful for other professional groups. Measurements of collaboration, such as team members’ attitudes towards collaboration (e.g. Hojat, Fields, Veloski et al. 1999) may not capture the complexity and the varied meanings of the phenomenon. Patients’ perceptions are rarely included in team collaboration research, and explorations of patients’ involvement in team collaboration are largely absent.
Further, although the dynamic nature of health care teams is acknowledged (e.g. Lingard, Espin, Evan et al. 2004), I found that the impact of frequent changes to team membership on collaboration remains unexplored, as research has tended to concentrate on stable and identifiable teams. Despite the majority of research exploring collaboration from narrow standpoints (such as that of particular disciplines interacting with each other, patients interacting with one professional group, or stable teams), the reality of collaboration involves a much broader range of health professionals and teams with changing membership.

In this thesis I acknowledge the importance of the organisational context of health care. Organisations have influence on the capacity for people to collaborate by ensuring sufficient time, structures, guidance and opportunities for team members to interact with each other. I also acknowledge the influence of the particular settings and the specific (patient-focused) situations in shaping collaborative practice. People working in different settings and situations require and exhibit varied needs of collaboration. For example, an established team of health professionals, with a clear understanding of responsibilities, roles, and communication styles, can plan, coordinate and provide clinical management for patients with uncomplicated medical conditions through regular team meetings and ongoing informal communication. This collaboration may be characterised by ease and familiarity in relation to the people involved and the resources and team processes used. In contrast, the clinical management of a patient with a complex medical condition living in a remote area may require geographically disparate staff to form a temporary team to negotiate roles, clarify expectations and monitor change. In this situation health professionals may have to explore and establish appropriate means of communication, to understand and be flexible with others’ capabilities, and to work within available resource and time constraints.

Although collaboration is important in all areas of health care, I have chosen to locate this research in the area of rehabilitation. Teamwork is a familiar concept in rehabilitation and I anticipated that this setting would be conducive to accessing a range of teams and health professionals’ experiences with collaboration. Rehabilitation can be viewed as one of a number of different types of health care. Polgar (1962, p.164) claimed that “the career of the client as his health status changes through time can be divided into the antecedents of illness, periods of altered health (including exposure to health action), and the side effects and after-effects of illness”. In relation to Polgar’s
patient-centred conceptualisation of health care, rehabilitation is concerned with addressing the side effects and after-effects of illness.\(^3\)

As collaboration is essentially an interpersonal\(^4\) activity, the notion of people is central to this research. People are present in this research through my framing of health care as being necessarily patient-centred, through my focus on the individual and collective capabilities of those involved in health professional practice, and through my recognition that people involved in collaboration may experience the phenomenon differently.

In this research I am seeking to understand and inform health care that values patients and health providers as people. This thesis starts from my stance that health care needs to be patient-centred, and that this patient-centredness values people; that is, the totality of each person and their values, situations and capabilities. In this stance patients are viewed as people with will, agency, needs and preferences rather than disease entities or objects for the delivery of cost effective services. I also include those who deliver health care as being integral to the practice and concept of patient-centredness. Because health professionals and other staff are affected by and effect patients’ health care, they are also persons of interest. This research considers patient-centred health care in relation to rehabilitation services delivered by teams of health professionals who work with each other and with their patients and carers.

The patient-centred stance of this thesis is strengthened by embracing the notion that people bring their own understandings and socialised perspectives to health care collaboration. Different meanings and interpretations of health care and collaborative situations are integral to patient-centred health care. I do not subscribe to a belief that there is one single truth about collaboration to be revealed. Rather, by exploring a phenomenon from various perspectives, research can generate different insights and meaning.

This project is significant because the complexity and multifaceted nature of collaboration was embraced and a broad view of collaboration was pursued. In this way this research provides a contextually relevant and situationally appropriate basis to

\(^3\) In this conceptualisation I consider injury to be included in the notion of illness.

\(^4\) In this thesis, “interpersonal” refers to interactions between people but is not necessarily restricted to interactions between two people.
inform the development of collaboration as an important component of patient-centred health care.

1.3 Research goals and questions

From the discussion above I established my starting point for this research as follows:

- collaboration is the phenomenon I am exploring
- collaboration among staff in rehabilitation teams in health care is the setting and context under investigation;
- effective collaboration is inherently situationally appropriate (no one approach to collaboration fits all circumstances and conditions);
- collaboration is a lived phenomenon (it is appreciated, enacted and experienced differently by different people).

Based on this interpretation of collaboration, the goal of this research was to inform the development of collaboration as part of patient-centred health care by (a) exploring conceptualisations of collaboration in the literature (in Study A, a philosophical hermeneutic study) and (b) illuminating experiences of collaborating in the setting of rehabilitation teams (in Study B, a hermeneutic phenomenology study). The first of these studies is important because it frames the expectations and current knowledge and insights of collaboration, the second because it reveals actual experiences and subjective realities of collaboration.

The overall research questions I explored were:

- What is the nature of collaboration?
- How do people experience collaborating in rehabilitation teams?
- How does effective collaboration in teams promote patient-centred health care?
- What organisational support is required for collaboration to flourish and effectively contribute to patient-centred health care?
Study A explored conceptualisations of collaboration in the literature with the following sub-questions:

- How is collaboration conceptualised in the literature?
- According to the literature, what is the nature of collaboration in health care (including in rehabilitation teams)?
- How can collaboration contribute to patient-centred health care?
- What organisational support is required for collaboration to flourish and effectively contribute to patient-centred health care?

Experiences of collaborating in rehabilitation were explored in Study B through the sub-questions:

- What is the nature of the lived experience of collaborating in rehabilitation teams?
- What dimensions of collaborating are evident in team members’ experiences?
- How can collaborating (by rehabilitation team members) contribute to patient-centred health care?
- How does organisational support for rehabilitation teams’ collaboration contribute to patient-centred health care?

The similarity of the two final questions in both studies provided a link to integrate the findings from Studies A and B.

The term *collaborating* was introduced in Study B to highlight the *actions* and *being there* of collaboration. As I began to engage deeply in both studies I came to the realisation that I was looking at two different aspects of the phenomenon of collaboration. Although collaboration was explored as an abstract noun in Study A (broad and interesting as an academic topic) I realised, as I explored how people experienced this abstract phenomenon in Study B, that I was exploring collaboration as a verb, that is *collaborating*. Further, the act of *collaborating* involves people engaging with each other, an explicit focus which strengthened the person-centred stance of this research. Thus, the verb *collaborating* provided me with an opportunity to explore the phenomenon of collaboration as the actions, motivations and choices of people as they are experienced in different ways by members of rehabilitation teams.
1.4 Context and boundaries of the project

This research is located within the frame of reference of patient-centred health care, in particular rehabilitation, and in the multifaceted area of health care teams, organisations, and professional practice.

1.4.1 Rehabilitation

People require rehabilitation for a range of reasons. They may require neuromusculoskeletal rehabilitation (for conditions including brain injury, stroke, spinal cord injury and musculoskeletal disorders such as arthritis, fracture and amputation), cardiopulmonary rehabilitation (for situations such as post-myocardial-infarct or chronic respiratory insufficiency) and rehabilitation for mental health and behavioural difficulties. Due to my particular interest and experience in neuromusculoskeletal teams, as well as the scope that field provided for exploring collaboration amongst a wide range of health professional disciplines, this research focused on teams providing neuromusculoskeletal rehabilitation (which for convenience is henceforth referred to as rehabilitation).

a) Definition

Rehabilitation is a complex health care intervention (Wade 2005). In response to his observation that there was no “fully agreed or widely used definition or model of rehabilitation” (p.813), Wade (2005, p.814) proposed this working definition:

Rehabilitation is an educational, problem-solving process that focuses on (addressing) activity limitations and aims to optimize patient social participation and well-being, and so reduce stress on carer/family.

Despite its limitations (including minimal recognition of the person with disabilities), and as one of a number of different definitions identified in the literature (see Table 2.8 in Chapter 2), this definition provides a starting point for framing the delivery of rehabilitation services in this thesis as the outcomes (what is required from rehabilitation), the structure (what is needed to provide rehabilitation services), process (what happens), and who is involved (health care staff, patients, carers and families).

However to fully encompass the notion of rehabilitation Wade’s definition needs to be augmented with the World Health Organization’s (WHO) explicit and well-recognised emphases on (a) functional limitations, and (b) rehabilitation overcoming these limitations rather than accepting them (“acceptance” is perhaps an erroneous
implication of Wade’s definition). WHO definitions have evolved over the years and refer to:

- “training and retraining the individual to the highest possible level of functional ability” (WHO 1969, cited by Glanville 1994, p.7);
- the “reduction or elimination of a disability” (WHO 1996, p.4);
- reaching and maintaining “optimal physical, sensory, intellectual, psychiatric, and/or social functional levels, thus providing them [i.e. those with disabilities] with the tools to change their lives towards a higher level of independence” (WHO 2001, cited by Disler, Cameron, & Wilson 2002, p.385).

By augmenting Wade’s definition with these WHO concepts relating to enabling broad functional abilities, rehabilitation is viewed in this thesis as:

an educational, problem-solving process involving people with disabilities that focuses on overcoming or reducing their functional limitations in order that they can optimise their social participation and well-being, and thus maximise independence within their lives and communities (and in doing so reduce stress on carer/family).

b) People and rehabilitation

With people and their unique situations being integral to rehabilitation, it is unlikely that people's rehabilitation experiences are identical. Not only does rehabilitation deal with a wide range of disabling conditions, the implications of disabilities arising from these conditions are different for each person. Patients require individual consideration of their physical, social and psychological functional limitations and the opportunities and capabilities for overcoming these limitations. The perspectives and actions of patients, their families and carers are integral to determining the goals of rehabilitation (Dobkin 2003).

As well as rehabilitation being a time of opportunity to overcome functional limitations, it can also be a time of vulnerability for patients and carers. Their current situations and future journeys can contain many unknowns as they simultaneously participate in rehabilitation and learn to understand and cope with disability (Dobkin 2003). As part of their disability, patients may experience cognitive and communication limitations which can challenge their involvement with decisions and participation in treatments. Health professionals may be required to use a range of strategies with patients and their carers in order to establish meaningful goals and implement effective therapy. Carers
have multiple roles in rehabilitation which often extend beyond the patient’s time in rehabilitation. Besides providing emotional support, carers commonly provide assistance with a range of functional activities. This assistance can involve providing physical help (with self-care and mobility), facilitating social involvement (such as aiding communication and guiding appropriate interactions) and advocating on behalf of patients (to ensure that fears, aspirations and perspectives are heard and acted on). However, patient-carer relationships can be complicated and caring can be challenging. Intense ongoing caring can lead to carers experiencing psychological distress (Hirst 2005).

c) Rehabilitation in Australia

In recent years the number of Australians with disabling conditions has increased considerably (Australia Institute of Health and Welfare 2003), with a resulting escalation in the need for rehabilitation services (Simmonds & Stevermuer 2008). Rehabilitation services in Australia vary in location, nature and sources of funding. Patients can be looked after by different teams in different locations during their process of rehabilitation. Services within acute care private or public hospitals are primarily aimed at stabilising medical problems. Patients tend to be transferred to an inpatient unit for ongoing rehabilitation, or they might receive therapy from rehabilitation teams on an ambulatory basis. Other rehabilitation services aim to integrate patients into their social, work and community roles on discharge from intensive therapy. Specialised units are commonly located in metropolitan areas. These units either accept patients transferred from rural and regional locations or provide outreach programs to these areas.

Rehabilitation services can be privately or publicly funded. Some privately funded services are available to patients who have compensation insurance, private health insurance or private means to cover financial costs. The majority of rehabilitation services, however, are funded by state, with the Commonwealth Government funding rehabilitation services required by war veterans and vocational rehabilitation following workplace injury. Specific rehabilitation conditions (such as stroke and acquired brain injury) may receive specific government funding to develop services.

The complexity of funding can lead to attempted cost shifting between departments and services, challenging the provision of long-term planning and the development of rehabilitation services. Health professionals working within rehabilitation may be required to ensure that patients are transferred appropriately to receive the most
applicable rehabilitation by the most suitable team. This thesis is located in the publicly funded rehabilitation service, with its diverse sources of state and commonwealth funding, its need to transfer patients between different health care locations, and its different degrees of specialised service.

d) Rehabilitation teams
Teams are a well-recognised means of delivering rehabilitation services. Some teams have a specialised focus, such as brain injury, stroke, spinal injury or work injury; others have a more general focus and accept patients with a range of conditions. Regardless of their focus, the long-term characteristic of division of roles among different professional groups in rehabilitation services (Gritzer & Arluke 1985) is common to rehabilitation teams.

With rehabilitation being beyond the scope of any one professional discipline and not the sole focus of any, the need for health professionals to work together to provide rehabilitation services is apparent. Doctors commonly act as gatekeepers for admission to rehabilitation and take responsibility for patients’ medical status (De Lisa, Martin, & Currie 1993). Core to nurses’ roles is maintaining patients’ physical wellbeing, care of their continence and skin, and continuation of therapy throughout the 24 hours (Waters & Luker 1996). Allied health professionals fulfil a number of roles including (in alphabetical order): dieticians, who aim to establish and maintain normal nutritional status; neuropsychologists, who manage patients’ behaviour and cognition; occupational therapists, who focus on patients’ self-care, productivity and leisure activities; physiotherapists, who facilitate physical recovery; social workers, who are involved in future planning for adjustments to disability and lifestyle changes; and speech pathologists, who aim to improve language and feeding (Allied Health in Rehabilitation Consultative Committee 2007).

Goal setting is a central feature in rehabilitation teams (Wade 2009). Team members typically meet on a regular basis to discuss patients’ conditions and situations and set goals for rehabilitation. These goals provide motivation to patients and team members, ensure that everyone is working towards the same outcomes, and allow for monitoring of plans and therapy outcomes.
1.4.2 Health care

Health care is a complex, evolving concept, meaning different things to different people. Views of health and ways of accessing and providing health care tend to reflect socially acquired attitudes and social structures (Giddens 1993). In this thesis I conceptualise health care as a complex, socially-constructed set of systems, providers, approaches and views that provides the framework and drivers for implementing health care strategies. Health care in Australia in current times is characterised by a multiplicity and fragmentation of health services and by the consequent need for health professionals to work together to integrate services and involve patients in treatment decisions (Duckett 2007). I recognise that challenges and opportunities for collaboration are contained within these fragmentations, differences and complexities.

a) Different perspectives of health care

Health care is rich in differing perspectives and ways of working. This dynamic heterogeneity has potential to “raise awareness, improve communication, and ... change the way services are delivered to and experienced by service users” (Williamson 2004 p.161). However, without recognition of the value of varied understandings and ways of working, these differences can also challenge open communication between those providing, receiving and managing health care.

A brief example of some of the various ways health care can be perceived is provided in Scenario 1.1. This scenario, compiled from views of health care I have encountered in my reading and experiences, is a general representation of different perceptions rather than relating to particular people, situations or authors. I use this scenario to provide an example of the wide range of different understandings of health care and the diversity of implications for action.

The hypothetical responses of different disciplines to a proposal by a health policy maker to develop understandings of health and improve health care illustrate differences in their conceptualisations of health care and what is required for improvement. In this scenario, the manager’s need for quantified information and efficiency of health care services conflicted with the patient’s valuing of personal experience as a source of understanding. The doctor’s preference for objective scientific evidence to support his current model of practice diverged from the social worker’s wish to expand understandings of social determinants of health. The philosopher’s question to the sociologist highlights an awareness that people’s conceptualisations of health can vary.
Through this scenario it can be seen that working with divergent views of health creates the potential for misunderstandings.

Scenario 1.1 Hypothetical examples of different conceptualisations of health care

<table>
<thead>
<tr>
<th>&quot;We need to develop our understanding of health and improve health care&quot;, proposed the <strong>health policy</strong> maker.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Those listening welcomed the statement. They nodded in agreement, each confident of their grasp of the implications.</td>
</tr>
<tr>
<td>&quot;About time&quot;, thought the <strong>health manager</strong>, &quot;we can target our health strategies more efficiently and get better value for the dollar.&quot;</td>
</tr>
<tr>
<td>&quot;Wonderful&quot;, concurred the <strong>doctor</strong>, &quot;we will have a better scientific evidence to guide our practice.&quot;</td>
</tr>
<tr>
<td>&quot;Sounds promising&quot;, speculated the <strong>social worker</strong>, &quot;we need a broader understanding of the social factors influencing health&quot; ... &quot;and the environmental factors&quot;, added the <strong>environmental scientist</strong>.</td>
</tr>
<tr>
<td>&quot;This has potential&quot;, enthused the <strong>complementary and alternative health practitioner</strong>, &quot;this might move the focus from illness to wellness&quot;.</td>
</tr>
<tr>
<td>&quot;At last&quot;, sighed the <strong>patient</strong> to the <strong>carer</strong>, &quot;they will listen to what it is like to live with this condition&quot;.</td>
</tr>
<tr>
<td>&quot;Hmm,&quot; said the <strong>philosopher</strong> to the <strong>sociologist</strong>, &quot;I wonder what they mean by <em>health and health care</em>?&quot;</td>
</tr>
</tbody>
</table>

I contend that in order to contribute positively to patient-centred health care, health professionals need to recognise how their own understandings fit with and contribute to those of others. Dunn’s (1959, p.789) assertion from 50 years ago has relevance for patient-centred health care today:

> It is natural for each group competent in a special field of knowledge to approach the study and care of the wellbeing of man from its own particular point of vantage, but this must not preclude considerations of the unity of man as a whole living within a constantly changing total environment. High-level wellness can never be achieved in fragments, ignoring the unity of the whole. Different understandings of health are framed in this project as playing a key role in maximising the potential for valuing, using and evolving multiple perceptions and approaches to collaboration that arise from the multifaceted nature of health care.

**b) Patient-centred health care**

Patients as individuals with worth and dignity who are part of wider societal contexts underpin patient-centred professional practice (Trede & Haynes 2008). At the centre of patient-centred care is the notion that the patient is viewed as the “most important component of any intervention” (Sumsion 2006, p.1) and as an embodied person rather than in terms of health outcomes or diseases. John Glossop (2006, p.xii), a strong proponent of patient-centred practice, explained the basis of this approach:
I am unique. I am not a collection of symptoms and physical problems. I am more than the sum of my disabilities. My goals may not be your goals; things which you consider necessary to your very existence may be of little or no importance to me.

Patients reportedly appreciate being at the centre of rehabilitation focusing on patients as people (Wain, Kneebone, & Billings 2008).

My conceptualisation of patient-centred approaches to health care in this thesis focuses on the balance between patients’ values and health professionals’ perceptions of patients’ needs. This conceptualisation is informed by Fulford’s (1996, p.13) proposition that patient-centred health care requires an appropriate balance “between science and the humanities, between disease categories and patients’ experiences of illness, between technological medicine and primary care, and, most important of all, a balance between patient’s wishes ... and the professional’s understanding of their needs”. Achieving such balance involves incorporating into health care decision-making both the patients’ personal experiences and values, and the health professionals’ knowledge (Fulford 1996). In patient-centred health care professionals and patients aspire towards democratic professional relationships when considering health care options.

In using the term patient-centred throughout this thesis I acknowledge that the appropriateness of the term patient is contested (based on Neuberger 1999). The terms patient, client, user, and consumer (Neuberger 1999) and co-producer of health (Leeder 2004) are labels that contain various connotations (Deber, Kraetschmer, Urowitz et al. 2005) and implicit assumptions (Wing 1997). Debate is evident in the literature about limitations arising from these meanings and assumptions, but there is lack of consensus about the most appropriate term. The terms client, consumer and customer have been criticised for their implications about the commercial nature of the relationship between providers and users of health care (Neuberger 1999; Leeder 2004; Deber et al. 2005; Hutchison 2006). On the other hand, the term patient, with its origins in Latin (meaning to suffer or bear), has been accused of implying passive roles for patients and domination by health professionals (Neuberger 1999). Furthermore, encounters that relate to lifestyle choices rather than illness, such as seeking advice on fertility or care during pregnancy, are not well served by the term patient (Neuberger 1999). However, when given the choice of the terms patient, client, customer, consumer, partner and survivor a group of surveyed health care users identified patient as being least objectionable as it was “based on a model other than that between buyer and seller”
(Deber et al. 2005, p.351). Another surveyed group of hospital patients preferred the term *patient* to *client* or other titles (Nair 1998, p.593), commenting: “‘client’ implies business, ‘patient’ affirms the service nature of hospitals” and “‘client’ sounds too commercialised”.

With the multiplicity of health meanings it appears unreasonable to expect one term to suit all situations. Therefore, although I recognise limitations with the use of *patient*, I acknowledge that this term has pervasive, though incomplete, acceptance by many users and providers of health care services, particularly in acute areas. My choice of the term *patient* for this thesis reflects these points. Furthermore it is a label that the participants in my research tended to use.

A range of terms denoting active participation and a focus on the patient as a person has been introduced with the shift in health care from patients being “the somewhat passive target of medical intervention” to taking active roles in their care and decision-making (Leplege, Gzil, Cammelli et al. 2007, p.1560). These terms include “patient-, client-, person-, individual-/centred, -oriented, -focused-, -directed” (p.1556). In choosing to use the term *patient-centred* in this thesis I acknowledge that terms denoting the patient as a person and active participant in their care may vary, be explicitly differentiated or be used interchangeably.

Freeth (2007) provides an example of an author differentiating between varied uses of the terms *patient-centred* and *person-centred*. She described (a) *patient-centred* as relating primarily to a clinical method and type of relationship between patients and health professionals that aims to understand the whole person, use shared decision making and achieve patient empowerment, and (b) *person-centred* as relating particularly to approaches underpinned by humanistic philosophy and involving an “ethical engagement with life, living and relationships” (p.15). For Freeth, person-centred (in health care) was a term that was particularly associated with mental health counselling and was informed by a deep understanding of theories of Carl Rogers. In this thesis, while acknowledging the value of Freeth’s clear differentiations, I also recognise that other authors may not use the terms with such precision.

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5 Carl Rogers (1902-1987) is commonly acknowledged as the founder of the humanistic approach to psychology.
Beyond the particular term used by authors, I concur with views that valued the people involved in health care. For example, Titchen (1996) and McCormack (2004) explored roles played by health care providers as people in developing relationships with, and providing patient-centred care to, patients as people. Titchen (1996, p.182) described patient-centred nursing in relation to an experienced nurse who was aware of “how she used herself in her relationships with patients” to provide care that was individually tailored to their needs. Expressing a similar idea, McCormack (2004, p.37) concluded that a person-centred model for nursing “appears to be a useful way of enabling older people and others significant to them to establish an interconnected relationship with nurses and other care workers”.

Patient-centredness has also informed other views of health care. Relationship-centred care, for example, is grounded in the notion patient-centredness but is explicitly concerned with the relationships between people in health care. Beach, Inui and The Relationship-Centered Care Research Network (2006, p.S4) explain that relationship-centred care “embraces and expands the principles of patient-centeredness within the patient-clinician relationship” and considers “the relationships of clinician-clinician, clinician-community, and clinician-self as foundational and intrinsic to health care”.6

c) The Australian Health Care System

The broad context of this research is the Australian health care system. A number of interrelated factors influence the provision of professional health care in Australia, as shown in Figure 1.1. Health professionals in Australia are not only required to work within complex health care systems, they also face challenges related to different meanings of health, changing demographics, economic constraints, increasing specialisation, the consumer movement and interprofessional practice. For example, with an illness view of health dominating the mainstream health care system and a wellness view of health being espoused as ideal, the health care system can at times lack conceptual clarity. Health professionals are required (and commonly desire) to collaborate with each other and with patients and carers to provide patient-centred health care, while simultaneously being accountable to health care systems that are struggling to cope with spiralling health care costs. Consumers’ expectations support the practice of humanistic health care in which patients have equity of access, choices in their health care, and input into their health care decisions; yet the need to constrain cost

6 Being relevant to collaboration, texts related to relationship-centred care are explored in Study A.
of health care needs supports managerial approaches to the provision of health care services. New technologies are being sought, yet these developments can increase the cost of health care.

**Influences from broad contexts**

**Changing demographics** in Australia

**Economic constraints** resulting from spiralling health care costs

**Globalisation** and rapid development of technology resulting in:

a) increasing number of therapeutic interventions

b) increasing complexity of therapeutic interventions
c) rapid increase in professional knowledge
d) rapid dissemination of health care information
e) increasing use of organisational theory in the management of health care
f) blurring of national boundaries

**Consumer movement**
The consumer movement both informs and is informed by:

a) new public health movement, with recognition of role of social factors in health
b) emphasis on human rights and equity
c) development of market-oriented health care
d) increasing education about health
e) increasing accessibility to health care information

(based on Carter and O'Connor 2003)

**View of health**

“Health as wellness” acknowledged as ideal model of health

“Illness” view of health dominates mainstream health care system

**Consequences for the provision of health care**

- Accountability of health care providers for the provision of health care is a focus of health care management.
- Health professionals are undergoing increasing specialisation.
- Continual ongoing professional education is considered vital.
- Teamwork and interprofessional collaboration are required to coordinate and integrate complex health care.
- Consumers are increasingly expecting:
  - representation in health policy review and planning
  - transparency, openness and accountability of health care services
  - choice in health care
  - equity of access to health care
  - input into individual health care decisions.
- Consumers are increasingly using the Internet to become informed about health issues relating to their individual care.

Figure 1.1 Influences on health care service provision in Australia
1.4.3 Organisations as a context for teams

Many forms of health care, including rehabilitation, occur in organisational contexts. Organisations play an important role in current society. The contributions of the eminent sociologist Etzioni (1964) to early organisational theory provide a framework for conceptualising the context of collaboration in rehabilitation teams. According to Etzioni (1964, p.3), organisations contain social units or human groupings that are deliberately planned, constructed and reconstructed to fulfil particular goals, and they are characterised by:

- “divisions of labour, power and communication responsibilities”;
- “the presence of one or more power centres which control the concerted efforts of the organization and direct them toward its goals”;
- “substitution of personnel, i.e. unsatisfactory persons can be removed and others assigned to their tasks”.

Each of these organisational parameters and characteristics has relevance for collaboration as explored in this thesis. Organisations are created by individuals, and collaboration within organisations is dependent on interpersonal interactions. Power, communication and the division of labour create the need for integration and coordination of services within and between organisations, which in turn create the need for collaboration. The location of power in different organisational centres may create challenges for collaboration between competing power balances. The substitution of personnel creates opportunities and challenges, as those involved in the collaboration may need to re-establish interpersonal communication. A key difference between the substitution described by Etzioni and that experienced in health care is that health care staff commonly change positions due to career or lifestyle, choices, personal interests and rosters.

Organisations have since been conceptualised in many different ways. Morgan (2006) described these conceptualisations in terms of metaphors related to different organisation and management theories. He contended that although metaphors enable us “to understand one experience in terms of another”, the understanding can be incomplete and misleading (Morgan 2006, p.5). The different metaphors he described to conceptualise organisations include *machines* (in which managers organise work, and workers are selected, trained and monitored to ensure they work efficiently), *organisms* (in which organisations are viewed as open systems that need to adapt to changing environments), and *instruments of domination* (where power, customs or legal
precedents determine leadership). It is important to recognise the extent to which the powerful insights created through metaphors can also become distortions, because the way of “seeing created through a metaphor becomes a way of not seeing” (Morgan 2006, p.5). Thus single metaphors can be too simplistic, can limit a whole understanding of organisations and can perpetuate particular views and ways of working within them.

The “organisation as a machine” metaphor for understanding has been brought to the fore by recent moves to rationalise health care costs through seeking predictable and reproducible services. This move was critiqued by Bohmer (2010, p.64):

A flaw in some of the proposals for fixing health care is the failure to address the complexity of patient care in which predictability and ambiguity exist side by side. For example, some hospitals have applied principles of the Toyota Production System to perfect the technique for placing a central venous line. This has allowed them to reduce the associated infection rate to zero—a remarkable achievement—but it has not helped in the management of patients with multiple diseases whose condition is rapidly deteriorating.

I concur with Bohmer’s concern about the use of car production strategies in complex health care. With the application of principles of car production it could be argued that this health care strategy exemplifies the metaphor of the organisation as a machine. Although not disputing the importance of decreasing infection rates, I argue that strategies based on car production techniques reflect the use of an organisational metaphor of health organisations as machines and that this view is insufficient for the complex health care needs of patients, including those within rehabilitation services.

The power of metaphors lies in their capacity to prompt reflection and critique. When relevant metaphors are viewed collectively these ways of conceptualising organisations can provide an overview of the insights and characteristics, the distortions and limitations, and that overview provides a strong foundation for a more complete view of organisations as settings for teams. Thus my stance on organisational understandings, while informed by Etzioni’s proposed characteristics of organisations, is not limited to any particular organisational metaphor. Rather, I recognise that various understandings and strategies are required to address complex health care. Throughout the project I sought to remain open to different ways of conceptualising organisational settings and the teams within them.
1.4.4 Health care teams

In Australia, comprehensive health care is commonly provided by teams of health professionals and involves collaboration between a varying number of health professionals from various health professional groups, and between health professionals and patients. The purpose of seeking to use effective teams to deliver health care is multifaceted and has been succinctly summarised by Mickan (2005) in terms of the benefits (a) to patients, by enhancing satisfaction and outcomes, (b) to team members, through facilitating greater role clarity and enhancing job satisfaction, (c) to teams, by maximising professional diversity, by improving coordination of care and enabling efficient use of health care services, and (d) to organisations, through reducing hospitalisation times and unanticipated admissions. However, despite the clarity of these benefits, conceptualising health care teams and teamwork is not straightforward.

a) Conceptualising health care teams

In acknowledging the lack of clarity surrounding conceptualisations of health care teams, I concur with the statement by Wieland, Kramer, Waite et al. (1996, p.656) that “what is meant by team is not obvious”. Definitions of the term vary, as shown by the examples provided in Table 1.1. Although these definitions refer to the characteristics of team location, member characteristics, team goals and processes, the authors’ recognition of ambiguity in relation to these characteristics varied. Wieland and colleagues explicitly acknowledged that teams differed in relation to membership. In contrast, Mickan (2005) specified that teams had small, manageable membership, and Thylefors, Persson and Hellström (2005) required representation of at least three different professions to constitute a team.

Table 1.1 Definitions of team (in health care)

<table>
<thead>
<tr>
<th>Definition</th>
<th>Key points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimally, a professional group is a team if it shares a common work setting and set of patients, but teams differ among themselves in their membership composition, commitment to shared goals, degree of collaboration in accomplishing team-related tasks, handling of leadership, and the kind of attention paid to team process. (Wieland et al.1996, p.656)</td>
<td>Team location Team processes Team goal</td>
</tr>
<tr>
<td>Teams contain a small manageable number of members, who have the right mix of skills and expertise, who are all committed to a meaningful purpose, with achievable performance goals for they are collectively responsible. Team members regularly communicate, solve problems, make decisions and manage conflict, while adopting a common approach to economic, administrative and social functioning. Each team member must have a distinctive and necessary role within the team. (Mickan 2005, pp.211-212)</td>
<td>Team member attributes and number Team processes Team goal</td>
</tr>
<tr>
<td>“an organizational work unit made up of at least three different professions” (Thylefors et al. 2005, p.105)</td>
<td>Team location Team member attributes and number</td>
</tr>
</tbody>
</table>
Although definitions such as those of Mickan (2005) and Thylefors et al. (2005) provide a useful starting point for conceptualising the complexity of teams, they assume a stability of team membership that is not necessarily present in all health care teams. In many areas of health care (including rehabilitation), team membership can change with work shift rosters, allocated position rotations or personal work choices. Furthermore, the definitions in Table 1.1 do not address the issues related to conceptualising large team entities with (a) fluid team boundaries, for example, teams with subgroups, and (b) teams with a number of members from the same discipline who hold additional meetings within their discipline. In articles where such team complexities were recognised, the core team of stable team members within the larger team tended to be the focus of the research rather than the more fluid aspects of the team (e.g. Baggs, Norton, Schmitt et al. 2004; Lingard et al. 2004).

In this thesis I acknowledge the varying forms of teams, the dynamic nature of team membership and the fluidity of team boundaries. To be able to embrace the complexity of teams in health care I adopted an inclusive conceptualisation of teams. For the exploration of literature in Study A, I began with an understanding of teams as groups of individuals with personal agency to use and to develop structures and frameworks for their collective and effective operations. I recognised varying forms of teams, and viewed the term team to broadly encompass established formal teams with regular meetings, temporary task groups formed to fulfil a particular goal, and informal networks whose members may communicate intermittently.

In relation to collaborating in rehabilitation teams (Study B), I chose to explore experiences in the entity that the participants viewed as their team (rather than what I deemed to be their team). For the purpose of identifying rehabilitation teams to participate in this research, I defined a rehabilitation team as:

- a group with a self-expressed identity of being a “rehabilitation team” whose major service function was rehabilitation of individuals with neuromuscular or musculoskeletal conditions that have been acquired or developed through trauma or disease; a group comprised of a minimum of three different health professional disciplines, that holds regular team meetings.

By taking this broad view I avoided being sidetracked by questions such as: How blurred can team boundaries be before the entity can no longer be considered a team? How interchangeable can team membership be, before the feeling of teamness is lost? How many concurrent teams can team members belong to before their loyalty to all is
unworkably compromised? This definition was sufficiently broad to avoid excluding team entities with dynamic and fluid natures.

b) Models of teams
Different models of teams and their accompanying implications for team members’ interactions with each other were found to be the focus of a large body of literature. In health care, the dominant interest was on models of teams related to the often used but poorly defined descriptors: multidisciplinary, interdisciplinary and transdisciplinary (based on Choi & Pak 2006). Common features of this interest were team members in relation to the discipline they represented, and the influence of team structure on the ways people worked together. Table 1.2 provides an example of one particular conceptualisation of rehabilitation team models. I provide this example to demonstrate how team members’ interactions and responsibilities vary between different team types.

Table 1.2 Rehabilitation team models
(based on Zorowitz 2006)

<table>
<thead>
<tr>
<th>Team model</th>
<th>Characteristics</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multidisciplinary</td>
<td>Doctor controls team</td>
<td>Patients not involved</td>
</tr>
<tr>
<td>team</td>
<td>Team meets to coordinate patient care</td>
<td>Services may be omitted, fragmented or duplicated</td>
</tr>
<tr>
<td></td>
<td>Patients are not included in decision-making processes</td>
<td>Team members’ expertise may not be used effectively</td>
</tr>
<tr>
<td>Interdisciplinary</td>
<td>The team is not necessarily led by the doctor. Team members work within their</td>
<td>Team meetings require time</td>
</tr>
<tr>
<td>team</td>
<td>areas of expertise and coordinate with the work of others</td>
<td>Team members may need to be trained in team processes</td>
</tr>
<tr>
<td></td>
<td>Reports of functional progress, decision making and care plans are developed at</td>
<td>Individual team members need to cede some control to the team so that</td>
</tr>
<tr>
<td></td>
<td>case conferences</td>
<td>patient care is driven by the team processes</td>
</tr>
<tr>
<td></td>
<td>The patient is the centre of the team’s focus and plays an important role in</td>
<td>The doctor needs to allow team decision making yet take medico-legal</td>
</tr>
<tr>
<td></td>
<td>goal setting</td>
<td>responsibility for outcomes</td>
</tr>
<tr>
<td></td>
<td>Ideas are exchanged that lead to changes in patients’ treatments</td>
<td></td>
</tr>
<tr>
<td>Transdisciplinary</td>
<td>Communication and shared treatment among team members</td>
<td>Team meetings require time</td>
</tr>
<tr>
<td>team</td>
<td>All team members have the opportunity to work on all areas of function</td>
<td>Team members may need to be trained in team processes</td>
</tr>
<tr>
<td></td>
<td>Team meetings are more oriented to patients’ function than to disciplines</td>
<td>Team members need to cede some control to the team so that patient care</td>
</tr>
<tr>
<td></td>
<td>In the case of discrepancies, leadership may be provided by the most relevant</td>
<td>is driven by the team processes</td>
</tr>
<tr>
<td></td>
<td>discipline</td>
<td></td>
</tr>
</tbody>
</table>

In this research I sought to remain open to how people (as individuals and as members of their professional discipline) rather than discipline entities worked collaboratively with each other. Thus, rather than making judgements as to the relative merits of these
different models of teams I acknowledged their differences as contributing to the complexity of resourcing, preparing for, and working in health care teams.

c) Teamwork and collaboration

The concepts of teamwork and collaboration were often used interchangeably in health care literature. Kvarnström (2008), for example, did not differentiate between teamwork and collaboration and Gibbon (1999) did not differentiate between team processes and collaboration. Similarly Wilson, Moores, Woodhead Lyons et al. (2005) did not differentiate between teamwork and collaborative practice. In contrast Reeves, Lewin, Espin et al. (2010) advocated for a typology of terms related to interprofessional work to facilitate the terms’ precise use; they distinguished teamwork from collaboration, coordination and networking. I chose not to start with differentiation between the terms since the literature has understanding to offer across the terms. Rather I sought to be open to all uses of the terms teamwork and collaboration, not wanting to exclude the notions of teamwork, coordination and networking from my exploration of collaboration in health care teams. For example, the concept of coordination became subsumed into emergent themes around shared decision making and the identification of networking teams as opposed to fixed and stable teams was an important part of my findings. Further my definition of teamwork for this thesis was deliberately broad and incorporated the ways people in a group work together, communicate with each other, and perhaps negotiate their roles, in order to achieve their shared aims.

Also informing my understanding of teamwork for this thesis were the characteristics of effective teamwork identified by Mickan and Rodger (2000a). These characteristics (shown in Table 1.3) were identified from the abundant empirical and anecdotal recommendations for effective teamwork. I acknowledge the influence of organisation, individual and team processes on teamwork. The multifaceted nature of these characteristics suited the complexity I embraced in this thesis.

Many of these teamwork characteristics (such as appropriate culture, self-knowledge and cohesions) take time to develop, defying easy prescription and resisting measurement-based approaches to assessment, teamwork and collaboration; these features have been described as “wicked competencies” (based on Knight & Page 2009). Thus, in this thesis I recognise that teams are complex entities with differing
purposes and multifaceted requirements for effectiveness, and that teamwork can present educational challenges. I embraced their “wickedness”.

Table 1.3 Characteristics of effective teamwork
(from Mickan & Rodger 2000a)

<table>
<thead>
<tr>
<th>Organisational structure</th>
<th>Individual contribution</th>
<th>Team processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear purpose</td>
<td>Self-knowledge</td>
<td>Coordination</td>
</tr>
<tr>
<td>Appropriate culture</td>
<td>Trust</td>
<td>Communication</td>
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<tr>
<td>Specified task</td>
<td>Commitment</td>
<td>Cohesion</td>
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<tr>
<td>Distinct roles</td>
<td>Flexibility</td>
<td>Decision making</td>
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<td>Suitable leadership</td>
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<td>Conflict management</td>
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<td>Relevant members</td>
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<td>Social relationships</td>
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<tr>
<td>Adequate resources</td>
<td></td>
<td>Performance feedback</td>
</tr>
</tbody>
</table>

1.4.5 Health professions and professional practice

Collaboration in rehabilitation teams involves health professionals, patients and carers, and occurs within our shaped and constructed understandings of organisations, health care and professional practice. Consistent with embracing complex meanings of organisations, teams and the people in this thesis, I similarly adopt a complex view of the concept of health profession. I acknowledge (a) that there are varied understandings of what is involved in being a health professional (and the related concepts of professional practice and professionalism), and (b) that the explicit requirements for regulating health professions are only one part of professions and professional practice.

a) Explicit requirements

Health professionals are required to work within sets of interconnected obligations and expectations, including professional registration regulations, professional association codes of conduct, and legal requirements (Delany & Griffiths 2008). To address these expectations, courses are accredited, individual practitioners are registered, and preferred conduct is monitored. In Australia, health professional education within accredited university courses prepares students for registration with the relevant professional licensing bodies. This credentialing has a number of roles, including regulating membership of health professions, ensuring competence (Longest 1996), and protecting public interest rather than the interests of health professional disciplines (Council of Australian Governments 2008).

7 My use of the term wickedness is based on Knight and Page’s (2009) term wicked competencies and Rittel and Webber’s (1973) notion of wicked problems. Characteristics of wicked problems include being unique; having no right-or-wrong or true-or-false solutions; being a symptom of another problem; showing that “solving” of one wicked problem leads to other different, interrelated problems.
b) Definitions and meanings

Descriptions and definitions of profession (Cruess & Cruess 2008) and professional practice vary (Kemmis 2006). In their exploration of different definitions of profession, as shown by examples in Table 1.4, Cruess and Cruess (2008) noted that simple definitions tended to focus on the knowledge base, service orientation, training and code of ethics. The more complex definitions encompassed notions such as professions having their own culture and ongoing development (Higgs, Hummell, & Roe-Shaw 2008) and professional status being a social contract with society (Cruess & Cruess 2008, p.11).

Table 1.4 Definitions of the term profession
(based on Cruess & Cruess 2008, Higgs, Hummell et al. 2008)

<table>
<thead>
<tr>
<th>Definitions of profession</th>
<th>Key points</th>
</tr>
</thead>
</table>
| An occupation that regulates itself through systematic, required training and collegial discipline; that has a base technical specialized knowledge; and that has a service rather than profit orientation, enshrined in its code of ethics. (Cruess & Cruess 2008, p.1, citing Star 1982) | • Specialised knowledge base  
• Service  
• Training  
• Code of ethics |
| An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments for the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice, and the privilege of self-regulation. Professions and their members are accountable to those served, to the profession, and to society. (Cruess & Cruess 2008, p.11-12, citing Oxford English Dictionary 1989) | • Specialised knowledge base  
• Service  
• Code of ethics  
• Social contract  
• Accountability  
• Self-regulation  
• Autonomy |
| A self-regulated occupational group having a body of knowledge, an inherent culture and a recognised role in serving society. Professions operate under continual scrutiny and development, and are self-regulated, accountable, and guided by a code of ethical conduct in practice decisions and actions. Membership of a profession requires completion of an appropriate (commonly degree-based) intensive educational program. (Higgs, Hummell et al. 2008, p.58). | • Specialised knowledge base  
• Service  
• Code of ethics  
• Social contract  
• Accountability  
• Self-regulation  
• Education  
• Continual development  
• Decision and actions |

The notion of professionalism is relevant to professions and professional practice and commonly refers to individual professionals behaving in a socially responsible and accountable manner. Professionalism also includes the image that health professionals project to others, and the role of this image in promoting successful relationships with patients and with each other (based on Brosky, Keefer, Hodges et al. 2003). How health professionals are perceived by others may influence many aspects of collaboration.
This thesis takes a complex view of profession. To explore the phenomenon of collaboration, it is necessary to acknowledge the ambiguities and complexities related to notions such as autonomy, accountability, education, professional development, and decisions and actions. I concur with the following view of professional practice:

[professional practice encompasses] the manner in which practitioners perform the roles and tasks of their profession in conjunction with individuals who are their clients or patients. It includes, but is not limited to, the application of theory and practice principles to real world problems. The difficulty for practitioners lies with the “messy” nature of these problems, unlike their “sanitized” textbook counterparts upon which much professional preparation is focused. (Higgs, Titchen, & Neville 2001, p.4)

This definition acknowledges difficulties in preparing theoretically for “real” situations and highlights the unpredictable nature of professional practice and the central role played by patients. These ideas are core aspects of my research frame of reference.

Kemmis (2006) also wrote about the complexity of professional practice, proposing a multi-dimensional understanding that viewed individual practitioners within their wider social contexts. He recognised the importance of patients in professional practice, saying that they were “not merely ‘objects’ operated on or influenced by practitioners, but persons-in-themselves who are, to a greater or lesser degree, knowing subjects who are co-participants in practice” (Kemmis 2006, p.5).

c) Components of practice

Practice has elements that are transferable and can be developed or taught. However, some of these elements may not be explicit (van Manen 1999a; Higgs, Titchen, & Neville 2001). Van Manen (p.65) acknowledged intangible practice dimensions in his description of practice as “the explicit and the tacit dimensions of the roles, precepts, codes, principles, guides, commitments, affects, and behaviors that one observes or recommends within a domain of action”. In another interpretation, Higgs and Titchen (2001, p.3) identified professional practice as an ongoing lived experience that involves practitioners “‘doing’, ‘knowing’, ‘being’ and ‘becoming’” as they are socialised into their profession and work towards developing practice that is people-centred, contextually relevant, authentic and wise. The authors noted the ephemeral dimensions of these qualities and proposed that rational, intuitive and creative thinking play a role in “professional journeys towards expertise” (p.5)
d) People in models of practice

A number of models of practice support a focus on people in health care. In the *interactional professional* model of professional practice, health professionals interact effectively with both patients and their dynamic environment (Higgs & Hunt 1999). This model of practice acknowledges the importance of patient-centredness and the need for interpersonal communication in professional practice. With a similar emphasis on communication, P. Clark (1997, p.448) proposed the *reflective practitioner* model as a basis for working with others: “The reflective practitioner is also the ‘hearing practitioner’, who is a good listener and whose own voice does not drown out the voices of other professionals or the patient”. These models emphasise the individuality of health professionals and the need for them to be responsive to their patients’ situations and concerns.

In embracing the complexity of professions, professional practice and professionalism I acknowledge that these concepts have both explicit and tacit qualities. I also recognise that care needs to be taken during education, ongoing professional development and research to ensure that the more visible qualities do not overshadow the roles of those qualities that are less visible.

### 1.5 Overview of the research strategy

The overview of the research strategy used in this project is shown in Figure 1.2. My ontological stance for this research was provided by idealism, the branch of philosophy that questions the notion that reality exists independent of human perceptions (Powers & Knapp 1995). The interpretive research paradigm provided the appropriate framework to interpret and illuminate the multifaceted, complex and human phenomenon of collaboration.

The two interrelated studies comprising this research used hermeneutic modes of inquiry. Study A was informed by philosophical hermeneutics and Study B by hermeneutic phenomenology. The philosophical hermeneutic study was undertaken to interpret the meanings of collaboration within the literature. The experience of collaborating within rehabilitation teams was illuminated through the hermeneutic

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8 Schön (1987) introduced the concept of the reflective practitioner, upon which this model is built.
9 Ontology is concerned with the structure of reality and the nature of existence (Crotty 2003).
phenomenology study. The interrelated nature of these studies enabled me to develop an iterative and synergistic understanding of collaboration throughout the research process.

1.6 Significance

This research embraced the complexities and multifaceted nature of collaboration to produce a model called RESP(PC)T, for Reflexive Endeavours (in) Supportive Practice (for) Person-Centred Teamwork. This model (a) illuminates avenues for achieving patient-centred rehabilitation, and (b) provides insights into ways of enhancing collaboration in rehabilitation teams through education and organisational support. This thesis contributes to the deeper understanding of collaboration in rehabilitation teams.

Figure 1.2 Overview of research strategy
1.7 Structure of thesis

The complexity of the research space, including an overview of components of the health care system in which rehabilitation is located, is framed in Chapter 2. Chapter 3 describes the research paradigm and provides an overview of the research strategy. Details of research approaches and explanations of research findings are presented in Chapters 4 and 5: Chapter 4 describes the research approach for and the findings of the philosophical hermeneutic interpretation of literature pertaining to collaboration (Study A); and Chapter 5 describes the research approach for and the findings of the hermeneutic phenomenology exploration of experiences of collaborating in rehabilitation teams (Study B). The product of this research, a model of collaboration, is presented in Chapter 6, together with a reflection on the quality of the research and implications for education and future research.

1.8 Definition of key terms

**Collaboration** (as initially understood in this thesis) is a broad term referring to the intentional process of sharing of knowledge, thoughts and perspectives between different people (through decision making and actions) to achieve a common purpose that is underpinned by effective communication and group facilitation skills.

**Patient-centred** is an adjective that embraces the notion of *people* in health care; that is, the totality of each person and their values, situations, needs, interests and capabilities. Patients are viewed as *people* with will, agency and preferences rather than disease entities or objects for the delivery of services. Because health professionals and other staff are affected by and affect patients’ health care, they are key players in patient-centred health care.

**Rehabilitation** refers to the educational, problem-solving processes through which people with disabilities work with their carers, families and health professionals to overcome or reduce their functional limitations in order that they can optimise their social participation and wellbeing, and thus maximise independence within their lives and communities (extending Wade 2005).

**Rehabilitation team** is a group with a self-expressed identity of being a “rehabilitation team” whose major service function is rehabilitation of individuals with neuromuscular or musculoskeletal conditions that have been acquired or developed through trauma or
disease; a group comprising a minimum of three different health professional disciplines, that holds regular team meetings.

**Team** is a term referring to a group of people working together with agency to use and to develop structures and frameworks for their collective and effective operations. Teams can encompass established *formal teams* with regular meetings, temporary *task groups* formed to fulfil a particular goal, and *informal networks* whose members may communicate intermittently.

**Teamwork** is a broad term referring to the ways people in a group work together, communicate with each other, and perhaps negotiate their roles, in order to achieve their shared aims.

### 1.9 Conclusion

In summary, my aim in this research was to develop a deeper understanding of the nature of collaboration and the experience of collaborating. The setting I chose was rehabilitation teams. The purpose was to inform the development of collaborative practice. The project consisted of two interrelated studies. Study A was a philosophical hermeneutic study of literature pertaining to collaboration (with a particular focus on health care and rehabilitation). Study B was a hermeneutic phenomenology study of experiences of collaboration in a group of Australian health care system rehabilitation teams. The nature of these studies enabled an iterative and synergistic understanding of collaboration to develop throughout the research process. By illuminating invisible elements and critically reframing visible, well recognised aspects of collaboration, this research has produced **The RESPECT Model of Collaboration**, where collaboration is presented as

\[
R \quad \text{Reflexive}
\]

\[
E \quad \text{Endeavours (in)}
\]

\[
S \quad \text{Supportive}
\]

\[
P \quad \text{Practice (for)}
\]

\[
E \quad \text{Engaged}
\]

\[
C \quad \text{Centred-on-People}
\]

\[
T \quad \text{Teamwork.}
\]
CHAPTER 2
FRAMING THE COLLABORATIVE CHALLENGES OF THE RESEARCH SPACE

“The health workforce is now characterised by a large number of separate professions, each with a different course of preparation, a different emphasis in practice, and, to some extent, a different ideological foundation in terms of the way in which the profession interacts with other professions and with patients and consumers.”
(Duckett 2007, p.69)

2.1 Introduction

In this research the phenomenon of collaboration was explored in relation to rehabilitation teams in the Australian health care system, a context in which health professionals commonly work together and with patients and carers to coordinate and integrate perspectives, goals and treatments. In this chapter I explore some characteristics of this context in relation to patient-centred collaborative health care and organisational influences on such health care. This chosen focus is situated in a person-centred framing of health and health care where organisations have influences over the capacity of people to collaborate. This chapter is based on the argument that despite the desire or requirement to collaborate, health professionals, patients and carers in rehabilitation face a number of challenges in relation to collaboration, including that (a) they have many different meanings of health and health care, (b) they face many uncertainties and unpredictabilities in professional practice, (c) they have to deal with complex and at times problematic structures and systems of the Australian health care system, (d) they work in a wide range of health professional disciplines involved in rehabilitation, and (e) they need to manage the many different rehabilitation situations and support their patients’ multiple complex needs.

2.2 Meanings and provision of health care

The case underpinning this section is that the way health care is defined and interpreted affects how health care is provided. Different understandings of health and health care can arise from discipline socialisation, personal and professional experiences, and organisational structures. These different understandings of health afford opportunities
for a range of health care strategies while simultaneously presenting challenges or opportunities for health professionals to maintain patient-centred collaborative practice.

Different meanings of health underpin varying personal roles and strategies in health care (Bandura 1997) and can be the basis of the “healthy mix of disciplines and the corresponding different value sets” in health care teams (Williamson 2004, p.161). It can be argued that by engaging with different understandings, collaborating practitioners can expand their perspectives of health and health care and can work towards ensuring that the “interests of the people for whom the service is provided” predominate (Williams 2004, p.153). However, developing such understandings is not necessarily straightforward, and may require personal willingness and ability to explore conceptual differences, and the time to do so (Williams 2004) as well as the readiness to question one’s own perspectives. In the absence of conceptual clarity, differing understandings can be the source of ongoing disagreements and conflict, or may produce differing expectations and misunderstandings (Williams 2004).

2.2.1 Purposes of different meanings of health

People bring to collaborations their own meanings of health. With people from diverse backgrounds participating in health care, different understandings and expectations for health and health care may be encountered. Although these differences contribute to the complexity of collaboration, I perceive that they are inherent to its value. Understanding the purposes behind definitions of health provides a means of making sense of the various meanings and provides insights into (a) different understandings health care team members can bring to collaborative situations and (b) why they may encounter difficulties or strengths in working with others.

In acknowledging that I bring my own understanding of health to this research, I sought to ensure that I did not exclude the understandings of others. I identified from the literature a wide range of meanings of the term health. Examples of articulated definitions and connotative meanings are shown in Table 2.1 (note that the purpose behind, and the origin of, the definition is discussed in subsequent paragraphs). These meanings extended my own understanding and provided the foundation for embracing the complexity of collaboration in a health care context.
<table>
<thead>
<tr>
<th>Examples of definition of health</th>
<th>Purpose behind definition</th>
<th>Origin of definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>“freedom from disease or ailment” (Macquarie dictionary 1992, p.443)</td>
<td><strong>Lexical</strong> definition, reporting the common usage of words (Swartz 1997)</td>
<td>Based on meanings in community</td>
</tr>
<tr>
<td>“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 1946)</td>
<td><strong>Persuasive</strong>, intending to influence attitudes (Swartz 1997)</td>
<td>Developed by a committee of WHO delegates</td>
</tr>
<tr>
<td>“influenced by social, economic and physical environments, individual capacity and coping skills, human biology, early childhood development and health services” (Federal, Provincial, Territorial, Advisory Committee on Population Health 1997, cited by Institute of Medicine 2003)</td>
<td><strong>Stipulative</strong>, specifying how a term should be used (Swartz 1997)</td>
<td>Provided by an epidemiologist commenting on public health policy</td>
</tr>
<tr>
<td>“a state distinguished by the absence of disease or of physical or mental defect, that is, the absence of conditions that detract from functional capacity whose incidence can be measured objectively. … [health is to be assessed] largely in terms of mortality and years of expectation of life, for which objective evidence is available for long periods throughout most of the world.” (Doll 1992, p.933)</td>
<td><strong>Experiential exploration</strong> (Swartz 1997)</td>
<td>Proposed by a hermeneutic philosopher and a phenomenological researcher into the embodied experience of health and illness</td>
</tr>
<tr>
<td>“We need only to reflect that it is quite meaningful to ask someone ‘Do you feel ill?’, but that it would border on the absurd to ask someone ‘Do you feel healthy?’ Health is not a condition that one introspectively feels in oneself. Rather it is a condition of being involved, of being in the world, of being together with one’s fellow human beings, of active and rewarding engagement in one’s everyday tasks, of engagement with the things that matter in life” (Gadamer 1996, p.113). “The homelike attunement of the healthy person indicates that he is experiencing wholeness in his being-in-the-world” (Svenaeus 2000a, p.100); “Illness is experienced … as a not being at home in my own world” (Svenaeus 2000b, p.126); “Health and illness – homelikeness and unhomelikeness in our being-in-the-world” (Svenaeus 2000a, p.165)</td>
<td></td>
<td></td>
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</tbody>
</table>
Through my analysis of these health definitions and meanings, four interrelated facets of understanding became apparent to me:

- focus on health in terms of illness and/or wellness;
- recognition of health as relating to physical and/or mental and/or spiritual aspects of being;
- position of health in relation to social (including cultural, political, environmental) and/or individual contexts;
- perception that health can be a goal and/or state and/or experience.

Identifying these facets enabled me to better grasp the complexity of health meanings, and highlighted the importance of appreciating the different purposes behind the uses of meanings of health.

Definitions and understandings of health do not necessarily encompass all its identified facets. For example, Baron (1985, p.609) wrote that health is the state of “unconscious being that illness shatters”, a definition that includes elements from three of the above facets of health; that is, health as an individual bodily experience that cannot co-exist with illness. In another example, the frequently quoted WHO (1946) definition stated that health was “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. In this definition all facets are encompassed; that is, health is identified as a state that can be conceptualised in terms of illness/wellness, physical/mental, and individual/societal elements.

I contend that the value of a definition relates to how well it fits its purpose. Rather than deeming the WHO definition as “better” than Baron’s definition, I argue that a definition’s value cannot necessarily be determined solely by the number of facets it includes: the purpose of the definition also needs to be considered. Thus Baron’s representation of health, although not as broad as the WHO definition, is evocative and meaningful in relation to illuminating how people experience health.

Swartz (1997) provided a useful way of conceptualising the different purposes definitions might fulfil. This conceptualisation was based on four purposes: lexical definitions, reporting the common usage of words; persuasive definitions, intending to influence attitudes; stipulative definitions, specifying how a term should be used; and

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10 This health definition from the WHO constitution is considered core to future WHO definitions (WHO 1998). The Australian Institute of Health and Welfare (2010, p.3) cites this definition in the section “What is health?”
experiential definitions describing experiences (Swartz 1997). Although not always explicitly articulated, these purposes can be recognised within health definitions, as shown in Table 2.1.

The purpose of a dictionary definition (for example “freedom from disease of ailment” from the Macquarie dictionary 1992, p.443), which aims to reflect common usage, can be contrasted to that of the WHO definition and the Federal, Provincial, Territorial, Advisory Committee on Population Health’s politically motivated definition, to shape new understandings. National delegates from a range of countries developed the initial WHO definition of health during 1945 and 1946 to “emphasise the importance of the preventative side of health” and to drive global health agendas (Sze 1988, p.33). This persuasive definition of what health should mean to health planners can also be contrasted to Doll’s (1992) stipulative definition of what health needs to mean to enable policy-makers to ascribe numerical values. Numerical values are an important focus for policy-makers because measurement of health has been deemed important to understand the health status of populations and individuals, to determine efficient allocation of scarce health care resources, and to inform future research (Larson 1991). These lexical, persuasive and stipulative definitions differ from the experiential definition that aimed to describe authentically what health and illness means to people. Svenaeus’s (2000a, p.165) thought-provoking experiential definition of health and illness as “homelikeness and unhomelikeness in our being-in-the-world” provided a deeper understanding of health and illness as an embodied phenomenon (Svenaeus 2000c). In his definition Svenaeus highlighted health and illness in terms of our relationships with our bodies and the world in which we live, and emphasised the subjective nature of these concepts.

I argue further that different meanings of health have different implications for action. Seeking to achieve absence of illness requires the treatment of disease; and facilitating wellbeing involves health promoting activities. Seeking new understandings of health may lead to innovations in delivery of health care services. Regaining “homelikeness” following illness or disability requires people’s adjustment “to a new way of being-in-the-world” (Svenaeus 2000b, p.135) and encourages health professionals to seek deeper meanings of what experiences of health and illness are like for individuals. As understandings of experiences with health underpin a patient-centred focus (Marcum 2004), I contend that experiential definitions provide an important basis for health care.
Different stipulative definitions of health underpin different ways of interpreting the health status of populations, including how health care is measured. For example, the collection of statistics related to distribution, determinants and frequency of selected diseases (Hennekens & Buring 1987) is actioned when health is stipulated as the absence of disease. By comparison, a broader basis for determining the health status of communities is required when health is stipulated as influenced by a range of interrelated individual and population characteristics and local and international issues and factors (Reidpath 2004). These individual and population factors are commonly categorised as “downstream” curative factors (including disease management and acute treatments), “midstream” preventive factors (such as lifestyle decisions and health promotion programs) and “upstream” environmental factors (such as government policies and global trade agreements) (Keleher & Murphy 2004, Reidpath 2004). Monitoring health thus involves awareness of the interplay between curative, preventative and environmental factors, such as individuals’ decisions, organisational structure and policy frameworks. In the clinical reality, however, more attention is given to downstream factors as they are associated with direct changes in health status, and hence are more visible, amenable to intervention and easier to measure than upstream factors (Reidpath 2004).

The framework for health and health care in Australia, as identified by the Australian Institute of Health and Welfare (AIHW) and shown in Figure 2.1, includes a broad range of determinants of health and wellbeing (such as biomedical factors, health behaviours, and socioeconomic and environmental factors) and a range of interventions (including curative and preventive strategies). Yet in the Australian health care system a tension exists between this rhetoric of a broad conceptualisation of health that encompasses wellness and the economic reality of health care being primarily funded for illness-based care. Although Australia supports the WHO definition of health, the biomedical model of health is dominant in terms of health care funding, with hospitals, medical services and pharmaceuticals accounting for the largest components of recurrent expenditure (AIHW 2004).

In this thesis collaboration is framed in a context where different meanings of health underpin various yet often unstated purposes. In practice, those providing health care services may also bring their own meanings of health to their work, and, depending on the situations, they might be required to work within other meanings of health that suit a variety of different purposes. For example, health professionals in rehabilitation might
be working with patients who are experiencing health as a physical phenomenon, yet be collecting health information for managers in the form of disease distributions while being part of a health care system that seeks health as a source of wellbeing. The notion of shared understandings of health and the purposes of seeking health care, as a foundation upon which collaboration is practised, is therefore unrealistic.

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**Figure 2.1** Conceptual framework for Australia’s health and heath care  
(Based on AIHW 2004)

### 2.2.2 Different frameworks of health care

Different meanings of health both contribute to the challenges of collaborating in health care and provide a rich source of perspectives that prompt different strategies for dealing with complex health conditions. Like the term *health*, the notion of *health care* has various frameworks, meanings and underpinnings. Different meanings of health care are briefly outlined in this section to (a) locate health professionals’ practice in the wider context of different health care frameworks, (b) emphasise the interrelationships between health care providers, and (c) highlight the changing nature of health care provider territories.

One way of categorising different frameworks of health care is based on different models of health and their related health care providers. In this way, health care can be conceptualised as predominantly fitting with biomedical, WHO, wellness and environmental models, and as provided by *health professionals*, nonprofessional *lay people* (Helman 1994), and *complementary and alternative medicine* (CAM) *practitioners* (Grace 2009). Table 2.2 provides an overview of this categorisation.
Table 2.2 Models of health underpinning frameworks of health care

<table>
<thead>
<tr>
<th>Models of health</th>
<th>View of health</th>
<th>Characteristics (Larson 1999)</th>
<th>Health-care providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomedical model</td>
<td>Health as the absence of disease or disability</td>
<td>Focus on disease and disability Machine model of the body Mind is separate from body Divides problems into understandable components Health professionals diagnose disease; people perceive illness</td>
<td>Health professionals providing acute health care, chronic health care and rehabilitation People undertaking self-medication and assisting others (such as friends and family) with management of disease and illness</td>
</tr>
<tr>
<td>WHO model</td>
<td>Health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 1946)</td>
<td>Health is a positive entity Holistic approach, includes social health of society and social health of individual Aims for optimal health</td>
<td>Health professionals involved in health promotion and preventive health strategies People making healthy choices and assisting others (such as friends or family) with their healthy choices Complementary and alternative (CAM) practitioners providing health care that lies outside the boundaries of dominant mainstream medical practices (Grace 2009)</td>
</tr>
<tr>
<td>Wellness model</td>
<td>“Man is a physical, mental, and spiritual unity – a unity which is constantly undergoing a process of growth and adjustment within a continually changing physical, biological, social, and cultural environment” (Dunn 1959, p.789)</td>
<td>Health is a positive entity Recognises linkages between mind, body and spirit: health is open ended</td>
<td>People making health promoting decisions CAM practitioners providing health care that lies outside the boundaries of dominant mainstream medical practices Health professionals using an integrative approach medicine</td>
</tr>
<tr>
<td>Environmental health model</td>
<td>The field of health can be broken into four elements: human biology, environment, lifestyle and health care organisation (Lalonde 1981)</td>
<td>Health is a positive entity Focuses on individuals’ adaptation to the environment Considers biological, social environmental aspects Social, political and physical environment are part of health</td>
<td>Health professionals working with public health strategies Other scientific professionals such as environmental scientists and engineers, and other health professionals Non-professional environmental strategists and lobbyists</td>
</tr>
</tbody>
</table>

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11 Based on Larson (1999)

12 The wellness movement is commonly considered to have been begun by Dunn (1895-1975)
The term *health professional* commonly refers to medical, nursing and allied health practitioners, some of whom tend to have higher status than other health care providers in the community (Helman 1994). Attributes of *professorial practice* are explored more thoroughly in Section 2.2.3. Provision of health care by lay people tends to be centred on family health care and relies on informal and unpaid healing relationships where credentials for care are based on the person’s experience with health problems (Helman 1994). Health issues are diagnosed and treated with readily available materials; for example, relatives may share medication for temperatures, sore throats, headaches and indigestion, and health information may be accessed from self-help groups (Helman 1994). The CAM health sector incorporates spiritual healers, herbal healers, osteopaths and chiropractors (Grace 2009). As there is no consensus regarding the occupations included as CAM practitioners, this sector tends to be defined in terms of exclusion (Grace 2009). CAM can include traditional medicine the origins of which reflect different cultural and philosophical backgrounds (WHO 2002a).

A feature of different models of health and providers of health care is their different language use. Pietroni (1992) outlined different language subsets used by professions to discuss health, (examples of which are shown in Table 2.3). He argued that professionals need to understand the languages of others to facilitate communication and to encourage creative reflective processes. These language differences further highlight the diversity brought to collaborative situations, and allude to the challenges these differences bring.

**Table 2.3 Language subsets of health professions**

<table>
<thead>
<tr>
<th>Language subsets</th>
<th>Key words describing health concepts</th>
<th>Key concepts used by professions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/molecular/material</td>
<td>Disease, symptoms, science, cure, diagnosis, treatment</td>
<td>Inductive reasoning, mind-body dualism, linear cause and effect, clinical trial</td>
</tr>
<tr>
<td>Psychological/ psychosomatic/ psychoanalytical</td>
<td>Mind/brain consciousness, human potential growth, desensitisation</td>
<td>The unconscious, defence mechanism, projection, client-centred</td>
</tr>
<tr>
<td>Social/cultural/ epidemiological</td>
<td>Culture, groups, public health, privilege, disadvantage</td>
<td>Health beliefs, illness, behaviour, knowledge/power, incidence, prevalence</td>
</tr>
<tr>
<td>Anthropological/ ethnological</td>
<td>Culture, context, field-work, ritual, family</td>
<td>Health beliefs, folk care, rites of passage</td>
</tr>
<tr>
<td>Prevention/promotion/ education</td>
<td>Risk factor, self-help, life-style, check-up</td>
<td>Prevention better than cure, empowerment, responsibility, positive health</td>
</tr>
<tr>
<td>Environmental ecological</td>
<td>Green, pollution, global warming, ozone layer</td>
<td>Effect of degradation of the environment on health and disease</td>
</tr>
<tr>
<td>Legal/moral/ethical</td>
<td>Rights, integrity, conscience, beneficence</td>
<td>Issues of morality (e.g. organ transplant), confusion and uncertainty of complex problems</td>
</tr>
</tbody>
</table>
The notion of patient-centredness varies between different models of health care, particularly in relation to the degree to which patients are seen as people with will, agency, interests and preferences. For example, within the biomedical model, patient-centredness may mean focusing on patients’ illnesses and/or their use of, and satisfaction with, health care facilities to treat these illnesses (e.g. Schmittdiel, Mosen, Glasgow et al. 2008; Tufano, Ralston & Martin 2008). Bensing (2000, p.17) stated that in a biomedical focus “the uniqueness of patients, their individual needs and preferences, and their emotional status are easily neglected” in decision making. Other authors similarly criticise health professionals’ control over decision making in biomedicine (e.g. Ford, Schofield, & Hope 2003). In contrast, patients as people (with will, needs, agency and preferences) are the focus of the WHO and wellness models of health care (see di Sarsina & Iseppato 2010). Incorporating the notions of patient participation and wellness into health care requires those working within a biomedical model to “readjust their goals, strategies and patterns of interaction with health care recipients” (Higgs, Neubauer, & Higgs 1999, p.31). (Patient-centred health care is discussed further in Section 2.2.3).

Despite their differences, models of health care are not mutually exclusive and boundaries between them are not clear cut. People may use therapeutic options from all sectors; for example, a person may self-medicate, visit a naturopath and consult a medical specialist for different health problems. Self-care and CAM are increasingly seen by patients as important options (Wearing 2004), particularly those who are dissatisfied with aspects of biomedical model of health care, including health professionals’ time pressures and poor communication skills (Bishop & Lewith 2007).

Thus the foundation of health care is dynamic. There are many possible permutations of meanings, models and frameworks that provide the foundations of understandings brought to collaborative situations. Although these differences contribute the potential for creativity from heterogeneity, shared understandings of health and health care should not necessarily be assumed in collaborative situations.

2.2.3 Health professional practice

With health professionals increasingly seeking and being expected to work with others, collaboration is an important component of professional practice. Health professionals bring to these collaborations their various understandings of health and health care that arise from their discipline socialisation and their personal and professional experiences.
In this section the interrelationships between individual development, professional education and socialisation, and managerial requirements for accountability are highlighted. Health professionals are framed as individuals who work within accountable systems and who bring to collaborative situations their professional and individual needs, perspectives, qualities and levels of development.

a) Health professional education and socialisation

In this section I highlight some complexities of health professional education (including ongoing professional development) and socialisation. Education and socialisation of health professionals into their specific disciplines and workplace cultures provide the foundation for the rich heterogeneous understandings that underpin collaboration. However, being predominantly discipline-specific, these processes are also responsible for establishing the discipline boundaries and differences in understandings that can potentially impede collaboration. I acknowledge that underpinning the first two parts of this section is the current predominantly silo-based nature of health professional education and socialisation. I explain key aspects of interprofessional education in part (iii).

i) Education for accountability and complex practice

Ideally, health professional education ensures clinicians’ compliance with accountability requirements of credentialing bodies, while preparing them for the complexity of professional practice (Higgs & Edwards 1999; Cherry 2005). However, different approaches to health professional education were evident within the literature. While some articles had a particular focus on accountability and the fulfilling of course requirements through prescriptive guidelines, others had a broader focus which recognised the importance of preparing health professionals for complexity and uncertainty.

Authors with a focus on accountability and regulation requirements have tended to favour measurable competency-based approaches. These approaches support the use of assessments to ensure that beginning practitioners reach a certain standard of practice.


14 A discipline-specific focus is often referred to in relation to “silos”; for example, Hall (2005, p.190) claimed that “each professional school will use methods best suited to its learners, which will further reinforce the walls of the silo”.

43
before graduation (Feletti 1999). However, such competency approaches have been criticised for their tendency for reductionism and oversimplification of behaviours (Fook, Ryan, & Hawkins 2000).

Education for regulation and accountability also tends to use measurement to validate and/or compare education approaches and strategies. For example, Sheehan, Robertson, and Ormond (2008) developed and validated a questionnaire to evaluate effective learning environments within clinical attachments for interns. Blackall, Melnick, Shoop et al. (2007) described a survey to determine attitudes to professionalism. Campbell, Lockyer, Laidlow et al. (2007) developed a reportedly feasible and valid tool to assess doctor-patient communication skills. Costa, van Rensburg and Rushton (2007) measured knowledge retention within different teaching styles. Although these studies framed accountability in relation to effective student learning, better care for patients and/or cost efficiency for funding bodies, the degree to which these tools could capture the complexity of these notions was unclear. Further, accountability for “efficiency, effectiveness, economy, responsiveness and quality” can be potentially conflicting (Eraut 1994, p.5); for example, economic accountability can affect quality, or a focus on effectiveness can affect measures of efficiency. Thus it could be argued that despite acknowledging the importance of accountability and fulfilling course requirements, reductionist views are insufficient to underpin the complexity of professional practice, including the preparation and ongoing development of health professionals to become capable of interacting with a range of people (including their colleagues, patients and carers) in various and particularised situations.

Authors concerned with preparation for complex practice have tended to focus on flexible implementation and uncertainty, recognising tacit elements of practice to a greater degree than those with an accountability focus. For example, flexible implementation principles rather than prescriptive guidelines were evident in Fook and colleagues’ (2000, p.5) contention that education needs to develop “principles for contextual knowledge translation” to allow practitioners to make knowledge from one situation relevant to another, thus enabling them to deal with uncertainty and contextualised practice.

Higgs, Hunt, Higgs et al. (1999, p.25) similarly emphasised flexibility in their proposal that universities should aim for program flexibility, close cooperation between universities and professional bodies, further research to develop deeper understandings
of how students learn, and “synthesis of educational philosophy and professional practice”. These authors claimed that such education would support the graduation of interactional professionals who display client-centredness, are aware of their personal frame of reference, are technically competent, and are able to meet future demands, demonstrate social responsibility and practise in a self-critical manner (Higgs, Hunt et al. 1999). Educating practitioners to be interactional professionals through “reshaped” universities has the potential to enable students to obtain suitable levels of competency and understandings of professional practice and professionalism prior to graduation, while developing interactional skills that enable them to engage with others to address changing needs (Higgs, Hunt et al. 1999). However, as the initial education of health professionals cannot provide all the skills and knowledge necessary for professional practice (Evetts 1999), professionals also need the capacity for ongoing development for future professional practice (Eraut 1994). This need for interactional professionals and their ongoing professional development supports the view of health professionals as individuals capable of working with others in particularised situations within dynamic health care contexts.

**ii) Socialisation of health professionals**

Health professional education is accompanied by a process of acculturation during which individuals are socialised into their particular health professional disciplines (Higgs, Hummell et al. 2008). Professional capabilities and a sense of identity and responsibility are acquired during this process (Higgs, Hummell et al. 2008). Through socialisation, members of each health profession discipline develop “common experiences, values, approaches to problem solving and language for professional tools” (Hall 2005, p.190), as well as “distinct models of care, different skills sets … and diverse political agendas” (Lingard et al. 2004, p. 407). Socialisation can be considered to establish the foundation for the dynamic heterogeneity of health professional collaboration.

This process of socialisation, through which learners observe and imitate their professional referents’ values, rules and behaviours (Thomas 2003), has tended to rely heavily on inherently implicit processes or osmosis (Davis 2005). It could be argued, however, that making processes of socialisation more explicit might provide a foundation for understanding how attitudes to other professions develop. Further, being able to articulate discipline practice models may provide a foundation for understanding some of the conceptual differences that are brought together in collaborative situations.
The benefits of making socialisation processes explicit have been acknowledged, and the need for educators at all levels to openly monitor and develop opportunities for students to reflect on their professional identities recognised (Richardson, Lindquist, Engard et al. 2002). Davis (2005) proposed that appropriate guidance during socialisation, such as reflection to clarify values, would help holistic growth permeate to deeper levels of self. Understandings of practice philosophies, of how knowledge is generated within their professions, and what truths and perceptions frame and define their professions were considered by Ewing and Smith (2001) to be important for authentic practice.

**iii) Interprofessional education**

The recent focus on interprofessional education indicates a growing awareness of the need for beginning health professionals to be well prepared for working with others from different disciplines. Interprofessional education has been defined as “those occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (Freeth, Hammick, Reeves et al. 2005, p.xv). This form of education developed in response to the traditional silo health professional education where opportunities to understand other professional roles were sparse. Students participating in interprofessional education have opportunities to understand the professional roles, skills and responsibilities of other disciples while clarifying their own roles and responsibilities (P. Clark 1997; Barr 1998; Cooper, Carlisle, Gibbs et al. 2001; Health Canada 2007; CAIPE 2008). Underpinning interprofessional education are the needs to understand and be responsive to other disciplines’ roles, relationships and views of health care, and to prepare students for collaboration.

The practice of different disciplines learning together through shared lectures, for example, appears to be based on an assumption that learning together will facilitate better understanding of each other’s roles, which in turn will facilitate interprofessional practice. However, interprofessional learning also needs to have an explicitly articulated focus, for example when students of different disciplines work together on a shared patient problem in a real or simulated situation to explore each other’s role contributions and understandings.

Interprofessional teamwork can be explicitly taught in workshops (e.g. Gilbert, Camp, Cole et al. 2000) and clinical situations. Hall and Weaver (2001) contended that to function well in teams, health professionals needed to be educated in teamwork. For
example, Ponzer, Hylin, Kusoffsky et al. (2004) identified benefits of teaching teamwork as a subject integrated into interprofessional clinical experience. After participating in interprofessional clinical education with a specific focus on teamwork, undergraduate health professionals in their study reported increased understanding of their own and others’ roles, and valued communication for teamwork more highly than before this type of education (Ponzer et al. 2004).

However, organisational, structural and attitudinal barriers to interprofessional learning have been identified, including differences in educational routines and timetables, students’ different levels of experience, differences in academic policies, rivalries between professions, and concern about insufficient attention to discipline-specific capabilities and characteristics (McPherson, Headrick & Moss 2001). In relation to the last concern it has been contended that interprofessional education needs to achieve a balance between the opportunities for own discipline socialisation and understanding other disciplines’ roles and ways of understanding and working (P. Clark 1997; Carlisle, Cooper, & Watkins 2004). McPherson and colleagues (2001, p.ii46) claimed that barriers to interprofessional education “will not disappear by simply being ignored, but they can be managed and overcome”. Their suggestions to overcome such barriers included that educators need to invest time to discuss issues, agree on what they hope to achieve, reflect on how people attend to others’ knowledge, invest time, and use “multiple methods of communication to bridge barriers of schedules and geography” (p.ii52).

**b) Health professional practice**

In this section I contend that health professionals are essentially individuals who (a) bring to their practice their personal and professional experiences, (b) (optimally) continue to develop as practitioners throughout their career, and (c) deal autonomously with the uncertainties and unpredictability of practice and contexts, despite their regulatory bodies endorsing accountable and evidence-based practice. Health professionals collaborating with each other are not interchangeable representatives of their disciplines; one health professional’s skills, knowledge and practice model are not the same as those of the person they are replacing in a collaborative situation.

**i) Clinical reasoning and different forms of knowledge**

An exploration of clinical reasoning highlights the individual nature of the capabilities and knowledge that health professionals bring to their practice. Clinical reasoning refers
to the thinking and decision-making processes individual health professionals undertake to provide treatments and therapies (Higgs & Jones 2008). Clinical decision making is a “complex, largely automatic and often invisible process” (Higgs, Trede, Loftus et al. 2006, p.1). The concepts proposed by Dreyfus and Dreyfus (1980), Schön (1983) and Eraut (1994) (key points of which are provided in Table 2.4) have informed much research and discussion about clinical reasoning, including that of Harbison (1991), Kelly and Horder (2001), Higgs and Titchen (2002), and Benner (2004). The notions that (a) practitioners are individuals and (b) professional practice can be developed underpin Dreyfus and Dreyfus’s skill acquisition, Schön’s reflective practice and Eraut’s types of knowledge.

Table 2.4 Key points from ideas informing understandings of professional practice

<table>
<thead>
<tr>
<th>Author</th>
<th>Examples of key contributions to understandings of professional practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dreyfus &amp; Dreyfus (University of California, USA)</td>
<td>Skill acquisition has different stages: “In acquiring a skill by means of instruction and experience, the student normally passes through five developmental stages which we designate novice, competency, proficiency, expertise and mastery. We argue, based on analysis of careful descriptions of skill acquisition, that as the student becomes skilled he depends less on abstract principles and more on concrete experience” (1980, p.1).</td>
</tr>
<tr>
<td>Schön (Massachusetts Institute of Technology, USA)</td>
<td>Practitioners can learn from reflection on action and reflection in action: “The practitioner allows himself to experience surprise, puzzlement, or confusion in a situation which he finds uncertain or unique. He reflects on the phenomena before him, and on the prior understandings which have been implicit in his behaviour. He carries out an experiment which serves to generate a new understanding of the phenomena and a change in the situation” (Schön 1983, p.68).</td>
</tr>
<tr>
<td>Eraut (University of Sussex, UK)</td>
<td>Professional practice incorporates different types of knowledge: “knowledge of people; situational knowledge; knowledge of educational practice; conceptual knowledge; process knowledge; and control knowledge” (1994, p.77).</td>
</tr>
</tbody>
</table>

Each profession has a discipline-specific knowledge base, but other types of professional knowledge also play an important role in clinical reasoning and decision making (Higgs & Jones 2008). Higgs and Titchen (2002) identified three forms of knowledge that individuals bring to professional practice: propositional, personal and professional craft knowledge. Knowledge from all three dimensions is “necessary for sound and responsible clinical reasoning” (Higgs & Jones 2008, p.5). Propositional knowledge is publicly available, objective in nature and derived from research (Higgs, Titchen & Neville 2001). This form of knowledge provides the basis for analysing patients’ problems in terms of pathology and illness, and enables practitioners to recognise meaning in results of assessments. Personal knowledge is based on practitioners’ individual life experiences and personal frames of reference. Practitioners use this
knowledge to understand and engage with patients and to situate problems within patients’ worlds. Professional craft knowledge is composed of past experiences with other patients and understandings of the current patient’s situations and contexts at particular times. This kind of knowledge tends to be tacit, and may require reflection to bring it to conscious awareness.

Parts of Schön’s (1983) influential writing on reflective practice provide guidance for making implicit knowledge explicit. He explained that tacit understandings can be brought to the surface to form explicit understandings by reflecting on uncertain situations and identifying the implicit prior understandings within them (Schön 1983).

Eraut (1994, p.112) claimed that professional practice involved deliberative processes where one single answer or obvious solution was rarely available; rather there would more likely be:

- some uncertainty about outcomes; guidance from theory which is only partially helpful; relevant but often insufficient contextual knowledge; pressure on the time available for deliberation; a strong tendency to follow accustomed patterns of thinking; and an opportunity, perhaps a requirement to consult or involve other people.

Expert practitioners are more able to deal with uncertainty (Fook et al. 2000), are more adept with complex clinical reasoning and are able to recognise the interplays between numerous elements in a particular situation (Christensen, Jones, Higgs et al. 2008). It is therefore likely that the nature of the contributions of health professionals make to collaborations at different stages of their development will differ.

As well as knowledge brought to collaborative situations, thinking abilities also vary between individuals. Thus members of a discipline are not interchangeable, and different ways of thinking can be challenging for those working together in collaborations. Cognitive capabilities for clinical reasoning have been identified as involving critical, reflective, dialectic and complex thinking (Christensen et al. 2008). Critical thinking enables practitioners to question taken-for-granted beliefs and habits of thought. The concept of reflective thinking is based on Schön’s concepts of reflective practice and involves reflecting “both when engaged with a patient over a period of time, considering and evaluating performance in past experience, and also in an immediate sense, reflecting in the moment while working with the patient” (Christensen et al. 2008,
Dialectic thinking requires practitioners to draw on and resolve tensions between different ways of thinking (e.g. biomedical aspects and lived experiences of patients’ worlds) to achieve a holistic understanding; complex thinking is non-linear, non-mechanical and able to deal with unpredictability. Therefore, it would be unreasonable to expect all members of a collaborative group to have similar cognitive abilities, and there may be different abilities to engage with complexities of clinical reasoning.

Nevertheless, practitioners can learn from their experience by thinking about what they do, why they make particular choices, what works and what does not (Jensen, Resnick, & Haddad 2008). The gap between knowledge and cognition is bridged by reflective self-awareness, also known as metacognition (Higgs & Jones 2008). Through reflective self-awareness clinicians can self-regulate their information collection, clinical reasoning and clinical performance, while maintaining awareness of a range of factors that can impact on their practice, such as knowledge limitations, beliefs and values, and propositional, personal and professional craft knowledge (Jones, Jensen, & Edwards 2008). Thus metacognitive skills are important for experiential learning and ongoing development of professional practice (Schôn 1983; Eraut 1994; Higgs & Jones 2008).

**ii) Accountability requirements**

Adding to the complexity of professional practice, health professionals also need to be accountable to others who are external to the immediate clinical situation, including managers, regulators and funders. Health professional membership is commonly regulated through credentialing, such as licensure and certification, which is designed to ensure competence (Longest 1996). In Australia, health professional education within accredited university courses prepares graduates for registration with their professional licensing bodies (where applicable), with the purpose of registration and licensure reportedly being to protect public interest rather than the interests of health professional disciplines (Council of Australian Governments 2008). Health professionals are required to work within sets of interconnected regulations, as was highlighted by Eraut (1994, p.5) who proposed that “the work of the professions can be viewed in terms of several interconnected sets of power relations: with service users, with managers of service-
providing organizations, with government, with a range of special interest groups and with other professions”. Thus, health professionals commonly need to integrate external influences into their clinical reasoning.

Accepting responsibility and being accountable for decisions are often considered integral to health professionals’ autonomous practice (Freegard 2006) and status as a profession (Cruess & Cruess 2008). In real practice situations however, health professionals may be accountable to many, and they are not completely autonomous in their decision making. Their scope and range of practice are influenced by many factors, particularly (a) regulatory body requirements, including the conduct, areas and standards of practice set out by the regulatory body, and laws and statutes defining the profession and personal qualities required to practise; (b) practitioners’ individual levels and types of knowledge and expertise, and their need for supervision or assistance in new areas of practice; (c) requirements to work with other health professionals (Cruess & Cruess 2008); and (d) patients’ preferences for their health care. Accordingly it could be argued that autonomy, as a feature of professional practice brought to collaborative situations, is a potentially problematic notion, particularly in terms of discipline territories and role overlaps.

**ii) Conceptualising health professional practice**

Fish and Coles (2006) proposed that health professionals are required to work within two largely incompatible views of professional practice: *technical rational* and *professional artistry*. Characteristics of these views are outlined in Table 2.5. A complementary view could be added to this, *professional judgement*, which was explained by Higgs, Fish and Rothwell (2008, p.164) as requiring self-critique and the “continual refinement and updating of practitioners’ knowledge”. Germane to the notion of professional judgement, Cicerone (2005, p.1074) claimed that “evidence-based practice therefore must incorporate not only our knowledge of the scientific evidence and our clinical judgment, but also the values and beliefs of the patients we serve”. Thus collaboration between patients and health professionals is at the core of patient-centred care.

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16 Autonomy can be best thought of as an expectation that a practitioner is competent to work without direct supervision, is capable of making sound professional decisions and is responsible for these decisions. It does not mean that the practitioner works alone with no formal lines of accountability or management/leadership.
Fish and Coles (2006) proposed that viewing professional practice as a technical and rational enterprise reflects bureaucratic needs for control of service delivery in health. This view does not embrace complexity, diversity and uncertainty or learning through reflection on practice. Accordingly, bureaucratic systems tend to value mechanistic and predictable practice. For example, in his discussion of workplace redesign Duckett (2007) proposed that substitution of one health discipline for another (such as nurses being substituted for medical staff in rural situations) can be “facilitated by specifying protocols for performance of the new roles outside traditional professional boundaries”, and that “protocol-based care might improve the quality of care by ensuring a sounder evidence base for provision” (p.113). Such reliance on protocols indicates an emphasis on propositional knowledge over personal and professional craft, with little recognition given to the need for situationally specific and contextually relevant practice.

On the basis of considering complexity, uncertainty and diversity in professional practice, it could be argued that over-reliance on rules to guide practice may neglect professional judgement and limit opportunities to learn from reflection and collaboration. However, despite working in a climate where predictability is valued, health professionals tend to understand the importance of being creative and reflective, and they recognise that professional practice cannot be confined to “a predetermined set of clear-cut routines and behaviours” (Fish & Coles 2006, p.291). Working within systems that value technical rational professional service delivery over professional

<table>
<thead>
<tr>
<th>Aspects</th>
<th>Technical rational</th>
<th>Professional artistry</th>
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<tbody>
<tr>
<td>Rules</td>
<td>Rules guide practice</td>
<td>Rules do not usually fit real practice; practice relies on</td>
</tr>
<tr>
<td></td>
<td></td>
<td>frameworks and rules of thumb</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Knowledge is factual and able to be mastered</td>
<td>Knowledge is dynamic and temporary; knowing processes is more</td>
</tr>
<tr>
<td></td>
<td></td>
<td>useful than knowing facts</td>
</tr>
<tr>
<td>Roles</td>
<td>Professional roles can be analysed in detail to provide job</td>
<td>Analysis of professional roles is subjective, practice requires</td>
</tr>
<tr>
<td></td>
<td>specifications, guidelines and protocols</td>
<td>scope for creativity</td>
</tr>
<tr>
<td>Improving practice</td>
<td>Skills training improves practice</td>
<td>Learning occurs from improvisation and reflection, collaboration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and dialogues</td>
</tr>
<tr>
<td>Quality</td>
<td>Visible performance is emphasised, quality is measurable</td>
<td>Moral dimensions of practice are not readily visible;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>professionals are responsible for reflecting and refining their</td>
</tr>
<tr>
<td></td>
<td></td>
<td>own practice</td>
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</table>

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On the basis of considering complexity, uncertainty and diversity in professional practice, it could be argued that over-reliance on rules to guide practice may neglect professional judgement and limit opportunities to learn from reflection and collaboration. However, despite working in a climate where predictability is valued, health professionals tend to understand the importance of being creative and reflective, and they recognise that professional practice cannot be confined to “a predetermined set of clear-cut routines and behaviours” (Fish & Coles 2006, p.291). Working within systems that value technical rational professional service delivery over professional
artistry approaches contributes to the complexity and challenges of health professionals’ clinical reasoning and professional practice.

c) Involving patients and carers in health care

With the increasing expectations for patients and carers to participate in their health care, health professionals are commonly required (and desire) to collaborate with patients and their carers and include them in their health care and decision making. I contend that patient-centred practice requires health professionals to (a) be aware of values and issues influencing patient-centred care and the relationships involved in this care, and (b) seek to maximise enabling factors and lessen the barriers of involving patients and carers in health care and health care decisions.

The use of the term “patient-centred” in this thesis encompasses people with will, agency, needs, interests and preferences rather than disease entities or objects for the provision of services (see Sections 1.2 and 1.4.2). In relation to rehabilitation, Leplege et al. (2007 p.1558) proposed that person-centredness could be conceptualised in terms of four major dimensions:

- respecting the person behind the impairment or disease;
- dealing with the person’s specific characteristics in a holistic manner: individuals are seen as unique (requiring tailored interventions rather than a “one size fits all” program) and needing to have their interdependence with others taken into account (highlighting the importance of friends and family in providing practical help and emotional support);
- using the expertise that patients have in their situations: patients are encouraged to be participants in, rather than objects of, their care and to establish dialogue with health professionals in order to articulate values and preferences (thus avoiding the directiveness that results from health professionals defining and determining what is in the patient’s best interest);
- addressing difficulties in everyday life: acknowledgement that some problems are related more to the environmental context than the individual involved.

The inclusion of health professionals as people, as well as patients as people, is implicit in Leplege’s and colleagues’ person-centred dimensions. Health professionals are the

17 I understand the term “person-centredness” in this article to be interchangeable with the term “patient-centredness”.

53
people who need to engage (with each other) in the co-construction of respectful negotiated health care with their patients as unique persons.

The exploration of barriers and enablers that has accompanied the increasing interest in patient-centred care has identified a broad range of factors, an example of which is shown in Table 2.6. These factors include contextual issues, organisational resources and support, individual capabilities, the nature of patients’ problems and conceptual challenges. However, in critique of the identified barriers, it could be argued that a patient’s communication problem should not preclude patient-centred care, as patients can still be approached as people regardless of their communication challenges, and less professional power to staff may result in empowered patients.

The biomedical model of health care (focused on disease and illness), with its de-contextualised focus on individuals and reliance on health professional “experts”, has been blamed for setting up barriers to health professionals involving patients in care (Silburn & Johnson 1999), as has the traditional health professional dominance over decision making (Trede & Higgs 2003). The increasingly technological approach to the provision of health care has also been decried as subsuming “the more humane elements of practice” (Macleod & McPherson 2007, p.1594). I contend that patient-centred practice requires that health professionals be aware of how these factors can influence the valuing of people in health care.

### Table 2.6 Barriers to and enablers of patient-centred care

(quoted from National Ageing Research Institute by Dow, Haralambous, Bremne et al. 2006, p.1-2)

<table>
<thead>
<tr>
<th>Barriers to patient-centred care</th>
<th>Enablers of patient-centred care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• time: various studies stated that person-centred approaches to care take more time</td>
<td>• having skilled, knowledgeable and enthusiastic staff, especially with good communication skills</td>
</tr>
<tr>
<td>• dissolution of professional power; that is, staff experiencing loss of professional status and decision-making power</td>
<td>• opportunities for involving the service user, carers, family and community (e.g. volunteers) in health care</td>
</tr>
<tr>
<td>• staff lacking the autonomy to practise in this way</td>
<td>• opportunities for staff to reflect on their own values and beliefs and express their concerns</td>
</tr>
<tr>
<td>• lack of clarity about what constitutes person-centred care, making it more difficult to practise and to explain to clients</td>
<td>• opportunities for staff training and education, including feedback from service users</td>
</tr>
<tr>
<td>• clients with communication difficulties</td>
<td>• organisational support for this approach to practice</td>
</tr>
<tr>
<td>• the constraining nature of organisations, including physically or spiritually impoverished environments of care</td>
<td>• working in an environment of mutual respect and trust</td>
</tr>
<tr>
<td></td>
<td>• physically and emotionally enriched care environments</td>
</tr>
</tbody>
</table>
The concept of a carer tends to be broad. It encompasses people who provide care for patients’ physical, social and emotional needs, with a distinguishing feature being the unpaid nature of the work. Although an unbalanced focus on this unpaid nature can lead to carers’ involvement being viewed as a cost-saving measure (Twigg 2000), I propose that it is carers’ knowledge and care of and for patients’ problems, capabilities, aspirations and situations that underpin their contributions to health care teams, rather than the unpaid nature of their work. In this research I acknowledge that carers have roles to play as valuable contributors to or members of health care teams. In hospitals, carers can contextualise patients’ problems and abilities, participate in goal setting, and ensure continuity of goals of treatments throughout staff changes (O’Connor 2007). They may also be able to provide staff with guidance on practical issues such as how best to assist the patient to move or communicate (Trede & Haynes 2008). It has been noted, however, that carers’ knowledge of patients can be overlooked and their views of discharge arrangements ignored (O’Connor 2007). Appropriate resources, such as discharge protocols (O’Connor 2007) and capabilities for developing person-centred relationships (Trede & Haynes 2008) have been identified as important for enabling carers to be valuable complementary resources.

The influences on, and requirements for, patients’ and carers’ participation in health care have received considerable attention in the literature. The increasing involvement of patients in health care and the more prominent roles of carers in treatments and decisions require health professionals to have ability to engage with people and establish trusting relationships (Trede & Haynes 2008). Health professionals’ and patients’ communication skills, preferences and expectations, their time constraints and the individual nature of each context can all influence the nature of the engagement between health professionals and patients and carers (Ajjawi & Patton 2008, Trede & Haynes 2008). Underpinning effective communication in health care are abilities to negotiate meanings, build interpretations on previous interactions, use a range of communication media, reach shared understandings, and work within varying organisational contexts and with a range of people from different backgrounds, experiences and roles (Ajjawi & Patton 2008). Communication skills required for verbal communication between health professionals, patients and carers, include attentive listening (to encourage speakers and hear their messages), questioning (to elicit information and understand perspectives of others), providing information (to explain and inform through accurate verbal explanations or written reports), responding (to provide feedback about messages
received), clarifying (to check understanding and highlight areas of tension) and empathising (to create an appropriate communication climate) (Croker & Coyle 2008).

From their experiences of working with patients and carers, Trede and Haynes (2008) identified a number of attributes that enhance health professionals’ engagement with patients and carers. These attributes include establishing dialogue, listening respectfully, showing compassion, explaining what is happening and what can be expected, ensuring that patients are worked with (rather than on), and creating safe, comfortable spaces for interactions. The research of Piccolo, Mazzi, Saltini et al. (2002) highlighted the importance of communication training for patient-centred approaches, and Laidlaw, Kaufman, Sargeant et al. (2007) found that patient-centred communication with adolescents relied on the doctor’s abilities to pose open questions, respond to patients’ cues, be flexible in sequencing of questions, use empathy and non-judgement, and self-reflect. Authoritative tones of voice, lack of compassion and empathy, and non-individualised communication have been identified by carers as blockages to communication (Artcraft Research 2002). Stevenson (2003) found that time constraints and patients’ preferences can also impact on patient engagement in shared decision-making. Trevena and Barratt (2003) acknowledged the uniqueness of each health professional-patient situation and proposed a new term, integrated decision making, to reflect the importance of incorporating the nature of health issues, patients’ preferences, clinical findings and research evidence. Patients with complex health problems often have multiple health professionals involved in their care, so integration also needs to entail these multiple perspectives.

Health professionals caring for the same patient might work as part of a team and communicate regularly, or they might interact informally and communicate on an ad hoc basis. Various formal and informal styles are used to communicate. Formal communication tends to be explicit and use recognised processes. Assessments, diagnostic reports, progress reports, discharge reports and referrals are examples of formal written systems that fulfil the dual purpose of information sharing and accountability (McAllister, Hay, & Street 2008). Informal communication tends to be spontaneous and casual (Higgs, McAllister, & Sefton 2008). The flexibility of informal communication processes can facilitate micro-negotiation between health professionals (Ellingson 2003) as well as provide opportunities for establishing rapport. Written communications such as diagnostic reports, progress notes, client records, medico-legal

56
reports and referrals require attention to accuracy, timeliness, relevance, content and style (McAllister et al. 2008).

The complexity of communication was further highlighted by Loftus’ (2006) identification of the repertoire of language tools employed when collecting information from patients and reasoning with other professionals. Rituals provided assistance with recalling what information was required and enabled practitioners to focus on the problem rather than having to recall that information. Metaphors enabled abstract concepts to be presented in concrete forms and narratives provided a contextual framework for patients’ stories; whereas rhetoric was persuasive of authority and legitimacy.

To summarise, health professional practice is characterised by uncertainty, unpredictability and complex communication. Moreover, with different understandings of health and health care arising from discipline socialisation and personal and professional experiences, health professionals face a number of challenges to patient-centred collaborative practice. Adding further to the complexity and challenges of such practice is the dynamic nature of the health care systems which provide the organisational context for and the key organisational influences on collaboration.

2.3 The Australian Health Care System

The Australian health care system is based on numerous interactions between health care providers and patients, undertaken within a complex array of governance, organisational and funding structures (Duckett 2007). In this section key features of these structures and their influences on collaboration are briefly explored. Underpinning this exploration is my position that organisational support is important for collaboration to flourish in health care.

2.3.1 Organisational and structural factors

Organisational and structural factors affecting the ways health professionals work together, and with patients and carers, are explored in this section, in relation to (a) the internal differentiations that require health professionals to work across departments and agencies in order to access services and resources, (b) cost containment and financial accountability that may influence clinical responsibilities and compete with patient-centred perspectives, (c) changing structures that alter lines of communication and
relationships between professions and departments, and (d) inequitable distribution of services that leads to gaps and overlaps in services.

a) Differentiations within the Australian health care

It can be argued that differentiations in the provision and funding of health services in Australia can be confusing for consumers and providers, and may encourage competition rather than collaboration between health professions. Services are administered and funded through the Commonwealth, State/Territory and Local Governments, as well as commercial and non-government enterprises. With the resultant overlapping responsibilities and split funding for services, comprehensive national health policies are difficult to develop (Duckett 2007). Difficulty transitioning between services, including rehabilitation (New & Poulos 2008), can also be experienced due to cost shifting between departments and levels of governments (Reid 2002; Stewart & Dwyer 2009). A simplified summary of the health responsibilities divided between governing agencies within the Australian health care system is provided in Table 2.7. These funding systems are currently (2011) in a state of flux and confusion due to the proposed restructuring of health funding.

Table 2.7 Outline of responsibilities in relation to Australian health services

<table>
<thead>
<tr>
<th>Area of Responsibility</th>
<th>Commonwealth Government</th>
<th>State Government</th>
<th>Local Government</th>
<th>Non-government (including religious, charitable and for-profit providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy-making for public health research</td>
<td>Leadership role</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy-making for national information management</td>
<td>Leadership role</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical services, not in hospitals</td>
<td>Predominant source of funding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health research</td>
<td>Predominant source of funding</td>
<td>Some provision</td>
<td>Some provision</td>
<td>Some provision</td>
</tr>
<tr>
<td>Public hospitals and community care for aged and disabled persons</td>
<td>Jointly funded</td>
<td>Jointly funded</td>
<td>Jointly funded</td>
<td>Jointly funded</td>
</tr>
<tr>
<td>Delivery and management of community public health services</td>
<td>Some provision</td>
<td>Primarily responsible</td>
<td>Some provision</td>
<td>Some provision</td>
</tr>
<tr>
<td>Support for private health insurance</td>
<td>Premium subsidies</td>
<td></td>
<td>Sell health insurance to individuals</td>
<td></td>
</tr>
<tr>
<td>Residential aged care</td>
<td>Regulation and some finance</td>
<td></td>
<td>Primarily responsible</td>
<td></td>
</tr>
<tr>
<td>Community services</td>
<td>Some provision</td>
<td>Some provision</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Through funding agreements between Commonwealth and State/Territory Governments, hospital services are the responsibility of the States and Territories (Duckett 2007). Local governments fund various locally responsive community initiatives, such as home care support. Health care services are also provided by private hospitals. Individuals may purchase health insurance to help cover the costs of accessing private health services. Public health services address health and disease at population levels through health protection, illness prevention, health promotion, and infrastructure development (National Public Health Partnership 1998, 2000) and are funded by all levels of government.

The Commonwealth Government’s Medicare scheme aims to provide Australians with free and equal access to public hospital services and to enable universal access to rebates for out-of-hospital services provided by medical practitioners (Elliot 2003). Rebates are also available for a limited number of services provided by other health practitioners, such as physiotherapy treatments for patients with chronic conditions coordinated by general practitioners (Foster, Mitchell, Haines et al. 2008). However, Medicare’s preferential funding of medical services can impede patients’ access to a range of nursing and allied health services, particularly on an ambulatory basis, if they do not have compensation insurance, private health insurance or private means to cover financial costs. It could also be argued that such preferential funding is more likely to engender territory protection than facilitate collaborative relations between disciplines.

Extra funding for specific initiatives related to particular priority areas can be made available at certain times. Although there are clear advantages to those consumers and providers who fall within the priority funding area, preferential funding in some areas is likely to result in disadvantage to other patient groups and services. Changes in funding priorities can also cause fragmentation and lack of sustainability in service availability. For example, following the identification of stroke as a Government Health Priority Areas Initiative, funding became available for the development of specialised units for the care of stroke (National Stroke Foundation 2008) while other conditions requiring rehabilitation tended to continue with the same levels of funding and benchmarking requirements to maintain this funding.

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18 Although private hospitals are not publicly owned or administered, they are regulated by the Government.
b) Cost containment

Managerial requirements, arising from measures aimed at containing spiralling health costs, have the potential to influence health care decisions and relationships between health professionals and patients. Over the next 50 years the proportion of the population over the age of 65 years is expected to double and the proportion of the population over the age of 80 years is expected to almost treble (Commonwealth of Australia 2001). These demographic changes are accompanied by an increasing need for health services to have a strong focus on ongoing rehabilitation as well as emergency treatment. Other causes of rising health expenditure include workforce specialisation, consumer expectations (Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare 1998), and the expansion of available diagnostic tests and therapeutic interventions (Duckett 2007). As a result of increasing health expenditure, cost containment measures have been introduced by governments.

One earlier cost constraint measure involved restricting the number of health professionals trained (Ross, Hallam, Snasdell-Taylor et al. 1999). Despite the Australian Medical Workforce Advisory Council’s concern for a shortage of doctors to meet growing health demands, the Commonwealth limited the number of medical places at universities in the 1990s in an effort to constrain growth in health expenditure (Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare 1998; Birrell & Hawthorne 2004). The resulting staff shortages from this miscalculated policy have affected the delivery of and access to a number of health care services (Van Der Weyden & Chew 2004; Productivity Commission 2005).

Another cost restraint measure introduced contract models of funding that distinguished between funders, purchasers and providers, and emphasised cost-effectiveness and managed care (Ross et al. 1999). The increased focus on financial accountability accompanying contract funding models requires health professionals to collect and process information for management purposes. This financial focus can compete with health professionals’ clinical responsibilities and patient-centredness. For example, inpatient rehabilitation staff in NSW are required to assess all patients using the Functional Independent Measure (FIM) instrument\(^\text{19}\) and submit this information to

\(^{19}\) The FIM instrument (correctly known as FIM™) is a commercial product [http://www.udsmr.org/WebModules/FIM/Fim_About.aspx](http://www.udsmr.org/WebModules/FIM/Fim_About.aspx), accessed 30/10/10
NSW Health for the purposes of benchmarking and costing of services (NSW Health 2008).

Allocation of funding on the basis of such benchmarking can entail financial disincentives for rehabilitation units exceeding the allocated length of stay for patients (Kok 2006). In another example of contract funding, hospitals that operate within state benchmarks for allocated lengths of stay may be rewarded through increased funding (NSW Health 2005). In such situations, humanistic decisions for patient care may be tempered with managerial and cost implications. For example, rehabilitation patients’ early discharge from hospital can be associated with significant and largely unrecognised physical, social and financial consequences for their unpaid carers (Dow 2004).

c) Changing structures

With structural, governance and management changes being common features of the Australian health care system (Dwyer 2004), many health professionals must adapt to changed lines of communication and altered relationships with other service providers. This frequency and constancy of change was recognised over a decade ago, as evidenced in this quote:

> The structures of the various Commonwealth and State and Territory health authorities have undergone frequent change, involving internal reorganisation, the transfer of functions to and from other departments, or the amalgamation of entire departments. Peripheral health units have had to make rapid adjustments to these changes in central agencies. … The momentum has been towards the creation of central agencies with varying degrees of delegation of responsibility to regional or area authorities. (AIHW 1998, p.158)

Change and movement towards central agencies have continued since 1998. In 2005 the NSW Health Department merged the 17 Area Health Services to form eight new Area Health Services.\(^\text{20}\) Although such centralisation has been credited as aiming to increase coordination between fragmented services, it has been criticised for lack of evidence in relation to improving patients’ navigation of the system, particularly those with long-term complex conditions (Dwyer 2004).

\(^{20}\) The Area Health Service in which the current research was undertaken experienced aspects of this move towards centralisation during the collection of data.
These continual changes to management structures may inadvertently reinforce barriers to health professionals’ collaborative practice (Hugman 2003). Further, because different professional disciplines tend to strengthen territory boundaries when competing against other professional groups, changes in policy and health structures may impede interprofessional practice (Hugman 2003). The Clinamen Collaborative argued that structural integration should not be confused with integration of services (Glouberman, Enkin, Groff et al. 2006). Based on their observations that health care practices were becoming more firmly entrenched in less stable environments, they proposed that stabilising [health professionals’] environment, reducing the overall threat [of unstable environments] and instituting relatively small changes that respond to local conditions can help them emerge from their defensive enclave in order to collaborate with colleagues and improve their practice (Glouberman et al. 2006).

Unfortunately for collaboration, however, there is no evidence in the current health care climate of such concerns about contextual instability being heeded by governments.

d) Inequitable distribution of services

With the majority of health care services concentrated in metropolitan areas (Duckett 2007) people in rural and regional areas tend to bear the burden of inequitable distribution of services. Problems associated with training, recruiting, supporting and retaining health professional in rural areas are well recognised (Veitch & Battye 2008). Many rural and regional areas throughout Australia experience shortages of health practitioners, and those living in rural areas commonly encounter difficulty accessing health care (Productivity Commission 2005; Duckett 2007; Greenhill, Mildenhall, & Rosenthal 2009). The situation is compounded for services with workplace shortages across all geographical areas. The disability sector is one such sector (Productivity Commission 2005). Despite high levels of disability in rural and regional areas (AIHW 2008a), people outside metropolitan areas are less likely to access disability services than those in metropolitan areas (AIHW 2008b). When accessing health services in metropolitan areas, patients and carers from rural and regional areas face the burden and cost of travel, accommodation and disruption to daily life (Veitch, Sheehan, Holmes et al. 1996; Harris, Thorpe, Rorison et al. 2004).

21 This small international study group includes a philosopher, a psychologist, a nurse and several physicians. It aims to increase understanding of the complex nature of health (Glouberman et al. 2006)
Rural and regional areas often have a high turnover of health staff (Struber 2004), and farewells and welcomes of staff are frequently experienced (Croker, Bent, & Milosavljevic 2008). When positions remain unfilled, health professionals may need to work in a less “discipline confined” manner to minimise gaps in services and address the needs of patients (Smith, Stone, & Bull 2008). Health professionals in rural and remote areas rely on broad understandings of health services and professional networks to facilitate smooth transition for their patients through different health care structures (Croker et al. 2008).

A number of strategies have been developed to enable people living in rural areas to undertake careers in health care and to encourage qualified health professionals to work in rural and remote areas. These strategies include the provision of scholarships and extra places in health courses for students from rural and remote communities, support to find suitable employment in rural and remote areas, professional development assistance and incentive packages (Croker et al. 2008). Innovative locally-relevant strategies have also been employed to enable health practitioners from metropolitan areas to travel to underserviced areas (Veitch & Battye 2008). Despite these strategies the distribution of health services across Australia remains uneven (Liaw 2008), and health care teams may be required to practise without a full complement of team members.

e) Consumer participation

Throughout the last decades, moves to make health systems more responsive to the needs of the public have focused on collaborative activities between consumers and health providers (Coulter, Parsons, & Askham 2008). Involving consumers in health care planning and policy has the potential to improve the relevance and accessibility of health services and enable “health consumers to have access to the services they need, rather than the services the health system wants to offer” (Consumers Health Forum 2009, p.1). In Australia, consumer participation in health occurs at a number of different government levels and in community organisations, and can involve consultation, information sharing and information seeking (Jolley 1995; Silburn & Johnson 1999). NSW Area Health Services have consumer representatives on advisory councils. However, despite a range of opportunities for community participation the degree to which consumers have effective voices in health policy development varies. As consumer participation commonly requires appropriate leadership, management, infrastructure and capacity, as well as knowledge of the health system, some groups of
consumers find it more difficult than others to be involved (Silburn & Johnson 1999). People who live in rural and remote areas, have a disability, belong to mental illness groups or have a chronic condition, are older and socially isolated, are among those whose participation may be marginalised (Silburn & Johnson 1999). Thus, despite articulated support for consumer participation in health, actual engaged participation is irregular and opportunistic.

f) Increasing specialisation
Increasing specialisation of Australia’s health workforce has been evident over the past 20 years within many professional groups (such as medicine, nursing and physiotherapy) as well as across professional groups (for example, postgraduate qualifications in occupational health and public health) (Duckett 2007). Although the in-depth skills developed within narrower fields of care have the potential for improving quality of care in specific aspects of health, the further differentiation of services accompanying such specialisation requires health professionals to work closely together to avoid losing the person focus. Teamwork has been identified as an important focus of undergraduate education to ensure that graduates are equipped to work effectively within the reality of increasingly specialised and fragmented practice (Duckett 2007).

2.3.2 Future directions
It can be argued that improvements to Australian health care services are needed to address problems related to structure and collaboration within these structures. Although Australia ranked well when compared to the United States, the United Kingdom, New Zealand and Germany in evaluations of health outcomes and accessibility of health care (Davis, Schoen, Schoenbaum et al. 2007)\textsuperscript{22}, a number of areas needing improvement have been identified, including coordination of services (Richardson 2005). Duckett (2007, p. 306) suggested that an ideal system for Australia would be “well integrated, accessible, dynamic and respectful of patient autonomy”. He proposed that such a system would address rural inequities, be accountable, and emphasise health promotion, community development programs and consumer choice. Team practice within health organisations, with leadership shared by a range of practitioners, was also considered important for future health care practice. A recent

\textsuperscript{22} In the Commonwealth Fund Study (Davis et al. 2007) Australia ranked second for equity of access, and first for health outcomes (evaluated through measurements of healthy life expectancy, infant mortality and mortality amenable to health care). Universal health insurance coverage was considered to make an important contribution to these rankings.
inquiry into NSW acute health care services (Garling 2008a) supported the emphasis on patient-centred, team-based care. Garling claimed that patients’ needs should be the “paramount central concern of the system and not the convenience of the clinicians and administrators” (Garling 2008a, p.7). He called for a new model of teamwork to replace independent professional care. I contend that the organisational support for such models of teamwork needs to be informed by deep understandings of the nature and experience of collaborative practice in health care.

2.4 Rehabilitation

Health care services vary in many ways including their purposes, the conditions treated, the people involved and nature of their involvement. This section highlights opportunities and challenges for collaboration in rehabilitation teams in relation to changes in rehabilitation conceptualisations, common conditions treated by rehabilitation teams and roles of team members.

2.4.1 Development of rehabilitation

The recent shift in focus from rehabilitation as primarily a medically driven mechanistic process to having a more socially aware perspective (Wade & de Jong 2000) has been accompanied by an increase in the number of professional disciplines working in rehabilitation and an emphasis on the involvement of patients and carers. In this section I explore key aspects influencing the ways health professionals, patients and carers work together in rehabilitation in relation to (a) the development of rehabilitation (as involving processes of restoration, expansion of health professional disciplines and patient participation) and (b) the WHO’s conceptualisation of disability.

a) From biomedical to biopsychosocial approaches

Although the beginnings of rehabilitation can be traced back to Hippocrates (Eldar & Jelic 2003), rehabilitation services are generally considered to have developed more recently as a response to the needs of the victims of the polio epidemic and the injured veterans returning from World Wars I and II (De Lisa et al.1993; Capilouto 2000; Eldar & Jelic 2003). Prior to those wars rehabilitation involved caregiving to people with disabilities in institutions or at home (Seidal 2003). The focus was on the provision of shelter and basic care rather than on achieving independence and functional competence. The post-war conceptualisation of rehabilitation as restoration expanded residential care to encompass restorative services aimed at enabling disabled veterans to resume social,
family and occupational roles. Rehabilitation involved mainly medical treatment, physical therapy and occupational or reconstruction aids (Eldar & Jelic 2003; Seidel 2003). Currently rehabilitation services are provided by a wider range of health professionals who work together as a team, including dieticians, neuropsychologists, nurses, doctors, physiotherapists, occupational therapists, social workers, and speech pathologists.

These professions, along with others, have expanded and evolved their roles in rehabilitation since the World Wars of the last century. In medicine, rehabilitation has developed as a medical speciality (Disler et al. 2002) and has widened its medical focus on illness and disability to encompass social psychological and social needs (O’Young, Young, & Stiens 2002). Physiotherapists are establishing theoretical models for rehabilitation (e.g. Carr & Shepherd 2003). Occupational therapists moved from interest in daily human occupation in terms of an “arts and craft” ideology (Schem 1994) to developing a range of consumer-centred approaches for meaningful occupations in people’s lives (Dibden, Zakrzewski, & Higgs 2002), and rehabilitation is becoming recognised as a specialist area of nursing care (Nolan & Nolan 1999). Neuropsychologists have moved from their early roles of assisting neurosurgeons locate brain lesions to an expanded role diagnosing and treating cognitive and behavioural disorders (Ruff 2003). However, as these expanding roles and specialisations have not necessarily developed in accordance with holistic or strategic views of rehabilitation, it is widely recognised that negotiations between team members are required to deal with the resulting overlaps, gaps and differences between perspectives.

The WHO has been influential in broadening the focus of rehabilitation to include patients’ broader social contexts and in facilitating shared understandings of rehabilitation ideals among health professionals. Since the WHO claimed in 1969 that “the patient himself and members of family may, in certain circumstances, become essential adjuncts to the team” (p.16), participation of patients and carers has been increasingly accepted as an integral aspect to successful rehabilitation. The WHO’s (2002b, 2004) more recent conceptualisations of rehabilitation (see Table 2.8) placed people with disabilities at the centre of rehabilitation, and used positive and active terminology, such as enabling, enhancing and training. Importantly this view highlighted the importance of patient-centredness, requiring a range of strategies aimed at broad functional change, and calling for the removal of barriers to social participation. This focus on people with disabilities and broad functional changes can be seen in many
other definitions of rehabilitation (as shown in Table 2.8) and supports patient-centred approaches.

Table 2.8 Examples of definitions of rehabilitation in the literature

<table>
<thead>
<tr>
<th>Definitions sourced from the WHO</th>
<th>Definitions not explicitly acknowledging WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The combined and co-ordinated use of medical, social, educational and vocational measures for training and retraining the individual to the highest possible level of functional ability (WHO 1969, quoted by Glanville 1994, p.7)</td>
<td>• Medical rehabilitation exists to enhance the functional capabilities of persons who experience activity limitations as a result of impairment in body structure or body function (Capilouto 2000, p.1)</td>
</tr>
<tr>
<td>• Rehabilitation is generally considered to be the component of tertiary prevention which focuses on reduction or elimination of a disability (WHO 1996, p.4)</td>
<td>• The process of making the person with a disability “maximally able” again, through the application of rehabilitation principles and techniques (O’Young et al. 2002, p.1)</td>
</tr>
<tr>
<td>• The term “rehabilitation” refers to a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric, and/or social functional levels, thus providing them with the tools to change their lives towards a higher level of independence (WHO 2001, p.290, quoted by Disler et al. 2002, p.385)</td>
<td>• Rehabilitation is the process of restoring an individual’s capacity to participate in functional activities when this capacity has been altered or limited by a physical or mental impairment (Seidal 2003, p.235)</td>
</tr>
<tr>
<td>• Rehabilitation is a process that assists people with disabilities to develop or strengthen their physical, mental and social skills to meet their individual/collective specific skills (WHO 2003)</td>
<td>• Rehabilitation: To restore condition, operation or capacity (Rehabilitation International 2004)</td>
</tr>
<tr>
<td>• The WHO definition of rehabilitation is: “The use of all means aimed at reducing the impact of disabling and handicapping conditions and at enabling people with disabilities to achieve optimal social integration” (Gutenbrunner, Ward &amp; Chamberlain 2006, p.292)</td>
<td>• Rehabilitation is conceptualised as a status passage in the career of chronic illness and disability that is directed to helping people to function as best they can within the limitations of their conditions and to prepare them to function in their homes and communities (Cott 2004, p.1418)</td>
</tr>
<tr>
<td>• Rehabilitation is the process of restoring an individual’s capacity to participate in functional activities when this capacity has been altered or limited by a physical or mental impairment (WHO 2003)</td>
<td>• Rehabilitation is an educational, problem-solving process that focuses on activity limitations and aims to optimize patient social participation and well-being, and so reduce stress on carer/family (Wade 2005, p.814).</td>
</tr>
</tbody>
</table>

b) Influence of WHO disability concepts

Discourse relating to rehabilitation terminology often refers to the WHO concepts of disability. Definitions for terms related to disability have been proposed by the WHO as part of their Family of International Classifications, the purpose of which was to “establish a common language to improve communication; [and] permit comparisons of data within and between … health care disciplines” (WHO 2004, p.1). WHO definitions and concepts of disability have developed over time; different versions being the 1980 version of the ICIDH\(^{23}\) and the 2001 version, known as the ICF\(^ {24}\) or ICIDH-2. The 1980 ICIDH version was based on model of causal linkages between disease, impairment, disability and handicap. This version was criticised as inadequately describing the

\(^{23}\) International Classification of Impairments, Disabilities, and Handicaps 1980

\(^{24}\) International Classification of Functioning, Disability and Health 2001
complexity of disablement (Halbertsma, Heekens, Hirs et al. 2000). The ICIDH-2 omitted the term “handicap”, rejected the causal model of disability and considered the concept of disability as “an umbrella term for impairments, activity limitations or participation restriction” (United Nations 2001, p.5). This version placed greater emphasis on the functional abilities of people with disabilities rather than focusing on physiological and psychological functions of disability (Pledger 2003). The definitions of the ICIDH-2 components of disability are shown in Figure 2.2.

Figure 2.2 Definitions of ICIDH-2 Components of Disability
(Reproduced from WHO 2002b)

| Body Functions | are physiological functions of body systems (including psychological functions). |
| Body Structures | are anatomical parts of the body such as organs, limbs and their components. |
| Impairments | are problems in body function or structure such as a significant deviation or loss. |
| Activity | is the execution of a task or action by an individual. |
| Participation | is involvement in a life situation. |
| Activity Limitations | are difficulties an individual may have in executing activities. |
| Participation Restrictions | are problems an individual may experience in involvement in life situations. |

The ICF model, while not established as a model for rehabilitation, has developed into one that both reflects and informs views of rehabilitation (Mant, Wade, & Winner 2002): “ICF offers an international, scientific tool for the paradigm shift from the purely medical model to an integrated biopsychosocial model of human functioning and disability” (WHO 2002b, p.19). Disler et al. (2002b, p.385) acknowledged that “with the new [ICIDH-2] terminology, rehabilitation is seen as a coordinated process that enhances ‘activity’ and ‘participation’ and increasingly rehabilitation is acknowledging the patient’s social context”. The use of the WHO’s classification of function, disability and health in physiotherapy has been proposed, and its usefulness for improving communication between health professionals and for guiding assessments and documents has been acknowledged (Allet, Burge, & Monnin 2008; Darrah 2008; Holmberg & Lindmark 2008; Mitchell 2008; Sykes 2008).

Within its scope as a conceptual model, the ICF can provide a structure for comparability of interprofessional assessments and facilitate a focus on the realities of patients’ lives (Bickenbach 2008). Wade and de Jong (2000, p.1385) highlighted the importance of re-conceptualising approaches to rehabilitation in their claim:

Rehabilitation has recently seen many practical innovations and new evidence for specific interventions, but the major advances in rehabilitation are conceptual rather than practical. Firstly, the approach to patients has moved from a predominantly medical one to one in which psychological and sociocultural
aspects are equally important. Secondly, the need for organised specialist rehabilitation services—for example, for neurological disabilities—is being recognised.

In reality, however, rehabilitation may not be as person-centred as suggested or as desired. Gzil and colleagues (2007, p.1616) claimed that “rehabilitation is more person-centred than it used to be but it could and should be more”. This claim was supported by the experiences of Rodger (2008, p.393) a patient who described how he was not automatically included in rehabilitation decisions: “the more perceptive of therapists began to acknowledge that they were dealing with an independent soul, and they enabled me to have more of a say in my treatment”.

Although rehabilitation has moved from care-giving through medical beginnings to become more patient-centred and socially aware, many rehabilitation services, particularly in the early phases of illness and disability, are located in acute medically oriented health systems. Such co-location can provide challenges to patients, carers and health professionals as they straddle interfaces between medical and rehabilitative perspectives and strategies, and work with a range of patients presenting a variety of disabling conditions.

2.4.2 Conditions requiring rehabilitation

Rehabilitation teams are responsible for providing services to people with a range of conditions. Common features include (a) physical challenges that limit activities and impede social participation and wellbeing, and (b) the slow nature of recovery and regaining of function. Some conditions, particularly those acquired through brain injury, can also involve behavioural, emotional and personality, communication, cognitive and intellectual aspects (Barnes 2006). These conditions can pose particular challenges for involving patients in decision-making (e.g. lack of speech or diminished cognitive capabilities). Further, patients with cognitive difficulties “are vulnerable to having their capacity in client-centred care questioned” (Hobson 2006, p.75). Conditions commonly treated by rehabilitation teams are outlined in Table 2.9.
Table 2.9 Characteristics of common neuromusculoskeletal rehabilitation conditions (based on Cooper 2006)

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquired brain injury</td>
<td>Causes include motor vehicle accidents, assaults, falls and sports injuries. Commonly causes a wide range of functional deficits due to motor, sensory, perceptual, language, cognitive and behavioural impairments.</td>
</tr>
<tr>
<td>Stroke</td>
<td>Caused by bleeding or occlusion of flow of blood to the brain. Can cause a wide range of functional deficits due to motor, sensory, perceptual, language, cognitive and behavioural impairments.</td>
</tr>
<tr>
<td>Spinal cord injury</td>
<td>Causes include car accidents, falls, violence, sports injuries. Lack of innervation of muscle groups can result in a range of deficits including difficulties with respiration, bladder and bowel function, and movement in general.</td>
</tr>
<tr>
<td>Musculoskeletal condition</td>
<td>Includes hip fractures (a common type of fracture in the elderly population that often requires surgical fixation), pelvic fractures, hip replacements, knee replacements, and conditions where physical functioning is inhibited by pain.</td>
</tr>
<tr>
<td>Amputation</td>
<td>Includes amputations that result from injury or vascular insufficiency. Often involves the use of prosthetics.</td>
</tr>
</tbody>
</table>

Some behavioural effects associated with acquired brain injury or stroke (such as agitation, confusion and restlessness) may be short-lived and manageable (Barnes 2006). But ongoing physical and verbal aggression can be significant barriers to rehabilitation and can require behavioural programs to minimise disruption and improve challenging behaviour (Barnes 2006). Emotional and personality problems (which may include egocentricity, lack of emotion, irritability and lack of social restraint) can affect relationships, integration into the community and return to work (Barnes 2006). Barnes (2006, p.537) noted:

> The more obvious physical problems, such as wheel-chair dependency, dysarthria\(^{25}\) or visual problems, are often coped with by family members more readily than the more subtle “personality” changes.

Those with emotional and personality challenges who have insight into their conditions can also be at risk of depression (Barnes 2006). As a consequence of cognitive and intellectual disorders, patients’ difficulties with memory, problem solving, attention, perception, language and learning may need to be addressed. Strategies addressing cognitive abilities often require extensive prompting, guidance and supervision by carers (Barnes 2006).

Rehabilitation patients spend considerably longer in inpatient rehabilitation facilities than the average length of hospital stay (Simmonds & Stevermuer 2008). Simmonds and

\(^{25}\) Dysarthria is the poorly articulated speech that results when the “muscles or nerves controlling the mouth, tongue, pharynx and lips are not functioning properly” (Allen, Lueck, & Dennis 2006, p.1190)
Stevermuer reported that in NSW, those patients receiving rehabilitation for acquired brain dysfunction (and who were considered most impaired) were, on average, in hospital for a period of 43 days.\(^{26}\) Stroke patients stayed in hospital for an average 28 days. Those with significant spinal cord injuries had average length of stay of 47 days, and patients with amputated limbs had an average length of stay of 32 days. Patients requiring rehabilitation for orthopaedic fractures had an average length of stay of 23 days. With these longer stays in hospital, patients and carers have opportunities to develop good professional relationships with health professionals that help both to understand each other’s needs, perspectives and ways of working effectively together.

Many people have ongoing disability following rehabilitation. The AIHW (2003) has estimated the prevalence of physical disability in Australia at between about 12% and 16% of the total population.\(^{27}\) Acquired brain injury, which tends to be associated with a range of ongoing physical, social and emotional difficulties, had an AIHW estimated incidence of between 57 to 377 per 100,000 population. Four fifths of those with a disabling condition from acquired brain injury reported a physical disability. Almost half reported a sensory/speech disability and a third an intellectual disability. Compared to rehabilitation patients with stroke, amputations and fractured hips, patients with acquired brain injury tended to be the youngest, with an average age of 52 years (Simmonds & Stevermuer 2008).

The slow nature of recovery and regaining of function, with perhaps ongoing disability, can require rehabilitation teams to involve other departments, agencies and organisations, such as employment centres, educational institutions and insurance organisations. Working across different organisations and agencies adds another dimension to the complexity of collaboration in rehabilitation.


\(^{27}\)In Australia, reports on disability for legislative and administrative purposes are based on five main disability groups that reflect activity limitation and participation restrictions as well as the underlying health conditions and impairments (AIHW 2003). These interrelated groups are: (a) intellectual (development delay, specific learning, autism), (b) psychiatric, (c) sensory/speech (deafness, blindness and speech impairments), (d) acquired brain injury and (e) physical/diverse. Neuromusculoskeletal rehabilitation is mainly concerned with the latter two categories. Acquired brain injury has a separate category due its association with a range of social, physical, social and emotional difficulties. These disability groupings are not classifications of people, but categorisation of “individuals’ experience in various domains of functioning and disability” (AIHW 2003, p.6).
2.4.3 Rehabilitation teams

As rehabilitation usually requires the active participation of patients, their carers and families, the need for collaboration among health professional disciplines, patients and carers is great. Goal planning is an important focus of such collaboration. Goal planning and goal setting provide motivation for the patients and the team to (a) strive for and monitor intended results of planned interventions and actions (rather just predicting what might happen), and (b) coordinate therapy (Wade 2009). Setting, planning and implementing goals is core practice for rehabilitation teams. This collaboration can occur between a few team members or on a broader collective basis, for example at weekly team meetings or case conferences. Patients and carers are not necessarily included in case conferences, but may have meetings arranged specifically for them where relevant members of the team attend and discuss issues. This section outlines the roles of those involved in rehabilitation teams, with a particular focus on their roles and the scope for discipline specialisation. The ambiguity surrounding patients’ and carers’ roles as team members is noted.

a) Health professional roles in rehabilitation teams

Health professions who provide rehabilitation services are often categorised as medical, nursing or allied health, with the term *allied health* loosely referring to non-medical and non-nursing health professionals (Lowe, Adams, & O’Kane 2007). With the varying roles, fragmentations and overlaps of therapy and care, patients might be expected to have difficulties in understanding “who does what and why”. Further, the opportunity to specialise in rehabilitation, where relevant, has the potential to lead to wide variations in health professionals’ qualifications and experience within and between teams. Rehabilitation teams can therefore be composed of a range of novice practitioners, highly experienced discipline specialists and those currently undertaking specialisation. This lack of homogeneity in experience and specialisation adds further to the challenges of collaboration while simultaneously providing opportunities for team members to learn from one another.

An overview of the roles of health professional providing rehabilitation services, and their opportunities for accredited specialisation in the area of rehabilitation, is provided in the following section (in alphabetical order to avoid implied merit or value). Although the professional disciplines are presented separately here, overlap between roles is common; for example, physiotherapists and occupational therapists may each consider that retraining hand and arm function is their role (Zorowitz 2006).
i) Allied health

- Dietetic management in rehabilitation aims at establishing and maintaining normal nutritional status in order to optimise the patient’s functional status and reduce medical complications (Allied Health in Rehabilitation Consultative Committee 2007).

- Neuropsychologists working in the area of rehabilitation use a range of diagnostic assessments to diagnose cognitive and behavioural defects (Ruff 2003). Information from neuropsychological assessments is used by other health professionals to manage individual patients’ problems of behaviour and cognition (Allied Health in Rehabilitation Consultative Committee 2007) and by neuropsychologists in behaviour therapy (Goldstein 1987). Neuropsychologists’ tests also “allow clinicians to monitor the course of recovery and the patient’s potential for return to the community” (Zorowitz 2006, p.519).

- Occupational therapists working in rehabilitation focus on patients’ self-care, productivity and leisure activities, using interventions such as training, retraining, remedial techniques, strategies for compensation, and adaptations to the patients’ environments (Allied Health in Rehabilitation Consultative Committee 2007). Different models of practice are used within occupation therapy, including biomechanical, cognitive-perceptual, motor control, sensory integration and spatiotemporal adaption (Kielhofner 1992). The Bobath and other functional approaches are used for treatment of stroke (Walker, Drummond, Gatt et al. 2000). Special interest groups within occupational therapy include those related to age of patients, such as aged care, to focus of services, for example occupational, and to nature of condition, or condition being treated, for instance neurology (OT Australia Victoria).

- Physiotherapists in rehabilitation facilitate physical recovery to maximal levels of independence and function (Allied Health in Rehabilitation Consultative Committee 2007). Their expertise lies in examining and treating neuromusculoskeletal problems that affect people’s ability to move (Zorowitz 2006). One or more different treatment approaches, informed by different theoretical bases, may be used; for example, stroke can treated by proprioceptive

neuromuscular facilitation, Brunnstrom, Bobath or the motor relearning programme (Langhammer & Stanghelle 2000). Rather than being specifically aimed at rehabilitation, accredited physiotherapy specialisations in Australia relate to body systems, including musculoskeletal, neurological and cardiothoracic physiotherapy, or to the age of patients, such as gerontology and paediatric physiotherapy (Australian Physiotherapy Association\(^{29}\)).

- Social workers are involved in future planning with patients and families to maximise adjustments to disability and lifestyle changes (Allied Health in Rehabilitation Consultative Committee 2007). They may also facilitate access to support services and provide counselling and debriefing services. Identifying suitable short-term or extended-care facilities can also be a role of social workers (Zorowitz 2006). A special interest group of the Australian Association of Social Workers provides opportunities for social workers in the area of rehabilitation to keep up to date with developments in the rehabilitation area and share knowledge and skills (Australian Association of Social Workers\(^{30}\)). Social workers contribute background information about patients and family situations, may coordinate funding resources, and consider aspects of a smooth transition back to the community (Winkler & Peden 2005).

- Interventions by speech pathologists are aimed at improving aspects of language, swallowing and feeding, respiratory dysfunction and cognition (Allied Health in Rehabilitation Consultative Committee 2007, Winkler & Peden 2005). Although Victoria has a group for speech pathologists interested in adult rehabilitation, other rehabilitation related special interest groups in Australia tend to relate to particular problems treated by speech pathologists (Speech Pathology Australia\(^{31}\)).

**ii) Medical**

Rehabilitation specialists in medicine focus on maximising residual capacity for impaired individuals and dignified integration into their communities rather than aiming

\(^{29}\) http://www.physiotherapy.asn.au/index.php/groups/groups, accessed 30/06/10

\(^{30}\) http://www.aasw.asn.au/about/specialinterest/index.htm, accessed 30/06/10

\(^{31}\) http://www.speechpathologyaustralia.org.au, accessed 30/06/10
to cure them (Australasian Faculty of Rehabilitation Medicine\textsuperscript{32}). Special interest groups within this accredited specialty include rehabilitation for spinal cord injury, neurological disorders, musculoskeletal problems and pain. With a broader basis than the “medical perspective” (Kahn 2009), rehabilitation aims to improve function and quality rather than focusing primarily on arresting pathology (Eldar 1999). Rehabilitation specialists work collaboratively with medical colleagues, allied health professionals and others in the development of rehabilitation (Australian Faculty of Rehabilitation Medicine). Rehabilitation specialists are often identified as team leaders (Winkler & Peden 2005) or team coordinators (Zorowitz 2006). They commonly act as gatekeepers for the admission of patients to rehabilitation units, coordinate information between other medical practitioners involved with patients’ care, supervise the medical status of patients, prescribe medications and control co-morbidities (De Lisa et al. 1993).

\textit{iii) Nursing}

Nursing is a multifaceted profession involving the practice of care, cure and coordination (Kelly & Joel 1996). In rehabilitation, nurses’ roles may include patient care to maintain physical wellbeing, ward management, care of continence and skin, and continuation of other professions’ therapy over the 24 hour period (Waters & Luker 1996). Rehabilitation nursing is a relatively new accredited speciality which entails a wellness model of care and is characterised by nursing activities being based on rehabilitation and restoration principles (Pryor & Smith 2000). Rehabilitation nurses’ holistic approach to meeting patients’ medical, educational, vocational, environment and spiritual needs involves applying principles taught by other disciplines (Zorowitz 2006).

The varying emphases on, and opportunities for, discipline specialisation in rehabilitation creates potentials for differences within teams and between teams. Further, whereas rehabilitation is be a specialty focus for members of some teams, in other teams, particularly in rural areas, health professionals may also have responsibilities to acute health services.

\textbf{b) Patients, families and carers in rehabilitation teams}

Rather than being a passive process, rehabilitation requires patients’ active participation to ensure that goals are meaningful and appropriate to them as they regain their functional abilities (Wain et al. 2008). Patients’ improvement through their involvement

\footnotesize{\textsuperscript{32} http://afrm.racp.edu.au, accessed 30/06/10}
in and control of their rehabilitation has been identified as contributing to positive experiences of rehabilitation (Wain et al. 2008). Families and carers also play important roles by providing patients with support and encouragement as well as assistance and opportunities to practise new skills (Internet Stroke Center 2010).

However, despite general agreement that patients, families and carers are integral to rehabilitative processes, the nature of their status and position in the teams is not well defined or understood. Some authors, such as Dodkin (2003), consider patients and carers to be part of the team, with their roles being to learn about their injury or illness, participate in therapies and contribute to goal setting. The Internet Stroke Center (2010) in the USA identifies patients and their families as important members of rehabilitation teams. Other authors (e.g. Allied Health in Rehabilitation Consultative Committee 2007) describe rehabilitation teams in relation to health professional roles, with patients being the focus of the team rather than in the team.

The roles of family and carers are further complicated by their need for support throughout the rehabilitation process and beyond. Rehabilitation patients’ illnesses and disabilities can be considerable sources of stress and distress for family and carers (Wade 2005; Rodger 2008). Although support for patients’ families and carers needs to be ongoing, multifaceted and situationally specific (Pierce, Steiner, Govoni et al. 2007; Smith, Gignac, Richardson et al. 2008), carers are not always included in treatments, discussions and education sessions (Eames, Hoffmann, KcKennas et al. 2008). Even written information, which is widely accepted as an important means of support for patients and carers (Smith, Forster, House et al. 2008) tends to be provided on an ad hoc rather than a systematic basis (Hoffmann, McKenna, Herd et al. 2007). Moreover, written information is a one-way communication tool that assumes health literacy.

Support for caregivers’ roles can also be impeded by limitations within the health care system, as indicated by the following caregiver’s experiences:

While we found particular individuals in the health care system to be personally admirable, long-held and system boundaries made it difficult for even them to adequately support my role as a carer for a person with serious chronic illness. (Williams 2007, p.171)

As care-giving is experienced differently by different people (Pierce, Steiner, Govoni et al. 2007), support needs to be targeted to specific carers’ needs on an ongoing basis.
2.5 Conclusion

The current moves towards patient-centred team-based care for patients with chronic and complex conditions (Duckett 2007; Garling 2008a) face a number of challenges in relation to the organisation’s facilitation and support of collaboration. Located within the Australian health care system (with its multiple meanings of health and involving complex professional practice), rehabilitation services may be subjected to fragmented funding, inequitable distribution of services, changing structures and managerial requirements. Health professionals are required to collaborate with patients, carers and other health professionals who bring diverse and at times competing expectations, perspectives and roles with them. Patients’ participation and involvement in shared decision making is further compounded by the broad and multifaceted nature of conditions for which rehabilitation is required, particularly when those conditions include communication and cognitive disorders. Deeper understandings of the nature and experiences of collaboration in complex settings such as rehabilitation are needed to provide a basis for collaboration that is well informed, prepared and resourced. By locating collaboration within a context characterised by (a) diverse meanings of health and health care, (b) elaborate health care structures, (c) complex professional practice requirements, and (d) challenges of team-based rehabilitation services, this chapter has emphasised the complexity of the contexts in which this research is located.
CHAPTER 3
OVERVIEW OF THE RESEARCH STRATEGY

“That which has already been understood always forms the basis for grasping that which remains to be understood.”
(Bontekoe 2000, p.2)

3.1 Introduction

An overview of the research strategy is presented in this chapter. Through this overview I establish a basis for the subsequent detailed descriptions of the research approaches in later chapters (i.e. Chapter 4 for Study A and Chapter 5 for Study B). Figure 3.1 provides an overview of the components of the research described in this chapter and subsequent chapters.

3.2 Research purpose and research questions

I view collaboration as a complex phenomenon that is essential to the provision of inter-professional patient-centred health care. My intention in this research was to develop a deeper understanding of the nature of collaboration and experiences of collaborating within rehabilitation teams by engaging with the overall research questions of:

- What is the nature of collaboration?
- How do people experience collaborating in rehabilitation teams?
- How does effective collaboration in teams promote patient-centred health care?
- What organisational support is required for collaboration to flourish and effectively contribute to patient-centred health care?

The orientation to the phenomenon, foci of the research and presentation of findings (as noted in Figure 3.1) indicate that this research operates within the framework of health care (specifically rehabilitation) as a patient-centred, team-facilitated endeavour that enhances patient wellbeing.
Figure 3.1 Overview of research project
<table>
<thead>
<tr>
<th>Issues</th>
<th>My perspectives and preferences used to frame my research question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal frame of reference</td>
<td>Health professional socialisation: initial socialisation as a physiotherapist provided me with a predominantly biomedical model of health service delivery Work experiences: working with a range of clients, health providers, community members, and policy-makers in a consumer organisation introduced me to a social ecology model of health and organisations Personal experiences: ongoing voluntary work in a range of community roles evoked my interest in personal agency and in constraints and enablers of change</td>
</tr>
<tr>
<td>Purpose</td>
<td>To understand the nature and experiences of collaboration To make implicit dimensions of collaboration more explicit To inform education for teamwork and development of patient-centred collaborative practice</td>
</tr>
<tr>
<td>Context of participants and topic</td>
<td>Rehabilitation teams: different types of teams work in a range of contexts with different opportunities and constraints Health professionals’ socialisation: team members socialised into different professions tend to have different ways of working and different ways of viewing health care Patients and carers: rehabilitation requires the active involvement of patients and their carers; peoples’ contexts, perspectives, problems and levels of agency are different</td>
</tr>
<tr>
<td>Philosophical framework and research design</td>
<td>Idealism: multiple constructed realities explain the different ways people understand their worlds; this directed me towards the interpretive research paradigm Interpretive research paradigm: this paradigm was compatible with my view of the world; research approaches of philosophical hermeneutics and hermeneutic phenomenology provided philosophical and methodological underpinnings for me to seek meaning, understand and interpret (a) literature related to collaboration and (b) participants’ experiences with collaborating</td>
</tr>
<tr>
<td>Theoretical framework a) Key theories</td>
<td>Social ecology Social cognitive theory Structuration theory</td>
</tr>
<tr>
<td>Theoretical framework b) Key literature content</td>
<td>Health care service: complexities and pluralities challenge health care delivery and education for health care practice Professional practice: much of professional practice is implicit; explicit aspects of professional practice can be taught Working with others: working with other professions and practising patient-centred care is important for complex health care Organisational theories: a range of theories and metaphors shape our understanding of organisations and the ways teams work</td>
</tr>
<tr>
<td>Strategy preferences</td>
<td>Embrace complexities of collaboration as explained and explored in the literature, and as experienced by team members Understand different perspectives and experiences of collaborating</td>
</tr>
<tr>
<td>Methods</td>
<td>Philosophical hermeneutic analysis of literature: to enable meanings and conceptualisation of collaboration in the literature to be made explicit and used to address research questions Observations of team meetings: to enable me to see what happens when team members collaborate to plan patient care Semi-structured interviews: to enable me to understand more about what I have seen, and what may not be visible at team meetings, and to hear the experiences of collaborating</td>
</tr>
<tr>
<td>Feasibility factors</td>
<td>Accessing rehabilitation teams, travelling and travelling expenses Ethics approval: different area health service regions require separate ethics approval processes Accessing individuals: enthusiasm for participation: gatekeepers, constant staff changes in rehabilitation teams and high workload constrained participation in the research Outsider status: had positive effects (e.g. no preconceived ideas of team’s collaboration) and negative effects (e.g. may not have accessed the “entire” collaboration)</td>
</tr>
</tbody>
</table>
Research questions need to be consistent with the phenomenon being researched, compatible with the researcher’s personal frame of reference and research paradigm, and feasible to research (Higgs & Llewellyn 1998; Lawler 1998). In this project I used the research question framework developed by Higgs and Llewellyn (1998), as shown in Table 3.1, as a basis for (a) identifying and articulating my personal frame of reference, philosophical and theoretical frameworks, and practical and contextual factors, as I developed my research questions and research strategy, and (b) ongoing reflection on this explicit information with the aim of achieving congruency between my personal perspectives and my research paradigm, strategy, question and purpose.

The key features of my research question framework are interrelated. They include:

- my experiences as a health professional working in teams, which led me to seek a deeper understanding of the challenges of working with other health professionals and patients in a patient-centred manner in health organisations;
- my purpose of informing education and ongoing professional development of health professionals, and helping patients’ voices to be heard during rehabilitation decision-making;
- my philosophical underpinnings that enabled me to frame the experiences we have in the world as the source of the meanings we make of the world.

The implications of this framework for my strategy were that I sought to interpret (a) how collaboration (notion, process and outcomes) is conceptualised in the literature, and (b) how collaborating (activity, personal engagement) is experienced in rehabilitation teams. Philosophical hermeneutics and hermeneutic phenomenology were utilised as rich and appropriate approaches to enable me to embrace different conceptualisations of collaboration and experiences of collaborating.

My primary research questions focused on collaboration between team members. Sub-questions were developed to guide the two studies. The questions in Study A, the philosophical hermeneutic study of the nature of collaboration and teams as presented and conceptualised in the literature, were:

- How is collaboration conceptualised in the literature?
- According to the literature, what is the nature of collaboration in health care (including in rehabilitation teams)?
- How can collaboration contribute to patient-centred health care?
- What organisational support is required for collaboration to flourish and effectively contribute to patient-centred health care?
For Study B, the hermeneutic phenomenological study of experiences of collaborating in rehabilitation teams, questions I posed to the experiential data were:

- What is the nature of the lived experience of collaborating in rehabilitation teams?
- What dimensions of collaborating are evident in team members’ experiences?
- How can collaborating contribute to patient-centred health care?
- What organisational support is required for collaboration to flourish and effectively contribute to patient-centred health care?

Thus, whereas Study A explored conceptual understandings of the notion, process and outcomes of collaboration (the noun), Study B explored experiences of the activities and personal engagement in collaborating (the verb). Key to my choice of exploring the verb was the active presence of people in collaborating. Bringing the actions of people collaborating into the concept of collaboration ensured the person-centredness of this research (discussed further in Chapter 5). The studies took different paths towards understanding yet both finished with a similar question: How can collaboration/collaborating contribute to patient-centred health care? Finishing with a question that was common to both studies facilitated the merging of the findings in relation to collaboration as an abstract notion and an experience.

3.3 Interpretive research paradigm

A research paradigm has been described as that “package of beliefs” about knowledge that influences how researchers make sense of and study the world (Crotty 2003, p.35) and “the net that contains the researcher’s epistemological, ontological and methodological premises” (Denzin & Lincoln 2000, p.19). Both these descriptions refer to the notion that researchers’ personal beliefs frame their views of the world and their actions (including research actions) in it.

In this research I use the interpretive research paradigm to explore collaboration. The choice of research paradigm for this project was guided by the premise that there should be a coherent relationship between (a) the phenomenon being investigated, (b) the researcher’s ontological and epistemological stance, and (c) the nature of the knowledge generated by the research (Denzin & Lincoln 2000; Higgs & Llewellyn 1998; Hughes 1990). Ontology is concerned with the structure of reality and the nature of existence (Crotty 2003). Epistemology relates to theories of how we know something, how we interpret the world and make sense of it (Crotty 2003).
Within the interpretive research paradigm, reality is assumed to be dynamic and negotiated (Minichiello, Aroni, Timewell et al. 1995). Knowledge in this paradigm is constructed from “the minds and bodies of conscious and feeling beings [and] is generated through a search for meaning, beliefs and values” (Higgs 2001a, p. 49). Researchers who adopt an interpretive paradigm perspective seek to understand a phenomenon from the perspective of participants, and to uncover thoughts and perceptions about “how people attach meaning to and organise their lives, and how this in turn influences their actions” (Minichiello et al. 1995, p.10). Interconnected interpretive practices are commonly employed to enable the action to be viewed in different ways to ascertain these different perspectives (Denzin & Lincoln 2000). The main aim of constructing knowledge in this paradigm is the promotion of understandings and insights related to human experience and social situations (Powers & Knapp 1995). I hold this philosophical stance.

Several different research approaches are located within this interpretive research paradigm, including hermeneutics, phenomenology and narrative inquiry (Higgs 1998). Researchers within the interpretive research paradigm share similarities such as (a) being self-reflective to enable personal responses to be illuminated, (b) being open to discovery of the unexpected and willing to redirect the research as new insights and understandings emerge; and (c) undertaking data collection and data analysis simultaneously (Powers & Knapp 1995). However, the differences in the historical origins, methodological underpinnings, and purposes of knowledge generation in the various interpretive research approaches lead to different intentions of what is to be explored, and to different implementations of the approaches (for example, the phrasing of questions and writing style for presentation of findings). Effective implementation of research approaches relies on achieving congruence between the research projects’ philosophy, purpose, questions and design (based on Carter & Little 2007).

### 3.4 Overview of hermeneutics

The word *hermeneutics* has been associated with the Greek god Hermes (Gadamer 1975) who, through his discovery of language and writing, is reported to have conveyed messages from the gods to humans (Palmer 1969). In this research, hermeneutics informed both the meta-strategy for meaning-making and the specific research approaches of Study A and Study B. The focus of hermeneutics is interpretation.
Interpretation is the process of making “something that is unfamiliar, distant, and obscure in meaning into something real, near, and intelligible” (Palmer 1969, p.14).

Hermeneutics has evolved from the initial interpretation of biblical texts to interpreting texts generated through interviews and dialogues, as well as through the arts. Palmer’s (1969) description of this development (as outlined in Table 3.2) acknowledges the contributions of a number of different philosophers. Critical hermeneutics, a more recent development of hermeneutics, based in the ideas of Habermas (born 1929), proposes that language is a source of power and domination (Thompson 1981).

As noted in Table 3.2, the philosophers Dilthey (1833-1911), Heidegger (1889-1976), Ricoeur (1913-2005) and Gadamer (1900-2002) were instrumental in developing the notion and practices of interpretation as a means of understanding our world. Some of these philosophers’ key ideas underpinned the philosophical hermeneutics and hermeneutic phenomenology modes of inquiry used in this project. Rather than following prescribed methods, modes of inquiry informed by these philosophies are developed by researchers in relation to their specific research questions and context, and in accordance with the core philosophical ideas and principles. Key philosophical ideas and principles are introduced in the following sections, and their uses explained in subsequent chapters.

3.4.1 Concepts orienting my understanding of hermeneutics

Two key concepts oriented my comprehension of hermeneutics. These concepts relate to the implicit nature of everyday understanding and the linguistic nature of understanding. A sound awareness of these concepts was integral to my authentic use of hermeneutics in this research project.

a) Implicit nature of everyday understanding

Our understanding of the world is embedded in our being part of the world (Heidegger 1962). Dilthey’s concept of historicality emphasised the contextual nature of meaning and called for the individual moments of meaning to be understood in terms of the dimensions of the past as well as future expectations (Palmer 1969). Heidegger (1962, p.192) explained “meaning is the ‘upon-which’ of a projection in terms of which something becomes intelligible as something: it gets its structure from a fore-having, a fore-sight, and a fore-conception”. Gadamer (1976, p.38) claimed that “reflection on a preunderstanding brings before me something that otherwise happens behind my back”.

85
Table 3.2 Overview of the development of hermeneutics
(summarised from Palmer 1969)

<table>
<thead>
<tr>
<th>General descriptions</th>
<th>Key contributions to the field of hermeneutics</th>
<th>Time and people</th>
<th>Characteristics of the type of hermeneutics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biblical</td>
<td>Theory of biblical exegesis</td>
<td>Term hermeneutics used in 17th century</td>
<td>Theory of exegesis, retrospectively extending to Old Testament times, provided rules and methods of interpreting biblical texts.</td>
</tr>
<tr>
<td>General</td>
<td>General methodology for non-biblical texts</td>
<td>Development of rationalism in 18th century</td>
<td>Interpretative methods applied to the Bible were considered appropriate for use with other books. Interpreters aimed to overcome advance judgements, become deeply involved with the text. The tools of natural reason were used to find the truth hidden within different historical terms.</td>
</tr>
<tr>
<td>Scientific</td>
<td>Science of linguistic understanding</td>
<td>Framing of hermeneutics by Schleiermacher in the early 19th century as the science for understanding</td>
<td>Understanding starts in the fixed expression of the text and goes backwards to the author’s thoughts, with interpretation consisting of both grammatical and psychological components. Hermeneutics was no longer seen to belong exclusively to the disciplines of theology, literature or law; it became relevant to any utterance in language.</td>
</tr>
<tr>
<td>Geisteswissenschaften</td>
<td>Methodological foundation of Geisteswissenschaften (all disciplines focusing on understanding human writing, art and actions)</td>
<td>In the late 19th century Dilthey placed hermeneutics in the context of interpretation in human studies and introduced the concept of historicity.</td>
<td>Hermeneutics was proposed to be the foundation for Geisteswissenschaften. Dilthey aimed to develop new methods to interpret the fullness of human phenomena and man's inner experience. Meaning was seen as changing over time and was related to the viewer's perspectives, without one true starting point. Constant reference to personal experience in &quot;the context of the past and the horizon of future expectations&quot; (p.101), together with various modes of interacting with this personal experience and the text, were required for understanding.</td>
</tr>
<tr>
<td>Philosophical</td>
<td>Phenomenology of existence and of existential understanding</td>
<td>During the 20th century Dilthey, Heidegger and Gadamer brought hermeneutics to the realm of philosophy.</td>
<td>Understanding was defined as a matter for epistemological and ontological consideration and became a theory of ontological disclosure, &quot;a theory of how understanding emerges in human existence&quot; (p.137). Hidden meanings are revealed and disclosed. Words play a key role in bringing about understanding.</td>
</tr>
<tr>
<td>Cultural</td>
<td>Interpretation of symbols and manifest content of the world</td>
<td>In the latter part of the 20th century Ricoeur focused on hermeneutics as iconoclastic interpretation.</td>
<td>Recollective and iconoclastic systems of interpretation used to find meaning and reality behind symbols and myths.</td>
</tr>
</tbody>
</table>
According to Gadamer, we need to be reflectively conscious of our own fore-structure of understanding to interpret the world. Plager (1994, p.72) explained this vantage point for interpretation as such:

Our world is already meaningful and intelligible, and our activities are constituted by and make sense in the world … we come to a situation with a practical familiarity, that is, with background practices from our world that make interpretation possible … because of our background we have a point of view from which we make an interpretation … and we have some expectations of what we might anticipate in an interpretation.

Awareness of the concept of fore-structure of understanding facilitated for me an ongoing awareness of the perspectives from which I was viewing and understanding the phenomenon of collaboration. I aimed to be aware of what Gadamer (1975, pp.271-272) discussed as my “own bias, so that the text can present itself in all its otherness and thus assert its own truth” against my own fore-structure of understanding.

b) Linguistic nature of understanding

According to Gadamer (1976, p.29) language is the means by which we know our world. He claimed that “language is not only an object in our hands, it is the reservoir of tradition and the medium in and through which we exist and perceive our world”. Thus language shapes our expectations and dealings with the world (Bontekoe 2000).

Accordingly, people are part of the texts they create, and their implicit understandings of their worlds are brought to their texts (Palmer 1969). These implicit understandings need to be sought and acknowledged in hermeneutics interpretation (Palmer 1969). For this research I sought not only to focus on what was explicitly said in texts, but also to dialogue with them in order to identify their implicit meanings.

3.4.2 Interpreting texts

Hermeneutics is concerned with interpreting texts (Gadamer 1975). Ricoeur’s (1981, p.145) definition of a text as “any discourse fixed by writing” underpinned my view of “what is a text” in this research. Text interpretation can be seen as a dialogue between the researcher and texts, a dialogue that involves posing questions to texts in order to “to facilitate new, creative, and liberating insights into them” (Trede & Loftus 2010, p.193).

My texts for Study A were collated from a wide range of literature. Interview transcripts formed the texts of Study B. My close reading and deep immersion in these text sets
allowed my understandings to be challenged by the ideas expressed and implied in the
texts (based on Trede & Loftus 2010, p.193). The questions I posed to the texts arose
from my emerging understanding of these ideas.

3.5 Introducing studies and research approaches

The studies and their specific research approaches are briefly introduced in this section
and are further developed in subsequent chapters.

3.5.1 Philosophical hermeneutics and Study A

Philosophical hermeneutics provided the framework for Study A, one of the two
interrelated studies comprising this research. In that study I dialogued with a broad
selection of texts in two text sets compiled from literature related to collaboration in
organisational, educational, research, political, and (in particular) health care and
rehabilitation teams. Through this dialogue between the texts and my research questions
I gained a deeper understanding of the nature of collaboration, particularly in relation to
health care teams.

My decision to use philosophical hermeneutics lay in the power of this methodology to
rigorously and deeply interpret existing literature. In addition, the literature relating to
my phenomenon of collaboration and my context of rehabilitation (health care) teams is
vast. Philosophical hermeneutics analytical approaches provide the researcher with
systematic as well as context relevant strategies to deal effectively with this volume of
literature and to build on past knowledge, research and interpretations of collaboration
and rehabilitation teams rather than seeing such texts as simply background material or
past research to critique. Using this approach I was able to make meaning from this
literature.

From my initial wide reading of the literature I came to the realisation that no one view
of collaboration presented in research, theoretical or policy literature adequately
encompassed the diversity I encountered. Undertaking a philosophical hermeneutic
study would enable me to identify a core structure of collaboration by abstracting
different meanings of, approaches to and details of collaboration in relation to each
other and to the whole of the phenomenon. Details of this approach are also described in
Chapter 4, including key concepts of philosophical hermeneutics, analytical tools
(hermeneutic circle, dialogue of question and answers, and fusion of horizons), and
construction and interpretation of texts.
3.5.2 Hermeneutic phenomenology and Study B

In the second interrelated study of this research I sought to illuminate the lived experiences of collaborating in rehabilitation teams using hermeneutic phenomenology. The movement of phenomenology began in the twentieth century as philosophers sought to develop a more complete account of the lived world than had been possible through empirical science. The world view of phenomenology was sourced from human experience, and encompassed descriptions and meanings of life’s experiences. My utilisation of hermeneutic phenomenology (a type of phenomenology) as a research strategy was informed by my understanding of hermeneutics (as outlined above) and the work of a number of scholars, particularly van Manen of the University of Alberta, whose explication of a hermeneutic phenomenological approach to human science was richly informed by eminent phenomenologists Husserl (1859-1938), Heidegger (1889-1976) and Merleau-Ponty (1908-1961). Hermeneutic phenomenology is explained further in Chapter 5.

Positioning Study B within phenomenological inquiry enabled me to explore the phenomenon of collaborating from the perspective of the participants’ experiences. Van Manen (1997, xi) claimed that by reflecting on the world that “is given to us, and actively constituted by us” we can understand humans and “the experiential reality of their lifeworlds”. The choice of hermeneutic phenomenology as a research approach was appropriate for accessing and interpreting experiential accounts of collaborating as a complex component of professional practice. In Chapter 5 I outline the phenomenological concepts informing this approach (including phenomenology as a philosophy and research method and my strategy for utilising hermeneutic phenomenology) and provide detailed explanations of the research approach (including ethical considerations, participation recruitments, data collection and analysis). In that study I observed the team meetings\(^{33}\) of rehabilitation teams and interviewed health care staff, patients and carers in this study. The meaning structures of experiences of collaborating were illuminated.

3.5.3 Using two research approaches to understand collaboration

Practice is an integral part of our life world; it is “not a secluded zone isolated from our daily life” (Henriksson 2007, p.5). Collaboration is a component of professional practice. Philosophical hermeneutics was chosen to gain an interpretation of

\(^{33}\) Team meetings were often referred to as case conferences by participants.
collaboration as described in the literature, reflecting on how it is understood by policy-makers, educators, team members and researchers. Hermeneutic phenomenology was chosen to illuminate the tacit knowledge, capabilities, actions and patterns of engagement involved in collaborating in rehabilitation teams. The synergy derived from using these two methods together facilitated the development of a richer understanding of collaboration by blending theory and practice, abstract and experiential, and collective and personal dimensions of collaboration.

Orientation to the phenomenon began within my understanding of collaboration gained through experience and initial reading. Interpretations of participants’ experiences in the hermeneutic phenomenology study provided new perspectives for further analysis of the hermeneutic study of literature, which in turn provided further perspectives for analysing participant experiences. Thus, despite being presented in this thesis as Study A and Study B, the two studies were interrelated. In these studies I aimed to challenge and extend my understanding of the phenomenon in order to avoid what Grondin (1994, p.15) described as the “lure of immediate meaning” and Fischer (1985) labelled as self-deception.

3.6 Overview of ethical considerations in this research

Ethical behaviour refers to the responsibilities researchers have towards their research participants and to the wider society (see Table 3.3). Researchers are obliged to obtain formal approval for the empirical components of their research through institutional research committees and to behave ethically during all phases of the research. As an interpretation of literature, Study A did not require ethical consideration of people being researched. My ethical concerns in this study were primarily related to acknowledging others’ contributions to the literature (in relation to the texts I had constructed) and reporting my findings in a manner that permitted public scrutiny. As Study B involved participants, ethical considerations for this study were more complex and extensive (see details in Chapter 5).

The National Health and Medical Research Council developed guidelines for the conduct of human research (NHMRC 2001) to help Australian institutional human research ethics committees protect the welfare and rights of research participants. This research project complied with those guidelines. Ethical approval was obtained from
The University of Sydney Human Research Ethics Committee\textsuperscript{34}, the Charles Sturt University Ethics in Human Research Committee, the New England Area Health Research Ethics Committee and the Hunter Area Research Ethics Committee. The latter two committees related to the institutions where my participants were employed or received health care.

### 3.7 Combining the findings of Study A and Study B

A dialogue between different conceptualisations of collaboration in health care identified in Study A and experiences of collaborating in rehabilitation teams illuminated in Study B was undertaken in Chapter 6. From this dialogue emerged a model of collaboration that is presented and described in Chapter 6.

#### Table 3.3 Behaving ethically (based on information from NHMRC 2001)

<table>
<thead>
<tr>
<th>Ethical responsibilities</th>
<th>Ethical behaviours in this research project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility to people being researched</td>
<td>• participants were fully informed of expectations and requests for participation</td>
</tr>
<tr>
<td></td>
<td>• participants were provided with sufficient information to give their informed consent</td>
</tr>
<tr>
<td></td>
<td>• participants were not coerced into participating</td>
</tr>
<tr>
<td></td>
<td>• participants were free to withdraw at any time</td>
</tr>
<tr>
<td></td>
<td>• respect for the participants included consideration of their feasibility to participate</td>
</tr>
<tr>
<td></td>
<td>• data were securely stored to ensure participants’ privacy and confidentiality</td>
</tr>
<tr>
<td></td>
<td>• participants’ comments (apart from use as quotes to illustrate findings) were not shared with other rehabilitation team members or anyone else beyond the research team</td>
</tr>
<tr>
<td></td>
<td>• participants and teams were not identified in my findings</td>
</tr>
<tr>
<td></td>
<td>• adequate research skills were developed to avoid harming or disrespecting the participants or wasting their time on poor research</td>
</tr>
<tr>
<td></td>
<td>• feasibility factors were considered when planning the research so that adequate resources to do the research were ensured</td>
</tr>
<tr>
<td></td>
<td>• unanticipated consequences were appropriately dealt with</td>
</tr>
<tr>
<td>Responsibility of researchers to each other’s intellectual property</td>
<td>• contributions to research were appropriately acknowledged</td>
</tr>
<tr>
<td></td>
<td>• plagiarism was avoided</td>
</tr>
<tr>
<td>Responsibility to wider society</td>
<td>• approval from human research ethics committees was sought and obtained</td>
</tr>
<tr>
<td></td>
<td>• research findings contributed to the knowledge reported</td>
</tr>
<tr>
<td></td>
<td>• research findings are being disseminated to contribute to public knowledge and permit public scrutiny</td>
</tr>
</tbody>
</table>

\textsuperscript{34} I originally enrolled in my PhD at the University of Sydney then later transferred to Charles Sturt University with my supervisor.
3.8 Conclusion

In summary, the complex and challenging phenomenon of collaboration was explored using two studies. The main research questions were:

- What is the nature of collaboration?
- How do people experience collaborating in rehabilitation teams?
- How does effective collaboration in teams promote patient-centred health care?
- What organisational support is required for collaboration to flourish and effectively contribute to patient-centred health care?

Both studies were situated in the interpretative research paradigm. Study A utilised a philosophical hermeneutics approach and Study B used a hermeneutic phenomenology approach. Details of these research approaches and my deeper understanding of the phenomenon of collaboration as conceptualised in literature and as experienced in rehabilitation teams are presented in the subsequent chapters.
CHAPTER 4
STUDY A: COLLABORATION IN THE LITERATURE – A PHILOSOPHICAL HERMENEUTIC INTERPRETATION

Although the collaboration imperative is a hallmark of today’s ... environment, the challenge is not to cultivate more collaboration. Rather, it’s to cultivate the right collaboration, so that we can achieve the great things not possible when we work alone. (Hansen 2009, p.88)

4.1 Introduction to Study A

The focus of this chapter is Study A, a philosophical hermeneutic interpretation of collaboration in the literature. The four research questions I addressed in this study are:

- How is collaboration conceptualised in the literature?
- According to the literature, what is the nature of collaboration in health care (including in rehabilitation teams)?
- How can collaboration contribute to patient-centred health care?
- What organisational support is required for collaboration to flourish and effectively contribute to patient-centred health care?

To answer these questions I undertook an interpretive question and answer dialogue (consistent with philosophical hermeneutics methodology) with a broad selection of texts compiled from literature related to collaboration in multiple contexts, including organisational, educational, research, political and, in particular, health care contexts and rehabilitation settings. My fore-structure of understanding and values (as described in Chapters 1 and 2) provided the starting point for my dialogue with these texts.

Section 4.2 provides an overview of my method for using philosophical hermeneutics to construct and interpret text sets. Section 4.3 presents the findings from my dialogues.
4.2 Method for Study A

*The real power of hermeneutical consciousness is our ability to see what is questionable.*  
(Gadamer 1976, p.13)

This philosophical hermeneutics approach is located within the interpretive research paradigm (as described in Chapter 3). My goal was to deeply understand the phenomenon of collaboration through an interpretation of other people’s interpretations, conceptualisations, theories and research findings about collaboration.

4.2.1 Philosophical hermeneutics

Philosophical hermeneutics commonly refers to Gadamer’s philosophy of understanding. Gadamer explained, “philosophical hermeneutics takes as its task the opening up of the hermeneutical dimension to its full scope, showing its fundamental significance for our entire understandings of the world” (1976, p.18). The key focus of this philosophy is interpretation, a concept encompassing the familiar world of the interpreter and the essential concerns motivating the texts that are being interpreted (Linge 1976). New understanding begins when “the interpreter genuinely opens himself to the text by listening to it and allowing it to assert its viewpoint” (Linge 1976, pp.xx-xxiv). Thus the interpreter aims to grasp the questions evoked by the text, and in answering them to be questioned further by the text. Rather than a method to be followed, philosophical hermeneutics seeks to “describe what actually takes place in every event of understanding” where “every interpretation attempts to be transparent to the text, so that the meaning of the text can speak to ever new situations” (Linge 1976, p.xxvi).

4.2.2 Analytical tools of philosophical hermeneutics

The key analytical tools of philosophical hermeneutics are the *hermeneutic circle*, *dialogue of questions and answers*, and *fusion of horizons*, as described below. Those tools were used in this study to guide my interpretation of collated text sets, thereby enabling me to make sense of the phenomenon of collaboration, its impact on patient-centred care, and the role of organisational support. Being metaphorical rather than prescriptive in nature, these tools provided guidance for my ongoing engagement with

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35 As explained in Chapter 3, hermeneutics is concerned with interpreting texts (Gadamer 1975). In this study I predominantly refer to written texts.

36 David Linge translated and edited a collection of Gadamer’s essays. This quote is from a section in that book, Editor’s Introduction, p.vii-viii.
texts rather than being a checklist of steps. In my interpretation of texts I sought to incorporate my interpretation of the *parts* of the text into my emerging *whole* understanding of it (based on the hermeneutic circle). I posed a series of *dialogue questions* to the texts (using a dialogue of questions and answers) as I moved towards the fusion of my initial horizon of understanding with the horizons portrayed in the texts I was interpreting (seeking fusion of horizons). An overview of the research questions, theoretical framework and examples of dialogue questions I posed to my two text sets is shown in Figure 4.1. The text sets were constructed using texts suitable to answer these questions. The two text sets related to:

- collaboration in organisations, education, politics, research and health care
- collaboration and teamwork in health care and rehabilitation.

**a) The hermeneutic circle**

The hermeneutic circle refers to the schematic representation of integrative aspects of human understanding that occurs when humans grasp the meaning of isolated parts of a text in relation to the whole (Bontekoe 2000). Friedrich Ast (1778-1841) is credited with introducing this concept of the circular structure of text interpretation (Bontekoe 2000). Subsequently Friedrich Schleiermacher (1768-1834) established the process within the field of textual interpretation, Dilthey widened the use of the hermeneutic circle to the interpretation of history, and Heidegger further extended its use to incorporate all human understanding (Bontekoe 2000).

In this unfolding process of comprehending the parts and the whole of a text, new understanding is constantly generated to form fresh insights as we recognise the way components of the whole relate to each other (Bontekoe 2000). The move towards a fuller comprehension requires recollection of the belief that is being altered. Bontekoe (2000, p.6) explained, “We cannot meaningfully revise our beliefs in the light of new information unless we remember what our beliefs are”. Acknowledgement of our beliefs and prejudgements is an important element in this unfolding process. A dialogue of questions and answers enables the shift of focus to move from part of the text to the whole of our understanding and back again in an open process of interpretation (Bontekoe 2000).
Dialog questions included:

“How diverse are understandings of collaboration in the literature?”

“What common threads link these different definitions of collaboration?”

“Who is collaborating?”

“How are the contexts of collaboration described and conceptualised in the literature?”

“What is sought from collaboration?”

“What sort of collaborative processes are used in collaboration?”

Research questions for the **first text set**: How is collaboration conceptualised in the literature?

First text set constructed from literature related to collaboration in organisations, education, politics, research, and health care

Research questions for the **second text set** (in relation to the dimensions of collaboration identified in the first text set):

How does the literature portray the nature of collaboration in health care (including in rehabilitation teams)?

How can collaboration contribute to patient-centred health care (particularly in rehabilitation teams)?

What institutional support is required for collaboration to flourish and effectively contribute to patient-centred health care?

Dialogue questions included:

“What scope do people working at different levels of health care have to influence collaboration?”

“What are the implications of different modes of operation for collaboration in providing patient-centred health care?”

“In relation to practising and supporting patient-centred collaborative health care, what are the implications of framing:

- the place of collaboration in terms of varying clarity of team structures and embeddedness in the wider social and institutional contexts

- the people who are collaborating as ‘particular individuals’ and ‘collective (discipline) entities’

- the purpose/s of collaboration as externally or internally instigated, and as seeking synergistic or integrative outcomes

- collaboration processes in terms of directed and self-directed communication?”

“How can different modes of operation for collaboration contribute to patient-centred rehabilitation?”

Second text set constructed from literature related to collaboration and teamwork in health care and rehabilitation

Dialogue between findings of Study A and Study B

Figure 4.1 Overview of research questions and text set dialogue questions in Study A
In this research I began by articulating my understanding of the phenomenon of collaboration in Chapter 1, and of characteristics of the health care and rehabilitation research space that could influence collaboration in Chapter 2. My initial understanding of collaboration brought to this thesis was that it was a broad term referring to the intentional process of sharing knowledge, thoughts and perceptions between people to achieve a common purpose that is underpinned by effective communication and group facilitation skills. I noted in Chapter 2 that the Australian rehabilitation setting of the research is characterised by (a) diverse meanings of health and health care, (b) elaborate health care structures, (c) complex professional practice requirements, and (d) opportunities for and barriers to collaboration and team-based rehabilitation services.

Throughout Study A I challenged this initial understanding of collaboration by interpreting others’ understandings as presented in texts and parts of texts. A question I often asked myself during this process was “how might I see collaboration differently?”. During this ongoing iterative process new information was brought into, and contested against, my evolving view of the phenomenon. Thus I moved sequentially from my (initial) whole understanding to the parts, and back to my (revised) whole understanding. Reflecting on and challenging my perspectives and beliefs at the starting point and throughout the interpretation of texts enabled me to move forward, integrating new understandings and avoiding what Bontekoe (2000) referred to as the vicious circle that can entrench original prejudices.

**b) Dialogue of questions and answers**

The role of the interpreter is important in hermeneutics. Gadamer (1975) contended that understanding is stimulated by the questions we ask. Questions open up possibilities for understanding (Gadamer 1975). Grondin (1994, p.117) explained:

> A text is given voice only by reason of the questions that are put to it today.

> There is no interpretation, no understanding, that does not answer specific questions that prescribe a specific orientation.

The reciprocal relationship of the question and answer dialogue is a key aspect of hermeneutic interpretation (Gadamer 1975). Thus, hermeneutic interpretation goes further than highlighting what the author intended to say; questions are asked of the text in order to go behind it and bring to light “what the author did not and could not say, yet
which in the text comes to light as its innermost dynamic” (Palmer 1969, p.147). However, rather than resulting in a better understanding of the author than the author him/herself had, such interpretation aims at penetrating the author’s words seeking to find “another kind of thinking, another grasp of truth, and language” (Palmer 1969, p.148).

In searching for questions to dialogue with texts I was influenced by Ricoeur’s categorisation of present-day hermeneutics as alternatively the “hermeneutics of suspicion” or the “hermeneutics of faith, confidence and attestation” (Grondin 1994, p.15). According to Grondin, “The hermeneutics of suspicion” (illustrated in the works of Nietzsche, Freud and Weber) looks backwards, mistrusting the immediate meaning and reducing meanings to unconscious drives and power issues (p.15). “The hermeneutics of faith, confidence and attestation” also avoids being trapped by the immediate meaning, but “is oriented in a forward direction, towards the world that presents us with meaning to be interpreted” (p.15). In this research I sought to remain aware of the power struggles inherent within the history of collaboration in health care, but primarily sought meaning as it was presented and experienced now. This stance helped me to avoid unintentionally bringing historically understood and enacted power based systems into my understanding of collaboration in rehabilitation teams.

Deeper questioning of my motive for choosing the approach/view of hermeneutics of faith, confidence and attestation over hermeneutics of suspicion underpinned my exploration of the literature for suitable theories that resonated with this choice and my view of collaboration, as well as providing an explicit frame of reference to view collaboration. The theories I chose were social ecology, structuration theory and social cognitive theory. These theories, presented in Section 4.3.3, enabled me to incorporate the notions of personal responsibility and agency into my dialogue of questions and answers, and to avoid inadvertently translating dominant social structures (such as health professional hierarchies and organisational preferences for visible, measurable and unambiguous processes) into my emerging understanding of the phenomenon.

c) Fusion of horizons

Gadamer (1975, p.301) proposed that hermeneutic interpretation involved the notion of fusion of horizons, in which a horizon was “the range of vision that includes everything that can be seen from a particular vantage point”. Inherent in Gadamer’s concept of

37 Referring to Heidegger’s Kant und das Problem der Metaphysik 1951, translated by Churchill 1962.
fusion of horizons is the notion of differences in understandings. Understandings of particular situations are neither fixed nor finite (Ricoeur 1981). Each situation can be viewed from another person’s point of view and thereby horizons can be “contracted or enlarged” (p.62). Understandings between “two differently situated consciousnesses” occur when their views intersect and their horizons fuse (p.62). Ricoeur (p.143) described the reader’s understanding of the world of the author as follows:

The [world of the work] is not behind the text, as a hidden intention would be, but in front of it, as that which the work unfolds, discovers, reveals. Henceforth, to understand is to understand oneself in front of the text. It is not a question of imposing upon the text our finite capacity of understanding, but of exposing ourselves to the text and receiving from it an enlarged self.

For Gadamer (1975, p.390), a fusion of horizons involved bringing the personal standpoint of interpreter to the text “as an opinion and a possibility that one brings into play and puts at risk and that helps to make one’s own what the text says”. In describing Gadamer’s concept, Linge (1976, p.xix) explained that understandings between texts and interpreters requires the formation of “a comprehensive horizon in which the limited horizons of text and interpreter are fused into a common view of the subject matter – the meaning – with which both are concerned”, but in which neither horizon is removed completely.

I came to this research having worked in a variety of teams and having read widely about collaboration and teamwork. I viewed teams as groups of individuals with personal agency who use and develop structures and frameworks for effective collaboration. I understood collaboration to be a broad term referring to the intentional process of sharing of knowledge, thoughts and perspectives between people to achieve a common purpose that is underpinned by effective communication and group facilitation skills. From my beginning horizon I viewed collaboration as integral to professional practice and as an important component of patient-centred team-based health care. To me, collaboration was a constructive process (in terms of both intention and outcomes), creating a positive frame and presence for patient-centred health care. From my perspective, collaboration had to be experienced for the depth of its potential to be truly understood. I also acknowledged that the space in which collaboration occurs in a rehabilitation team is complex. I saw the role of the organisation as logically being in support of collaboration. This understanding informed my frame of reference and my beginning horizon.
In this Study A of my research I aimed to fuse the horizon of my understanding of collaboration with others’ horizons of collaboration as interpreted from the literature. I sought to expand my initial horizon by being open to possibilities for different meanings in varied contexts to reach a deeper understanding of the phenomenon.

In aiming to be open to others’ understandings of collaboration I took a broad and inclusive view of the phenomenon as it was presented in the literature. Therefore, rather than undertaking in-depth engagements with a small selection of texts, I sought to dialogue with two text sets as noted above. These two text sets challenged my horizon of understanding and enabled me to develop deeper understandings. The text sets were compiled to answer the dialogue questions that emerged as my horizon of understanding changed. My ongoing compilation and my dialogue with each text set was repeated until I gained a broader understanding of collaboration resulting from fusion of my horizon of understanding with those presented by the selected literature.

4.2.3 Theoretical framework for viewing collaboration

In reading extensively across literature related to organisations, social theories and psychology I identified three main fields of study as having most relevance to my four research questions. These areas of study were social ecology, structuration theory and social cognitive theory. I used these theories to develop a frame of reference that would enable me to embrace the challenges of the health care and rehabilitation team research space (as outlined in Chapter 2) and extend my initial horizon of understanding of collaboration and re-view the multifaceted and complex nature of collaboration, and the space in which it occurs, through a person-centred perspective. Thus I examined collaboration in terms of:

- *its broad social context*, in particular the responsibility people have to shape their contexts, and reciprocally, the way context influences people’s behaviours, agency and experiences, through the theory of social ecology originated by Murray Bookchin (1921-2006);
- *its organisational structures* (including the impact of these structures on people), with reference to the recursive nature of social interactions (particularly the social structures that guide and shape these interactions and understandings), through Giddens’ (1986, 1991) theory of structuration; and
- *its personal and interpersonal situations*, with a focus on people’s agency, through Bandura’s (1989a, 1997) social cognitive theory.
The combination and interrelationship of these theories are depicted in Figure 4.2. The notions of interrelated organisational influences and personal responsibility and agency in collaboration were important notions to my interpretive frame of reference, enabling me to interpret multiple levels of influence on patient-centred collaboration when dialoguing with the text sets. By informing and critically challenging my view of collaboration this theoretical frame of reference guided the selection of texts (see Section 4.2.4) and questions that I posed to them (see Section 4.2.5).

Figure 4.2 Theoretical framework for exploring collaboration
a) Social ecology

The social ecology movement is commonly considered to have begun in the 1960s with the social philosopher Bookchin (1921-2006). Social ecology refers to the dynamic interplay between people’s social, institutional and cultural contexts (Stokols 1992). Central to this interplay is “the importance of the individual self embedded within communities of communities” (Wimberley 2009, p.35). As explained by Stokols (1999), a social ecology perspective recognises multiple levels and perspectives within social phenomena, as well as the dynamic and interrelated nature of historical, cultural, social and institutional contexts affecting people’s lives. Interdisciplinarity, interrelated systems and blurred boundaries are important concepts within social ecology. Social understandings of phenomena are developed through the varying views of different disciplines and are established using varied methods.

My previous experience and readings had led me to understand collaboration as a complex, dynamic and experiential phenomenon involving a high level of interpersonal involvement. Social ecology provided a useful, insightful perspective for embracing the complexity of collaboration in relation to the interplay between the ways people deal with each other and their organisational contexts. It also provided a rationale for understanding the phenomenon of collaboration in relation to patient-centred practice and organisational support.

Social ecology calls for us to explore our socially formative world, to use thinking that is organic and developmental in nature, and to highlight the ways people deal with each other and with the world they live in (Bookchin 1993). From his stance that the current impersonal imperative for objective economic growth was eclipsing the valuable subjectivity and flexibility of human interactions, Bookchin advocated social ecology thinking as a means for positively informing societal changes.

Various implementations of social ecology are described in the literature. For example, Stokols (1992) proposed that social ecological analysis of health promotion is beneficial for maintaining health environments, and Hill (2004) explored the role of social ecology as a framework for understanding and working with sustainability. J. Clark (1997)


39 The term ‘boundary’ refers to the place where different contexts, entities and systems meet: “The realm that separates entities is as important as the entities themselves” (Cole & Pearl 2007, p.2).
identified a range of applications for social ecology’s dialectical and holistic thinking, including the social and ecological consequences of global, political and technological systems.

Despite the abundant writings and actions by proponents of the social ecology movement in relation to social change, there is lack of clarity around its definitions (Wimberley 2009). For this thesis I utilise J. Clark’s (1997, p.3) definition of social ecology as “the awakening earth community reflecting on itself, uncovering its history, exploring its present predicament, and contemplating its future.” The value of Clark’s definition is its emphasis on our responsibility in shaping the future of our society. This responsibility for health professionals was clearly articulated by Higgs, Neubauer and Higgs (1999, pp.37,30) in their view of the changing health care context in relation to globalisation and social ecology:

[Beginning health care practitioners] are faced with both an unprecedented dynamic of change and a growing emphasis on the wider social responsibility, social relevance and interactional role of service providers. ... Health professionals are immune from neither the effects of nor responsibilities for the changing health care context and need to participate in shaping the future of the health care system.

As part of the framework for this research, social ecology oriented me to the interplay between social, institutional and cultural contexts and the responsibility of people for shaping these contexts.

**b) Structuration theory**

Giddens, an eminent British sociologist (born 1938), was interested in understanding the constitution of day-to-day life, a term he claimed encapsulated as “the routinized character which social life has as it stretches across time-space” (1986, p.xxiii). He claimed that social structures and actions of individuals are created *and* reinforced by their social environments:

The social environments in which we exist do not just consist of random assortments of events or actions – they are *structured*. … Social systems are made up of human actions and relationships: what gives them their patterning is their repetition over periods of time and distances and space (1993, p.18).
For Giddens the reproduction\(^{40}\) of institutionalised practices could be understood through the study of the routines and contexts of day-to-day life. Such study involved (a) exploration of a number of factors including space and boundaries, the symbolic or physical markers of time, the individuals involved and their means of communication, and the means by which these factors influence or control the flow of interaction, and (b) the relation between “reflexively monitored and unintended aspects as the reproduction of social systems” (1986, p.285-286). He proposed that his theory of structuration was a conceptual scheme allowing us to understand how “actors are at the same time the creators of social systems yet created by them” (1991, p.204), and where humans are viewed as “knowledgeable agents” who are often bounded by unconscious and unacknowledged or unintended reproductions of systems and structures (1986, p.281).

Key points of Giddens’ *structure, systems and structuration* influencing this research are outlined in Table 4.1.

Table 4.1 Key points of structuration and their relevance to analysing the research data (based on Giddens 1986)

<table>
<thead>
<tr>
<th>Key points of structuration theory</th>
<th>Implications for my philosophical hermeneutic study</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Structure</em> is conceptualised as sets of <em>rules and resources</em> recursively organised as properties of social systems.</td>
<td>Principles and schemas for collaboration as presented in literature were explored.</td>
</tr>
<tr>
<td><em>Systems</em> are the relationships and activities of human agents reproduced over time and place to be regular social practices.</td>
<td>Commonly discussed systems, relationships and activities were identified from the literature.</td>
</tr>
<tr>
<td><em>Structuration</em> represents the duality of structure and systems. “The structural properties of social systems are both medium and outcome of the practices they recursively organise” (p.25). Social systems create the structural properties and at the same time ensure that these social properties are reproduced.</td>
<td>Conceptualisations of structures and relationships were identified and explored, particularly in relation to the reproduction of views of collaboration.</td>
</tr>
</tbody>
</table>

Structuration theory has been criticised for providing “too little space for free action” or alternatively, for underestimating “the influence of structural constraint” (Giddens 1991, p.204). However, in response to these criticisms, Giddens contended that:

> The theory of structuration is not a series of generalizations about how far “free action” is possible in respect of “social constraint”. Rather it is an attempt to

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\(^{40}\) I understand Giddens’ term “‘reproduction’” to mean *the translation of abstract into practice*, rather than a *fixed and exact replication*. The notion of an exact copy is inconsistent with the philosophical stance of the interpretive research paradigm, in which people construct their own meanings and understandings of the world. According to my understanding of Giddens’ term, reproduction has an organic quality.
provide the conceptual means of analysing the often delicate and subtle interlacings of reflexively organized action and institutional constraint.

He explained the pervasive nature of the systems in which we live:

All of us have some kind of “faith” in the systems that surround us and enter into the most intimate parts of our lives – the systems that provide water, generate food production, transport us from one place to another, interpret health and disease and a multitude of other things ... There is a constant tension between the appropriation of knowledge on the part of experts and other officials and its re-appropriation by lay actors in the contexts of day-to-day lives (p.210) ... Of course, there are limits to how far any given individual can disengage from the whole range of expert systems that permeate modern life (p.211).

I propose that Giddens’ contention regarding the permeation of these official systems into modern life is relevant to the ways people collaborate with each other, particularly in relation to the interests of the official systems in which they work. People may inadvertently reinforce dominant systems, structures and processes that are created by others. Using a framework informed by structuration theory I sought to (a) identify visible and less visible principles, schemas, relationships and activities within the structure and systems of collaboration, and (b) understand more deeply their permeation and recursive nature, and how they are reproduced, made routine or translated into other situations. Thus, for this research, the value of structuration theory lay in the standpoint it provided that there was a need to examine the organisational structures and processes that surround collaboration.

c) Social cognitive theory

In keeping with the interpretive research paradigm of this research (which recognises that people make meaning in their lives and turn this meaning into actions), I acknowledge that people bring to collaborative situations the influences of their individual situations and understandings. To more fully explore the agency of people and how they respond to their own situations and the situations of others, I chose to include social cognitive theory in my frame of reference to guide the dialogue with texts. Bandura proposed a social cognitive theory to provide a model of emergent interactive

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41 In acknowledging the limitation of the term “reproduction” I also use other terms, including “made routine” and “translated into other situations”. 

105
agency in which people are “agents of experiences rather than simply undergoers of experiences” (Bandura 2001, p.4).

Bandura (1991, p.14) referred to personal agency operating “within a broad structure of sociocultural influences”. Such agency enables people to be purposive and self-reflective. Central to personal agency is the notion of efficacy, which is the belief people have in their capability of exercising some degree of control over their personal functioning and contexts (Bandura 2001). Core features of personal agency are intentionality (which refers to intentional planned acts), forethought (which considers the motivation from projected outcomes and goals), self-reactiveness (which requires the ability to shape activities and regulate their execution), and self-reflectiveness (which concerns the evaluation of motivation, values and meaning of goals and actions).

Bandura’s (1989a) social cognitive theory recognises the role of individuals’ motivations and situations in controlling their lives:

In social cognitive theory, people are neither driven by inner forces nor automatically shaped and controlled by the environment. … They function as contributors to their own motivation, behaviour, and development within a network of reciprocally interacting influences. People are characterised within this theoretical perspective in terms of basic capabilities (p.8).

The basic capabilities that characterise Bandura’s social cognitive theory are outlined and expanded in Table 4.2. These characteristics enable people to take responsibility for aspects of their lives. Inherent in the notion of such responsibility is Bandura’s concept of self efficacy. Self efficacy is the “belief in one’s capabilities to organize and execute the courses of action required for producing given attainments” (1997, p.3). Bandura contended that “beliefs of personal efficacy constitute the key factor of human agency” (1997, p.3).

As well as self efficacy, Bandura also recognised the concept of collective efficacy. As personal efficacy does not occur in isolation of social systems, Bandura proposed that the concept of collective efficacy was relevant to group endeavours. Collective efficacy is “a group’s shared belief in its conjoint capabilities to organize and execute the courses of action required to produce given levels of attainments” (Bandura 1997, p.477). The performance of a group depends on interactive dynamics of group members, its structure, leadership, and the coordination of skills and efforts. Therefore the group’s perceived collective efficacy is an “emergent group-level attribute rather than simply the
sum of the members’ perceived efficacies” (p.478). The concept of collective efficacy added another layer to my social cognitive theory perspective. This perspective enabled me to explore how people involved in collaboration conceptualise and have agency for their collaborative endeavours, and how collective endeavours were portrayed in the literature.

Table 4.2 Social cognitive theory capabilities (Bandura 1989a)

<table>
<thead>
<tr>
<th>Capabilities</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symbolising capacity</td>
<td>People have the capacity to use symbols (such as verbal or image symbols) to process experiences and “test possible solutions in thought and discard or retain on the basis of estimated consequences before plunging into action” (p.9)</td>
</tr>
<tr>
<td>Vicarious capability</td>
<td>People have the capability for vicarious, or observational, learning which enables them to learn from the actions of others. “Much social learning occurs either deliberately or inadvertently by observing the actual behaviour of others and the consequences for them” (p.21)</td>
</tr>
<tr>
<td>Forethought capability</td>
<td>“Most human behaviour is purposive and ‘regulated by forethought’” (p.39)</td>
</tr>
<tr>
<td>Self-regulatory capabilities</td>
<td>Psychosocial functioning is “regulated by an interplay of self-produced and external sources of influence” (p.47)</td>
</tr>
<tr>
<td>Self-reflective capabilities</td>
<td>People gain knowledge about themselves and the world around them by reflecting, and they can “monitor their ideas, act on them and predict occurrences from them, judge from the results the adequacy of their thoughts, and change them accordingly” (p.58)</td>
</tr>
</tbody>
</table>

Thus, through the perspective of social cognitive theory I could explore the purposes of people’s actions in collaborations, and how people control these actions and shape their environments.

**d) Frame of reference for viewing collaboration**

The theories of social ecology, structuration theory and social cognitive theory contributed to the frame of reference I used to view collaboration in this study. This frame of reference enabled me to embrace the interplay between people’s social, institutional and cultural contexts (social ecology), the social structures that regulated and influenced relationships and actions in particular settings (structuration theory) and personal agency in responding to diverse situations (social cognitive theory). With this frame of reference I could view the individual health professional and the collective team as part of an organisational context and wider society, where they experienced recursive structures and processes, and power, roles, agency. Thus this frame allowed me to embrace and scrutinise the complexity of the phenomenon of collaboration and its varied meanings. Using this frame I constructed and interpreted texts from a perspective that (a) embraced the interrelated influences on collaboration, (b) explored people’s agency in their actions and how they worked within structures that might direct their
actions, and (c) recognised people’s responsibility to shape their contexts appropriately for patient-centred health care.

4.2.4 Constructing and dialoguing with text sets

In preparation for constructing and dialoguing with the text sets I spent 12 months undertaking detailed database, internet and library searches and reading widely across the literature. Key terms for searches included collaboration, collaborative practice, interprofessional practice, interdisciplinary team, multidisciplinary team, transdisciplinary, health care team and teamwork. This step ensured that this study was grounded in a current and comprehensive understanding of the existing knowledge base.

My construction and dialogue with written text sets was guided by the four research questions and informed by my chosen theoretical frame of reference. In Figure 4.3, key points related to constructing text sets are outlined, examples of questions I posed to these text sets are provided, and the interactive and ongoing nature of interpretation of different understandings of collaboration is highlighted.

a) Constructing text sets

The two text sets constructed for this study came from literature related to:

- collaboration in organisations, education, politics, research and health care (the first text set)
- collaboration and teamwork in health care and rehabilitation (the second text set)

Through my initial engagement with literature I recognised that collaboration was a multifaceted phenomenon with various meanings in diverse contexts. No one text embraced all meanings and conceptualisations. Guided by my research strategy and my theoretical frame of reference I chose a range of articles that encompassed issues related to individual agency and responsibility and to organisational influences in collaboration and their interplay. Underpinning this decision, and based on the theory of structuration, my aim was to ensure that I did not unconsciously or unknowingly restrict exploration to principles and schemas of collaboration that were inherent in the health literature, or fail to challenge the unquestioned drivers for these health discourse schemas. Therefore, in my first text set, I included texts from broad areas not specifically related to health. Through this text set I engaged with diverse perspectives of collaboration and challenged my entry horizon of understanding.

Texts were research reports, reviews of literature, viewpoints, policy documents or discussions obtained from multiple sources, including database searches (primarily Web
Research questions explored in Study A
How is collaboration conceptualised in the literature?
How does the literature portray the nature of collaboration in health care (including in rehabilitation teams)?
How can collaboration contribute to patient-centred health care (particularly in rehabilitation teams)?
What institutional support is required for collaboration to flourish and effectively contribute to patient-centred health care?

Theoretical frame of reference
(guiding question and answer dialogue with text sets):
social ecology, theory of structuration and social cognitive theory

Text sets:
constructed from literature related to collaboration in organisations, education, politics, research and health care (text set one)
collaboration and teamwork in health care and rehabilitation (text set two)

Examples of dialogue questions with text sets
Text set one:
“How diverse are understandings of collaboration in the literature?”
“What common threads link these different definitions of collaboration?”

Text set two:
“What scope do people working at different levels of health care have to influence collaboration?”
“What are the implications of different modes of operation for collaboration in providing patient-centred health care?”

Findings
Collaboration can be conceptualised in terms of the dimension of people, place, processes, and purpose. In relation to these dimensions patient-centred collaboration involves intertwined ordered and organic modes of operations. Support for intertwining these modes of operation is required from people at different levels within health care organisations, including those working at governance level (setting policies and directives for health care), education level (educating and socialising health professionals to work in their disciplines), and organisational management (including team management).

Figure 4.3 Overview of research questions, text sets, examples of dialogue questions, and findings for Study A
of Science and CINAHL), Google Internet searches, reference lists and citation links. The first text set centred on texts with the word *collaboration* in the title, abstract or key words. In this first text set, and in the later text set, I also sought articles that embraced individuals’ agency and responsibility, and articles where the interplay between individuals and organisational structures was prominent, as well as those in which it was not. Inclusion of texts in each text set was on the basis that they enriched and/or challenged my horizon of understanding. Thus I sought (a) to move beyond my familiar taken-for-granted view of collaboration in order to develop new insights and meanings into this phenomenon, and (b) re-vision my horizon of understanding informed by the horizons of understanding provided by the texts.

From my initial interpretation of collaboration in organisations, education, politics, research and health care (in the first text set), I moved to a more specific focus on collaboration in health care and rehabilitation (in the second text set). This second text set included articles that explored the notion of collaboration and/or teamwork and/or interprofessional practice. My rationale for including texts related to these notions (rather than just including texts with collaboration in the title, abstract or key words) was based on the following:

- health care is delivered in an organisational context, of which teams are a common component;
- the terms *collaboration*, *teamwork* and *interprofessional practice* were often used (interchangeably) in health care; and
- I sought to be inclusive of texts that would enrich and/or challenge my horizon of understanding of how people work together to deliver health care.

There was a small overlap between the two text sets, with some key texts included in both. The meanings of collaboration in text set two provided insights and conceptualisations of collaboration that informed my interpretation of patient-centred collaboration in rehabilitation teams. The questions posed to this text set were influenced by my evolving understanding of collaboration identified in earlier dialogues.

**b) Overview of questions guiding my ongoing dialogue with text sets**

In Figure 4.3 I have included an overview of the key dialogue questions that guided my ongoing *dialogue of questions and answers* with my two constructed text sets. The findings from each dialogue evoked the questions and were incorporated into the questions (and subquestions) for each successive dialogue. Guided by my theoretical
frame of reference, these questions enabled me to be open to both individual and organisational influences on collaboration. Of particular relevance in this figure is the funnelling that began with a broad text set related to organisations, education, politics, research and health care. I looked through and into this diverse range of texts and aimed to see what was not immediately evident to me (somewhat like standing back from a sculpture to see it in its entirety, then moving forward again to examine the detail). The more focused choice of texts related to health care and rehabilitation (in the second text set) enabled me to explore the nature of the organisational support required for patient-centred collaboration and to dialogue more deeply with collaboration in this context (health care) and setting (rehabilitation).

4.2.5 Presentation of findings

The interplay between researcher and texts is an important aspect of hermeneutic writing (Loftus & Trede 2009). To write in this manner requires that researchers acknowledge and honour their views and perspectives of their world, then make explicit the interplay between their perspectives and those of other authors and the questions researchers pose to their texts. Accordingly, in presenting my findings from the philosophical hermeneutic study of this research I sought to make visible my dialogue with texts through articulating the questions I posed to my texts. The structure and labelling of the sections within Section 4.3 (as highlighted in Table 4.3) reflects the meanings I made through my dialogues. The findings in these sections are supported by a diagrammatic representation of key points (provided in Section 4.3.3).

Alliteration is evident in the labels I chose for the interpreted dimensions of collaboration described in the findings (people, place, purposes and processes). These labels emerged during my interpretation of the first text set, perhaps reflecting a cognitive/memory technique used when I engaged deeply with many varied and extensive texts (alliteration of emerging themes provided me with a kind of “cognitive coat-hanger” on which to hang and easily remember my emerging insights during ongoing interpretations). The repeated letters also serve as a heuristic device to facilitate recall of the dimensions of collaboration identified in this research and their relationships (alliteration is also used for dimensions identified in Study B). Thus my choice to use alliteration is underpinned by both opportunistic (using my personal style of interpretation) and purposive (employing a heuristic device) elements. I hope the heuristic will be of use to people seeking to use these dimensions for their own work and understanding of collaboration.
### 4.3 Findings of Study A: philosophical hermeneutics

*Collaborative environments of organisations are not fixed, immovable frameworks, but rather frameworks constructed by people, involving people, developed by people, maintained by people and capable of being changed by people*  
(Lawrence & Lorsch 1967)

This section presents the findings of my question and answer dialogue with my two compiled text sets in which I broadened my initial view of collaboration and fused it with the horizons of understanding interpreted from these text sets. My initial impression when exploring different understandings of collaboration in the literature was one of wonder at the range of different meanings, and depths of meanings, for the term. It seemed that authors of different texts did not share the same understandings of what collaboration was or what it involved. Motivated by this, I sought to challenge and
broaden my beginning horizon of collaboration to incorporate their different understandings.

4.3.1 Overview of diversity of understandings of collaboration: Text Set 1

**Question Box 4.1**

The main questions informing my dialogue with the first text set (composed of various definitions, connotations, theories and models of collaboration from health, organisation, education and research literature) were:

“How diverse are understandings of collaboration in the literature?”

“How can this diversity be explained?”

While noting that the literature abounds with different explicit definitions, connotations, theories and models of collaboration, I acknowledged that I was not alone in my observation of varied meanings. Difficulties in defining collaboration have been noted by many authors over the last few decades, including Gregson, Cartlidge and Bond (1991), Wood and Gray (1991), King, Lee and Henneman (1993), Taylor (1996), Sullivan (1998a), Dillenbourg (1999), Kinnaman and Bleich (2004), D’Amour, Ferrada-Videla, Martin-Rodriguez et al. (2005), Kezar (2005), Longoria (2005), Todahl, Linville, Smith et al. (2006), Boon, Mior, Barnsley et al. (2009), and Thomson, Perry and Miller (2009).

Even before exploring the differences in meanings of the term *collaboration*, I found that the extent to which the phenomenon was defined and conceptualised differed among texts. Many authors used the term without definition or reference to different understandings of collaboration (e.g. Popich, Louw & Eloff 2005; Uzzi & Spiro 2005; Wilson et al. 2005), whereas others specified their interpretation of phenomenon clearly (e.g. Pasquero 1991; Loisel, Durand, Baril et al. 2005; Boon et al. 2009). Others provided a few different definitions but without synthesis (e.g. Henneman, Lee & Cohen 1995; Dougherty & Larson 2005). Further, where collaboration was defined, different degrees of scope were evident. Dougherty and Larson’s (2005, p.244) brevity in defining collaboration as “to work together” can be contrasted to the detailed specifics in the definition of Robert and Bradley (1991, p.212):
Collaboration is a temporary social arrangement in which two or more social actors work together toward a singular common end requiring the transmutation\textsuperscript{42} of materials, ideas and/or social relations to achieve that end. From my beginning exploration with this first text set it appeared that authors varied in their need for, recognition of, or capability to engage with the complexities related to collaboration. Some authors went to great lengths to clarify and stipulate meanings; others did not.

I noted that definitions, even when explicitly stated, could contain unstated assumptions that limited the relevance of the definition. For example, Wood and Gray (1991, p.146) defined collaboration as occurring:

\begin{quote}
when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structures, to act or decide on issues related to that domain (p.146).
\end{quote}

Although each element of this definition was clearly expanded and defended in the text, the minimal attention to individuality and evolving relationships meant that the definition might be better suited to explorations of collaboration where the focus was on stakeholders of organisations and disciplines rather than on particular individuals. Wood and Gray’s definition of collaboration informed a number of other explorations of collaboration, including that of Longoria (2005) and Thomson et al. (2009), who similarly focused on collaboration between organisations rather than between particular individuals.

I also found different approaches to the phenomenon of collaboration in similar contexts. For example, in the context of health care, Briggs (1997a) dealt with collaboration as a component of team meetings in early intervention teams (that is, teams providing a range of services, including health care, to infants and young children). She provided a set of principles and a “toolbox” of ideas to guide team members’ interactions and decision making. In contrast, the approach of D’Amour, Goulet, Labadie et al. (2008) towards collaboration was broader and more conceptual. They stated, “collaboration is an integral part of everyday life, and under certain conditions it can be transformed into collective action” (2008, p.13). They proposed a model of interprofessional collaboration that highlighted (a) shared goals and vision,

\textsuperscript{42} Transmutation refers to the change or fashioning of a “set of raw materials (objects, ideas, or social relations) into a developed product” (Robert & Bradley 1991, p.212).

114
which recognised that individuals might have divergent motives, multiple allegiances and differing expectations; (b) internalisation, referring to interdependence and trust between health professionals; (c) formalisation, clarifying expectations and procedures; and (d) governance which provided direction and support. Although both texts focused on the who and how of collaboration, their approaches were underpinned by different intentions. Briggs’ messages targeted members of early intervention teams. She advised readers to “select from the suggestions above and carefully assemble your own toolbox to accompany you to your next meeting” (1997a, p.211), whereas D’Amour et al. (2008, p.1) sought to provide a model for researchers, administrators and professionals that could be used to “analyse collaboration and identify areas for improvement”.

In my question–answer dialogue with diverse understandings, I also explored different theoretical perspectives behind varied understandings of collaboration. Having identified my own theoretical frame of reference for interpreting collaboration, I was interested in what theories others used to frame their understandings of collaboration. A small number of authors articulated their theoretical perspectives, simultaneously explaining the foundations of their exploration of collaboration and confirming for me the elusiveness of a single definition or understanding of collaboration for all contexts and purposes. For example, the theoretical perspectives included systems theory, which highlighted the interrelatedness of the community, organisation and collaborating individuals (e.g. Salmon & Faris 2006), and complexity theory, which provided a framework for understanding collaborative problem solving in situations with low certainty of outcomes and low professional agreement about approaches (e.g. Kinnaman & Bleich 2004). As well, structuration theory was used to facilitate understandings of

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the social and organisational issues that surround the use of information technologies for collaboration (Evans & Brooks 2005). Authors exploring the notion of computer-assisted collaborative learning included shared cognition approaches\(^{46}\) as one of the approaches underpinning their claims for shared meaning making in groups (Dillenbourg, Baker, Blaye et al. 1996; Dillenbourg 1999; Stahl 2003, 2005). Lamb and Davidson (2005) identified interactionism\(^{47}\), poststructuralism\(^{48}\) and network theory\(^{49}\) as the theoretical perspectives informing their research on scientists’ professional identity in research collaborations. Each different theoretical perspective contributed different views, with no particular one able to provide all answers. A common feature of these different perspectives was the framing of collaboration as a complex phenomenon that defied simplistic interpretation. Such framing facilitated the acknowledgement and exploration of ambiguous and uncertain aspects and characteristics of collaboration, as well as highlighting interrelated layers of influence.

The importance of clear definitions of collaboration for framing research was noted by a number of authors (including Schmitt 2001; Hara, Solomon & Sonnenwald 2003). Thomson et al. (2009, p.24) noted that “lack of consensus among scholars on the meaning of collaboration makes it difficult to compare findings across studies and to know whether what is measured is really collaboration”. King and colleagues (1993) argued that essential elements of collaboration needed to be identified in order to inform education for collaborative practice in health. These authors assumed that consensus about the meaning of collaboration was possible across contexts and purposes.

However, not all authors sought or valued consensus of meaning. Dillenbourg (1999), the editor of a book about collaborative learning, challenged claims of a need for clear definitions, proposing that convergence of shared understandings of collaboration across

\(^{46}\) Shared cognition is “thinking at group level” (Ensley & Pearce, 2001).


\(^{49}\) Network theory is “the disciplined inquiry into the patterning of relations among social actors, as well as the patterning of relationships among of actors at different levels of analysis (such as persons and groups): p.505 in Breiger, R, 2004 The Analysis of social networks. Handbook of Data Analysis, edited by Hardy, M and Bryman, Sage Publications, p.505-526.
different disciplines for a variety of uses should not be forced; rather, different understandings should be allowed for readers to engage with the phenomenon. Dillenbourg proposed that embracing different meanings of collaboration and acknowledging their limitations provided a space for understanding what was encountered in collaborative situations. For him the variety of meanings of collaboration was framed as an opportunity rather than a limitation.

Thus in my initial dialogue with my first text set I identified a number of different approaches to, and understandings of, collaboration. With my expanding horizon of understanding, I concurred with authors who proposed that the difficulties in defining collaboration could be attributed to the complexity of the construct and the different degrees to which this complexity was embraced. For example, Gregson and colleagues (1991) recognised the variety of superficial definitions of collaboration, and Wood and Gray (1991, p. 143) noted that each had “something to offer but none being entirely satisfactory by itself”. I also agreed with Thomson et al. (2009), who claimed that the wide range of theoretical perspectives used to view collaboration could contribute to the lack of clarity and shared understandings about the phenomenon.

Thus, guided by my theoretical frame of reference (social ecology, structuration theory and social cognitive theory), I began my engagement with the complexity of collaboration through my initial question-answer dialogue with the first text set. I noted that there was a lack of consensus for a particular definition, as well as different recognitions of the complexity of collaboration, reasons for defining, theoretical underpinnings and opinions about the limitations imposed by lack of clarity. A broad yet integrated understanding of collaboration appeared difficult to obtain from the literature. Collaboration appeared to be a somewhat elusive phenomenon. The diagrammatic depiction of 20 definitions as a “word cloud” (as shown in Figure 4.4) provides a representation of how baffling an overview of the definitions of collaboration can be. The variety of words and their different frequencies of use (reflected in larger font size) indicated to me that deeper interpretation was needed to understand the nature

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50 Questions posed to the text set were: “How diverse are understandings of collaboration in the literature?” and “How is this diversity recognised and how can it be explained”?

51 The 20 definitions listed in Table 4.4 that I identified in the literature were used in the diagrammatic depiction.

52 This word cloud features the 150 most common words used in 20 definitions of collaboration that I had identified in the literature (words appearing most frequently have greater prominence). The word cloud was developed from Wordle © 2009 Jonathan Feinberg. <http://www.wordle.net/> accessed 3 September 2010
Figure 4.4 Word cloud of collaboration definitions
of collaboration as presented in the literature. Interestingly, it seemed that because collaboration is a familiar word used in everyday language, this very familiarity created problems when the concept and phenomenon became the objects of investigation.

Throughout this initial dialogue with the text set I was reminded of the fable of the blind men describing an elephant, where each man described characteristics of a different part without an overall view of the whole: thus an elephant was deemed to be like a rope (tail), fan (ear), tree trunk (leg), spear (tusk) and wall (stomach), as illustrated in Figure 4.5. Each man comprehended the part of elephant he felt, but could not comprehend the entire form.

Figure 4.5 Elephant as described by blind men

From this horizon of understanding I wondered if the uniqueness or particularity of the phenomenon as investigated by different people could relate to the various perspectives of the authors, and the nature of their focus and their context. Perhaps, like the blind men in the fable, different authors’ various perspectives contributed to the elusiveness of understanding of the entire phenomenon. This proposition formed the basis of the next question and answer dialogue with the first text set (relating to different definitions of collaboration) wherein I sought to identify the commonalities and differences within these perspectives, between the varied understandings of collaboration. Consistent with Dillenbourg’s (1999) positive framing of differences of meanings providing space for understandings, I acknowledged the importance of being open to a variety of meanings of collaboration in my continued dialogue with the first text set.

53 Acknowledgement of illustration: © Jason Hunt from http://naturalchild.org/jason/blind_men_elephant.html accessed 1/09/10
4.3.2 Dimensions of collaboration: Text Set 1

In seeking the “whole elephant” view of collaboration in order to understand the commonalities in what was being described, I dialogued with definitions, connotations, theories and models of collaboration presented in the literature. This section explains the dimensions of collaboration identified from the first text set.

a) Identifying dimensions: people, place, purpose and processes

Question Box 4.2

The questions informing my dialogue with the first text set (composed of various definitions, connotative meanings, theories and models of collaboration from health, organisation, education and research literature) were:

“What common threads link these different definitions of collaboration?”

Examples of definitions of collaboration from text set one are shown in Table 4.4. Through this ongoing dialogue of questions and answers I identified four dimensions of collaboration: people (the doers of collaboration in terms of “who” is interacting), place (related to the “where” of collaboration in terms of its socially situated location and structure), purposes (concerned with the “why” of collaboration) and processes (referring to “how” things are done and the interactions involved in collaboration). I labelled these dimensions the PPPP dimensions of collaboration.

As is evident from the definitions, not all authors included all aspects of each dimension. For example, some authors focused on one particular dimension (e.g. the dimension of people in the definition by Dougherty & Larson 2005), and others referred to all dimensions (e.g. Stahl 2005). Definitions of collaboration highlighted authors’ different perspectives and purposes rather than indicating shared understandings of the phenomenon across different contexts.
Table 4.4 PPPP dimensions of collaboration in examples of definitions

<table>
<thead>
<tr>
<th>Definition</th>
<th>Discipline literature</th>
<th>People</th>
<th>Place</th>
<th>Process</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>The base meaning of this word [collaboration] is to work together (Dougherty &amp; Larson 2005, p.244).</td>
<td>Health</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>A working definition of collaboration in health care includes the concepts of an organized division of labour, with unique expertise being contributed by different professionals (Poldre 1998, pp.23-24).</td>
<td>Health</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>... collaboration (creating new value together) rather than mere exchange (getting something back for what you have put in) (Kanter 1994, p.97)</td>
<td>Organisation</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>For the purpose of this paper, we employ the more generic term, collaborative, to indicate teams that are interdependent and at least attempt to share power and responsibility (Bourgeault &amp; Mulvale 2006, p.482)</td>
<td>Health</td>
<td>x</td>
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<tr>
<td>The collaborators will normally include the following: (a) those who work together on the research project throughout its duration ... (b) those whose names or posts appear in the original research proposal, (c) those responsible for one or more of the main elements of the research. (Katz &amp; Martin 1997, p.7)</td>
<td>Research</td>
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<tr>
<td>Collaboration is defined as a dynamic, transforming process of creating a power sharing partnership for pervasive application in health care practice, education, and organizational settings for the purposeful attention to needs and problems in order to achieve likely successful outcomes. (Sullivan 1998b, p.6)</td>
<td>Health</td>
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<tr>
<td>Supraorganizational systems of collaboration are defined here as loosely coupled, multilayered networks of referent organizations designed to lead stakeholders to take voluntary initiatives towards solving a shared social problem. (Pasquero 1991, p.38)</td>
<td>Organisation</td>
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<tr>
<td>In order to be considered collaboration, it is key that the processes entail an interactive process (relationship over time) and that groups develop shared rules, norms and structures ... it is important to understand that the literature is typically divided into two areas: internal (intra) and external (inter) collaboration. (Kezar 2005, p.833-834)</td>
<td>Organisation</td>
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<td>The term collaboration conveys the idea of sharing and implies collective action oriented toward a common goal, in a spirit of harmony and trust, particularly in the context of health. (D’Amour, Ferrada-Videla, Martin-Rodriguez et al. 2005, p.116)</td>
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<tr>
<td>Collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structures, to act and decide on issues related that domain (Wood &amp; Gray 1991, p.146)</td>
<td>Organisation</td>
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<tr>
<td>… in the CSL [computer-supported collaborative learning] perspective, it is not so much the individual student who learns and thinks, it is the collaborative group … in situation of collaborative activity it is informative to study how processes of learning and cognition take place at group level ( Stahl 2005, p.79)</td>
<td>Education</td>
<td>x</td>
<td>x</td>
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</tr>
</tbody>
</table>
Table 4.4 PPPP dimensions of collaboration in examples of definitions (continued)

<table>
<thead>
<tr>
<th>Definition</th>
<th>Discipline literature</th>
<th>People</th>
<th>Place</th>
<th>Process</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration is a temporary social arrangement in which two or more social actors work together toward a singular common end requiring the transmutation of materials, ideas and/or social relations to achieve that end. (Roberts &amp; Bradley 1991, p.212)</td>
<td>Organisation</td>
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<td>… interdisciplinary collaboration is an effective interpersonal process that facilitates the achievement of goals that cannot be reached when individuals act on their own (Bronstein, 2003, p. 299)</td>
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<td>Collaborations can open the door to a synergistic success when people bring their separate skills and organizations together to focus on a single concern fuelled by the power of their combined passion. Real collaboration always results in change: it spreads responsibility, engaging and empowering a wide range of people. … However, when there is a thoughtful, deliberate collaboration among groups that traditionally do not share similar views, but coalesce around a mutual interest, then collaboration truly can take us where we cannot go alone. (Soonkeum, van de Flier Davis, White et al. 2008, no page number)</td>
<td>Organisation</td>
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<td>Interdisciplinary collaboration is perceived as a process by which individuals from different professions structure a collective action in order to co-ordinate the services they render to individual clients or groups (D’Amour, Sicotte, Levy 1999 in Sicotte, D’Amour, Moreault 2002, p.992)</td>
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<td>Collaborating (“to labour”) signifies a more durable relationship. Separate organizations enter into a new structural arrangement with formal roles and full commitment to a common mission. Comprehensive planning and clear communication channels are needed at all levels. Consensus is used in shared decision making. Risk increases because each organization contributes resources as well as its reputation. Partners jointly secure or pool resources and share results and rewards. Trust levels and productivity are high. Power may not be equally shared. (Butterfoss 2007, p.28)</td>
<td>Health</td>
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<td>Based on this review, collaboration is essentially an interpersonal process that requires the presence of a series of elements in the relationships between the professionals in a team. These include a willingness to collaborate, trust in each other, mutual respect and communication. Yet, even though the above conditions may be necessary, they are not sufficient, because in complex health care systems professionals cannot, on their own, create all the necessary for success. Organisational determinants play a crucial role, especially in terms of human resource management capabilities and strong leadership. (Martin-Rodriguez, Beaulieu, D’Amour et al. 2005, p.145)</td>
<td>Health</td>
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<tr>
<td>Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organisations to achieve results they are more likely to achieve together than alone. (Kagin 2000, p.48)</td>
<td>Organisation</td>
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</table>
b) Exploring the four dimensions: people, place, purpose, processes

To dialogue more deeply with these concepts I returned to my first text set, and identified differences within understandings of collaboration in relation to the PPPP dimensions. These dimensions are outlined below and discussed in more detail throughout this chapter. My theoretical frame of reference enabled me to be open to structural, organisational and individual aspects of collaboration and the interplay between them.

The PPPP dimensions of collaboration and their related elements identified in this research are:

- **people**: units of interactions (these being individuals or collective entities of organisations, disciplines and agencies\(^{54}\));
- **places**: the context of collaborating entities (i.e. collaboration occurring in contextual continua or demarcated territories);
- **purposes**: intended (and actual) outcomes (in terms of synergy or coordination and integration) and type of instigation (having internal or external momentum); and
- **processes**: means of interaction (in terms of emphasis on relationships and structures that are externally directed or internally evolving).

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\(^{54}\) The use of the term *agency* in this context refers to a body of people providing a specific service.
These *place, people, purpose* and *process* dimensions are an interpretation of how collaboration is portrayed and conceptualised in the literature. Identifying these dimensions addressed the first *research question* of Study A: How is collaboration conceptualised in the literature?

**i) People involved in collaboration: individuals and collective entities**

**Question Box 4.3**

The questions informing this phase of the dialogue (with the first text set) were:

“*Who is collaborating?*”

“*How are they portrayed in the literature?*”

*People* in collaboration were frequently portrayed in the literature as the *doers*. I found that people described in the texts tended to be conceptualised in relation to being *particular (and collaborative) individuals or collective entities* (where the collaborative entity was amalgamated to higher levels such as the organisation, discipline or agency represented). Particular individuals represented their embodied, individual selves. They brought to the collaboration their personal qualities as well as perspectives and conventions from their organisation and their discipline socialisation. However, in collaboration between *collective entities* the characteristics of the organisations, disciplines and agencies tended to be the primary concern. This appeared to take the focus off the person who was collaborating and place it on the role or entity being represented.

The *individual* in collaboration was a focus of many texts. Evident in this focus was recognition that people differed in the individual qualities they brought to collaborative situations (such as values, experiences, and socialised organisational or discipline perspectives). Although the emphasis in a number of texts was on integrating these differences into shared understandings within the collaboration (e.g. Sonnenwald 1995) some authors explicitly valued the uniqueness of individuals’ different ideas and perspectives and their potential to spark creativity and transform understandings. For example, Uzzi and Spiro (2005, p.447) claimed that “creativity is spurred when diverse ideas are united or when creative material in one dimension inspires or forces fresh thinking in another”. However, differences could also bring challenges, as recognised by Bammer (2008, p.877):
The differences between partners cannot be limited to those which progress the partnership. Differences in world-views, motivations and ways of doing things will also provide potential sources of unproductive conflict. Managers of research collaboration therefore have to deal with two categories of differences – integrating diverse relevant contributions and ameliorating problems arising from attributes which are incidental to the partnership.

In relation to the differences that people bring to collaboration, the choice of appointing appropriate individuals to collaborations was also highlighted by some authors (including Austin & Baldwin 1992, Huxham & Vangen 2005).

In contrast to the emphasis on individuals within collaboration, I found that many texts did not conceptualise the doers in terms of people. Rather, collaboration was depicted as occurring between amalgamations of people or collective entities, including organisations, (e.g. Logson 1991; Ranade & Hudson 2003; Cummings & Kiesler 2005), research communities (e.g. Bordons, Zulueta, Romero et al. 1999; Bougrain & Haudeville 2002), disciplines (e.g. Reese & Sontag 2001; Lowe & Phillipson 2009), and agencies (e.g. Selden, Sowa & Sandfort 2006). Differences between collective entities, in terms of organisation, discipline or agency characteristics, were framed as having the potential to create value as well as provide challenges (e.g. Selden et al. 2006). A number of texts explored collaborative issues in terms of socialised characteristics of groups. For example, Abramson and Mizrahi (1996, p.280) concluded that “the differences we identified in perspectives [of collaboration] between the two professions [of social work and medicine] support the importance of understanding the distinct socialization experiences of each profession”. Thus, exploring collaboration between professional discipline groups contributed to understandings of the implications of professional socialisation.

It was interesting to note that the division between particular individuals and collective entities was blurred in some texts, with an unacknowledged interweaving of the two interpreted views of people. At times this resulted in ambiguous collaborating entities. For example, in Westley and Vredenburg’s (1991) focus on collaborative relationships between organisations, key individuals were credited with instigating and developing collaboration. It was unclear from this research whether collaboration depended on organisational characteristics (such as processes, structures and roles) or individual qualities, or a combination of both. Longoria (2005) did not differentiate between individuals and organisations as collaborating entities; he proposed that relationships
were a key component of collaborations and these relationships could be between individuals, groups, organisations or societies. With the understandings of who is collaborating blurred, it was unclear what role particular people as individuals played in collaboration, and in developing and maintaining relationships between organisations.

In contrast, some authors acknowledged ambiguities. For example Katz and Martin (1997, p.9) noted that although “it is people who collaborate, not institutions”, policies related to collaboration were often aimed at interactions between higher levels of departments, organisation, sectors and geographical regions. Other authors, such as Kinnaman and Bleich (2004), avoided such ambiguities by articulating the relationship between disciplines and individuals. These authors stated that collaboration occurred between people who “are of different disciplines, organizational ranks or institutional settings” (Kinnaman & Bleich (2004, p.311). Similarly Creamer (2003) recognised that individuals represented disciplines, but proposed that a rigid or blind tenacity to discipline loyalty could inhibit the achievement of a synthetic conceptual framework with other collaborators.

On the basis of my interpretation of people involved in collaboration, I propose that where collaboration is viewed as occurring between collective entities, there is a risk of people being viewed as interchangeable contributors to the collaboration in relation to the organisations or disciplines they represent. In such situations insufficient attention might be given to developing interpersonal relationships; the focus might not be on individuals who are collaborating but rather on the characteristics of the discipline or organisation they represent. Thus the way people are conceptualised in collaboration can have relevance to the provision of resources to support collaboration and to the time allocated to developing relationships and scope for individual agency.

**Summary Box 4.1: People**

- **Particular individuals** bring their personal qualities as well as the perspectives and conventions from their organisation and their discipline socialisation.
- **Collective entities** [e.g. (people in) groups, disciplines] bring to the collaboration socialised ways of knowing from and characteristics of organisation, discipline or agency and acting.
- **Appointments** (i.e. addition of staff) to the collaboration can be on the basis of individual qualities or related to representation of particular disciplines, organisation or agencies.

55 Note that this claim relates to team members’ contribution to the dynamics of collaboration rather than the fulfilment of their discipline role. When physiotherapists are rostered to replace each other in a ward team, for example, it is appropriate that their physiotherapist roles be interchangeable.
ii) Place of collaboration: contextual continua and demarcated territories

The place deals with the “where” of collaboration in terms of its socially situated location and place in the organisational structure. The dimension of place, as described in the texts, was interpreted in terms of the interrelatedness of the collaborative entity (e.g. team) with its wider organisational and societal environment. I conceptualised this interrelatedness along a spectrum: at one end was the notion of contextual continua, in which collaboration was embedded and related to wider contexts; and at the other end of the spectrum were demarcated territories, where collaborative entities were viewed in relative isolation of their wider contexts.

Texts describing collaboration in relation to contextual continua highlighted the importance of the wider environment. In these texts collaboration was influenced by background contextual factors including government policy, legislation, financial constraints (Salmon & Faris 2006; D’Amour et al. 2008), strategic contexts of other organisations (Ariño & Torre 1998), disciplinary and departmental boundaries, community values (Briggs 1997b) and the knowledge ecosystem in which the collaboration was undertaken (Pennington 2008). Evans and Brooks (2005) argued that social issues and organisational structures were embedded in practice and influenced the ways people interacted with each other. Pasquero (1991, p.61) contended that collaboration processes were integral to “larger social processes, of which they are simultaneously causes, effects, and elements”. Intrapersonal, social, physical environmental, and organisational factors were portrayed by Stokols, Harvey, Gress et al. (2005, p.204) as antecedent conditions that “influence collaborative ‘readiness’ of research teams and centers”, in their working model of scientific collaboration.

In contrast to the recognition of collaboration as embedded in the values, practices and structures of the wider environment, collaboration was presented in some texts as occurring within demarcated territories, most commonly in teams with defined boundaries. Patel, Cytryn, Shortliffe et al. (2000) explored collaborative roles and interactions between health professionals in a clearly defined primary care unit team.
without reference to the complexities of the wider collaborative context. The notion of collaboration occurring in demarcated boundaries tended to be used for measuring and monitoring collaborative processes and outcomes. For example, in measuring nurse-physician collaboration in intensive care units, Higgins (1999, p.1436) claimed that “organizational and managerial influences were controlled methodologically by the use of one site”. However, when evaluating the benefits of using delineated protocols and guidelines to improve interprofessional collaboration in discharge planning, Atwal and Caldwell (2002, p.366) observed that health professionals were still subjected to organisational pressures and constraints: “few organisations find themselves in an environment that is not in a consistent state of flux”. Through this observation, these authors acknowledged a limitation of viewing collaboration in isolation from its wider contexts. Thus, I argue that despite researchers’ and/or management’s desire or need to view collaboration in relation to demarcated territories, it is difficult to segregate collaboration from its wider contexts, including embodied values and practices.

Acknowledging collaboration in relation to its wider contextual continua allowed the complexity of collaboration to be embraced. However, the lack of circumspection of the phenomenon provided challenges for those seeking to control (and/or understand) collaboration through monitoring and measuring. It could be argued that although a more defined view might be required for these purposes, it is important that the need for demarcation of the collaborative context does not lead to a simplified overall view of collaboration, particularly in relation to unexamined assumptions about values and practice, and lack of acknowledgement of the influence of contextual factors.

Summary Box 4.2: Place

- Being embedded in wider social and organisational contexts, collaboration operates in a contextual continuum, and is influenced by contextual factors (e.g. community values, financial constraints, and organisation and discipline cultures and territories).
- Measuring collaborations and treating people as simply replaceable members of groups in demarcated territories risks overlooking the complexity of the contextual influences.
iii) **Purposes of collaboration: instigators and outcomes**

**Question Box 4.5**

The questions informing this phase of the dialogue (with the first text set) were:

“*What is sought from collaboration?*”

“*What/who are the instigators of collaboration?*”

“*What are the implications of evaluating collaborative outcomes?*”

In literature related to collaboration, *purposes* were concerned with the “why”, and often related to the instigators and intention of collaboration. The multifaceted nature of this dimension was identified. The purposes of collaboration, as described in the texts, related to both *instigators* and *nature of expected change*. I interpreted the instigators as being either internal to the collaboration or located externally; that is, some collaborations were initiated by those wishing to collaborate whereas others were associated with *external* triggers or drivers. The nature of the expected changes also differed. At one end of the spectrum of expected change was *synergy* (where the outcomes could not necessarily be predicted at the beginning of the collaboration and innovation was commonly sought) and at the other end was *coordination* (where particular outcomes were anticipated and planned in advance and control was valued). This dimension was further enriched by collaborations often having multiple (and at time unexpected) outcomes. Ascertaining success could be problematic. For example, the measurement or evaluation of success was challenging in terms of which outcomes would be measured; those that were the most meaningful or those that were easiest to measure?

Internally instigated collaborations resulted from individuals identifying common purposes and taking initiatives. Such collaborations tended to originate from individuals seeking to work together and taking responsibility for doing so in a mutually advantageous manner. For example, the research collaboration of Eisenhart and Borko (1991, p.139) was based on a “curiosity about each other’s discipline” that led them to develop their collaborative relationship. In this type of instigation, effort of individuals involved in the collaboration was often required to overcome contextual challenges presented by organisational structures and lack of resources. As noted by Schmitt (2001, p.62), “Too often the implementation of collaboration has to depend on individual
professional commitments strong enough to overcome institutional barriers”. Similarly, the successful collaboration between two universities described by Flanigan, Payne, Simmons et al. (2009, p. S59) was “rooted in the individual commitment of key investigators who shared a common goal that transcended institutional allegiances”. In that instance, the collaboration began among a few, subsequently involving others as the project expanded and developed a supportive infrastructure, thus moving from internal to external instigation over time.

Inherent in texts describing external instigators was the notion that the responsibility for initiating collaboration lay primarily with others, often through management directives or policy; that is, the collaboration was required or driven by outside motivation and resources. External triggers described in texts included organisational incentives to collaborate with co-workers (Cummings & Kielser 2005; Kezar 2005), funding for specific collaborative activities or projects (Bordons et al. 1999; Pfaffly, Baher, Jones et al. 2003, Selden et al. 2006), supportive legislation (Sohlberg, McLaughlin, Todis et al. 2001) and the collaboration itself being a research intervention (Gilbert, Roughhead, Beilby et al. 2002). Encouraging participation was a challenge for some externally driven collaborations. Kezar (2005), for example, reported that mission statements, new norms of operating, supportive networks and rewards, and leaders were required in higher education organisations to change campus members’ attitudes towards collaboration.

In terms of the outcomes of collaboration, different expectations for change were evident in texts. For many authors, synergy rather than coordination was a key factor identifying the practice as collaboration. Kanter (1994, p.97), for example, contended that collaboration involved “creating new value together” rather than being a “mere exchange (getting something back for what you put in)”. Peters and Armstrong (1998, p.75) represented this extra value in collaborative learning as “1+1=3”, and explained that the synergistic element reflected the collectives’ contribution.

Synergistic outcomes of collaboration took different, though interrelated forms, including creativity (e.g. Austin & Baldwin 1992; John-Steiner 2000; Uzzi & Spiro 2005; Sawyer 2007), learning (e.g. Ariño & Torre 1998; Evans & Brooks 2005; Stahl 2005), personal development (e.g. Bennett 2004), competitive advantage (e.g. Sharfman, 2005),

56 Collectives in this case refers to those involved in collaboration, rather than the collective entities that individuals may represent.
Gray, Yan 1991; Liedtka, 1996), problem solving (e.g. Pasquero 1991; Shoffner & Briggs 2001; Kinnaman & Bleich 2004; Ramsey 2008) and innovation (e.g. Paulus & Nijstad 2003; Kinnaman & Bleich 2004; Cummings & Kiesler 2005; Stokols et al. 2005). Some texts described interrelationships between these forms of synergy. Sawyer (2007, p.7), for example, argued that collaboration “drives creativity because innovation always emerges from a series of sparks – never from a single flash of insight”. Creativity was framed as involving new ways of thinking and learning from others. John-Steiner (2000, p.3) described this as follows: “generative ideas emerge from joint thinking, from significant conversations, and from sustained, shared struggles to achieve new insights from partners in thought”. Liedtka (1996) highlighted the learning that occurred when participants in collaboration brought questions that drew on the wisdom of others rather than simply seeking solutions.

Varying degrees of synergy were also sought from collaboration. Roberts and Bradley (1991, p.220) proposed the notions of radical and incremental innovation in relation to collaboration for public policy innovation. Radical innovation was applicable to organisations described by Evans and Wolf (2005, p.96), where collaboration was “unleashed” to “break through traditional organisation barriers”; whereas continual problem solving was more consistent with incremental innovation. Parker-Oliver, Bronstein and Kurzejeski (2005), for example, highlighted the ongoing nature of problem solving in health professional collaboration.

Although a predominant focus on synergistic outcomes was noted, coordination with an underlying premise of integration and cooperation was evident in some texts. For example, Selden et al. (2006, p.419) identified collaboration between early child care centres as “a sound management strategy for bringing in more resources to better support and promote greater satisfaction among staff”. For Uzzi and Spiro (2005, p.458), collaboration between artists in a musical production enabled them to “simultaneously incorporate their separate material into a single, seamless production”. For these authors it appeared that innovation and creativity were not important outcomes of collaboration; rather, they focused explicitly on bringing together resources and structures. The importance of collaboration having clear purposes and outcomes was acknowledged by a number of authors. Longoria (2005, p.135) cautioned against “overzealously embracing a vague notion of interorganizational collaboration” without a clear understanding of outcomes, and Hansen (2009) urged companies to determine whether the costs of collaboration outweighed the gains.
Determining clarity of purpose, however, was not necessarily straightforward, and the extent to which authors acknowledged multiple and interrelated purposes varied. Some texts focused on a single overarching purpose of collaboration for particular stakeholders, such as scientists’ research publication productivity (Yoshikane & Kageura 2004; Lee & Bozeman 2005); others focused on a range of interrelated purposes. For example, Katz and Martin (1997) proposed that scientific collaborations promoted effective use of skills, transfer of knowledge, development of new insights, provision of intellectual companionship and enhanced visibility of findings.

Determining whether purposes of collaboration had been achieved was described as problematic by a number of authors, particularly those who recognised multiple interrelated purposes of collaboration. In relation to interprofessional collaboration in health, Schmitt (2001) identified a large number of possible outcome measures, including measures of processes (such as leadership, communication, co-ordination and problem-solving), outcomes of care (including decreased morbidity, mortality, adverse events and length of time receiving care), patient functional abilities (for example self care and health promoting behaviours), and patient and family satisfaction, staff satisfaction, staff retention, cost, and policies promoting collaboration. She expressed insightful concerns about measuring these numerous possible outcomes:

Outcomes assessed often have been convenient, rather than theoretically related to the nature of the health problems being treated and the team resources available to address the problem ... in most studies of the effectiveness of interprofessional teams, the focus has been on short-term effectiveness, either related to differences at discharge or within a few weeks or months of discharge.

(Schmitt 2001, p.53)

Challenges for measuring collaborative outcomes were also noted by Dillenbourg et al. (1996) who deliberated on whether the effects of collaborative learning should be measured in relation to individual or collective learning. However, the approach of other authors did not indicate that they shared this awareness of the complexity of measuring outcomes of collaboration. For example Bordons et al. (1999) measured interdisciplinary research collaboration simply in terms of papers published. I contend that reliance on such simplistic measures of collaboration effectiveness overlook the multifaceted and contextualised nature of collaboration.
Issues related to the purposes of collaboration are complex. From my dialogue it appeared that collaboration required a balance of resource support that often accompanied external triggers of collaboration and the “ownership” of collaboration that tended to be integral to internal instigations of collaboration. For example, ideally, encouraging collaborative research through funding would occur alongside researchers’ desire to collaborate with each other. Further, where the collaboration has multiple outcomes, those who are collaborating might have difficulty establishing shared understandings and expectations. For example, some research collaborators might primarily seek to co-author publications, whereas others might aim that their findings were used to change practice. Moreover, the common need to measure collaborative outcomes may not capture what people consider to be most important. When measurable outcomes are the preferred focus for collaboration (for example, articles published and resources used) the value of the more ambiguous and subjective outcomes of creativity, insights, learning and problem-solving might be overlooked.

### Summary Box 4.3: Purpose

- The instigation of collaboration does not necessarily coincide with the availability of resources and support. For example, **internally instigated** collaborations may have committed collaborators but limited resources, and **externally instigated** collaborations may have adequate resources but participants might need encouragement.
- **Synergistic outcomes** can be creative and unexpected, and **integrative outcomes** can be intended, controlled and more measurable.

### iv) Processes used in collaboration: relationships and interactions

#### Question Box 4.6

The questions informing this dialogue (with the first text set) were:

"What aspects of collaborative processes are important for successful collaboration?"

"What factors underpin or facilitate these processes?"

Processes are about “how things get done”. The descriptions of processes in the texts were commonly presented in terms of relationships and interactions. These relationships and interactions tended to be shaped and directed by people and the collaborative structures within which they worked. Qualities people brought with them to collaborations and qualities developed between people during collaborative processes influenced the nature of relationships. **Prescribed** and **chosen** forms of communication
guided peoples’ interactions. Chosen forms were those that evolved in response to particular self-initiated collaborative situations, whereas prescribed communication tended to be organisationally structured and determined.

Relationships between collaborating participants were reported in the literature to be integral to collaboration. Hutchings, Hall and Loveday (2003, p.27) contended that the fundamental building blocks of collaboration were interpersonal relationships: “only the persons involved ultimately determine whether or not collaboration and partnership occurs”. According to a number of authors the quality of relationships positively influenced the nature of collaboration (e.g. Liedtka 1996; Ariño & Torre 1998; Shoffnez & Briggs 2001; Epstein 2005). The need to develop relationships was acknowledged in a number of texts. For example, Svendsen (1998, p.137) claimed that attaining a “‘collaborative mind’ doesn’t happen after one or two meetings, but requires an extended period of building mutual understanding, developing shared values and interests”. Time and proximity were considered important for the development of productive collaborative relationships (e.g. Lindeke & Block 1998; Epstein 2005; Moffitt, Mordoch & Wells et al. 2009). For example, Lindeke and Block (1998, p.216) claimed “it is difficult to know others as persons beyond professional symbols without shared space and time”.

Power differences and inequality were identified as inhibitors for developing collaborative relationships (e.g. Reese & Sontag 2001; Ramsey 2008). In relation to interdisciplinary activities in health care, Lindeke and Block (1998, p.215) explained that “participants are imbued with positional power that may be symbolic of their profession, their gender, or their socioeconomic class”. Braye and Preston-Shoot (2000, p.146) explained that power needed to be managed “in a manner which empowers colleagues and users alike” and proposed that the transfer of power requires “a willingness to cede, not just share control ... [and] an ability to identify, value and use their power and authority” (p.146). Addressing issues relating to the power differentials and the transfer of power between disciplines was identified as important for collaboration.

The personal qualities of willingness to work with others, respect, trust and mutuality were fundamental components of successful collaborative relationships (Arslanian-Engoren 1995; Hill, Bartol, Tesluk et al. 2009; Thomson & Perry 2006). Willingness to work with others, a quality that people brought to collaborations (Epstein 2005), related
to sharing information, accepting others’ differing interests, and monitoring their own and others’ compliance with the collaborations agreed ways of working (Thomson & Perry 2006). Opinions differed as to whether the notion of respect was brought to collaboration or developed within it. For example, Hawrluck, Espin, Garwook et al. (2002) noted that respect for other health professional roles could be taught at undergraduate level in preparation for teamwork. The view of respect as a unidimensional construct, capable of being explicitly taught and implemented, risks inappropriately simplifying this complex construct and lived reality. Although respect for other professions can be introduced during discipline socialisation, it also needs to be developed through positive experiences working with other professions.

Trust and mutuality were viewed in some texts as developing at the same time as collaborative relationships are being established. For example, Patel et al. (2000) claimed that trust had to be built, and Purnell (2008, p.98) proposed that “trust is not a given, but has to be established”. Time and face-to-face interactions were important for those collaborating to develop trust in each other (Hill et al. 2009). Hutchings et al. (2003) highlighted the value of “time, effort and productive outcomes” for deepening and enriching trust. Mutuality facilitated common understandings between collaborators (Abramson & Mizahi 1996; Hill et al. 2009). In health care teams, D’Amour et al. (2005, p.127) described the development of trust and respect as the “construction of a team life”. Young (2004) claimed that collaborative relationships developed as participants let go of their personal needs. Respect and mutuality were also identified as capable of reducing differences in power and equality among those collaborating (Ranade & Hudson 2003). Although authors differed in the degree of complexity with which they viewed respect, trust and mutuality, they were unanimous in the framing of these constructs as positive and enabling requirements of collaboration.

In contrast, the roles of conflict and autonomy within collaborative relationships tended to be viewed more ambiguously. At times there was a lack of clarity as to whether these concepts were enablers or constrainers, and whether they related to the individual or the collective entity the individual represented. Dillenbourg et al. (1996) clearly conceptualised conflict as having both positive and negative roles in collaboration. They articulated different forms of conflict: (a) social conflict unrelated to the collaborative purpose, such as criticism and name-calling, that was constraining to collaboration; and (b) cognitive conflict that facilitated collaboration through valuing the differing perspectives people brought to the collaboration. In contrast, a completely negative view
of conflict was presented by Nijhuis, Reinders-Messelink, de Blécourt, Olijve et al. (2007), who proposed that conflict impeded communication and needed to be resolved.

Autonomy, although not a well-defined or conceptually clear notion in texts, tended to be presented as an important characteristic of collaboration. Ranade and Hudson (2003) and Boon et al. (2009) noted that threats to autonomy could be a barrier to collaboration, and Wood and Gray (1991, p.148) presented autonomy as a condition of collaboration in their claim that “if stakeholders relinquish all autonomy, a different organizational form is created – a merger, perhaps, but not a collaboration”. On the other hand, D’Amour, et al. (2005) proposed that health professionals needed to be independent rather than autonomous, and Thomson and Perry (2006, p.26) viewed autonomy in relation to the dual identity of collaborative partners where “they maintain their own distinct identities and organizational authority separate from (though simultaneously with) the collaborative identity”. The inherent complexities of the notions of conflict and autonomy in collaboration raised questions about the extent to which shared understandings of these multifaceted constructs could be assumed (are these authors talking about the same thing?), and highlighted the different understandings and conceptualisations of collaboration that people bring to collaborative situations.

Positive relationships within collaborations were often viewed as the basis of personal or collective growth, particularly in relation to reflection. Roberts and Bradley (1991) reported that reflexive, self-evolving, collective interactions among stakeholders involved in policy development were experienced in terms of a growth experience. Ferrier-Kerr (2003) described situations in teaching where critical reflective journals facilitated collaborative professional relationships and individual learning. Time to reflect and learn from others was an important element for developing collaborative working skills in collaborative online learning projects described by Bennett (2004). Reflection, engendering deeper understandings of intentions, purposes, actions and values, and ultimately reliant on individuals’ insight and reflective capabilities, needs to be encouraged and facilitated; it cannot be prescribed.

Prescribed interactions were frequently explored in terms of organised and predictable modes of communication. Regular team meetings and clear lines of communication were identified as important means of maintaining clear communication in collaborative research described by Clark, Dunbar, Aycock et al. (2009). Formal team training was claimed to improve collaboration in intensive care units (Despins 2009). Sohlberg et al.
(2001, p.508) proposed that collaboration between clinicians and clients could be aided by practitioners being provided with standard “easy to use procedures” to incorporate into their ongoing work with clients and families. Similarly, coordination and reproducibility was apparent in a collaborative service delivery model developed for general practitioners and pharmacists that was based on a flow-chart style model with “standard forms for documenting relevant patient information, reports and action plans” (Gilbert et al. 2002, p.189). Processes that supported equality were also considered important for collaboration (e.g. Reese & Sontag 2001; Nijhuis et al. 2007; Ramsey 2008). Adiyta and Ramakrishna’s (2007, p.8) proposal that effective communication processes should be measured in terms of “the number of violations in responding to email, attending meetings, or following up action points within agreed timeframes” was evidence of their emphasis on systematic prescribed communication in collaboration.

However, although organised means of communication provided a framework to guide and monitor interactions, over-reliance on prescribed processes could limit the scope and agency for adapting to particular situations and maximising individual qualities. Supporting this claim was the identification by Hinojosa, Bedell, Buchholz et al. (2001, p.209) of difficulties experienced in developing collaborative practices in clinical settings “when bureaucracy determines the amount and type of interaction that takes place”. Similarly Kanter (1994, p.97) noted that collaborative alliances “cannot be ‘controlled’ by formal systems but require a dense web of interpersonal connections and internal infrastructures that enhance learning”.

I consider that chosen interactions incorporate self-directed processes (introduced informally by those who are collaborating) and are based on relationships (underpinned by complex notions and practices such as respect, trust and mutuality). These chosen, self-directed interactions received less attention in the literature but were alluded to by a number of authors in terms of their unifying purpose and social nature. For example, Hinojosa et al. (2001, p.215) noted the importance of a range of spontaneous social-style interactions aimed at “trying to get along” that included “aspects of humor, empathy, caring, and attempts to accept one another’s perspectives and unique skills”. These interactions were also employed when people needed to be responsive to rapidly changing situations. Hawryluck, Espin, Garwook et al. (2002) and Lingard et al. (2004) referred to a range of informal situationally responsive negotiations in their descriptions of interprofessional collaboration in an intensive care unit. Thomson and Perry (2006,
p.25) recognised the complementary nature of self-directed and prescribed interactions in their proposal that:

the key to getting things done in a collaborative setting rests in finding the right combination of administrative capacity (through coordination and elements of hierarchy) and social capacity to build relationships.

Summary Box 4.4: Processes

- The source and ownership of collaboration influences the nature and outcomes of collaboration. For example:
  a) **Chosen communication** strategies are founded on personal qualities (such as willingness to work with others, respect, trust and mutuality) and requiring resources (such as time and proximity), and they facilitate collaborations in rapidly changing situations.
  b) **Prescribed interaction** approaches provide a framework to guide interactions and enable communication to be organised and predictable, but may not be sufficiently flexible for changing situations.
- Different views of the roles of conflict and autonomy may hinder shared understanding of collaborative processes.

4.3.3 Collaboration in the health care literature: Text Set 2

This section deals with text set two. I begin by exploring the scope and nature of organisational support for patient-centred collaboration. I then introduce and explain two interpreted modes of collaboration (*ordered* and *organic*). These build on the ideas of prescribed and chosen process approaches/frameworks introduced above. *Ordered* collaboration was featured in texts where the motivation was to plan, resource and evaluate collaboration (e.g. to ensure efficiency and cost-effectiveness) and address discipline-related issues systematically (such as dealing with discipline power imbalances and clarifying territory boundaries). This mode of collaboration is predominantly predictable, controllable and measurable in nature. *Organic* collaboration values the uniqueness of individuals and responds to the dynamic, complex nature of contexts. It is less recognisable than the more formal ordered mode of collaboration, and can be difficult to predict, control or measure. In the next section I contextualise these *ordered* and *organic* modes of collaboration in the health care and rehabilitation literature in relation to PPPP dimensions of collaboration. The section concludes by considering how people in rehabilitation teams work within both *ordered* and *organic* collaboration to provide quality patient-centred health care.
In this interpretive dialogue with text set two I sought to answer the remaining three research questions for Study A:

- According to the literature, what is the nature of collaboration in health care (including in rehabilitation teams)?
- How can collaboration contribute to patient-centred health care?
- What organisational support is required for collaboration to flourish and effectively contribute to patient-centred health care?

a) Organisational influences on collaboration

**Question Box 4.7**

The initial question informing my dialogue with the second text set was:

“**What influences does the organisation (and the people working at different levels of health care) have on collaboration?”**

“**What is the nature of this influence?”**

In my initial question and answer dialogue with the second text set I explored the scope for and nature of organisational influences on and support for collaboration. The importance of organisational influences on collaboration is well recognised in the literature (e.g. Strasser, Falconer & Martino-Saltzmann 1994; Strasser, Smits & Falconer 2002; Bloor 2006; Sinclair, Lingard & Mohabeer 2009). Some texts focused on the organisational culture of team (e.g. Strasser et al. 2002; Bloor 2006); others considered the organisational context as contributing to the multitude of factors influencing teamwork (e.g. Suddick & De Souza, 2006; Sinclair et al. 2009). Bourgeault and Mulvale (2006) addressed the issue of organisational influences specifically and in detail. They described multi-level factors that facilitated or impeded collaborative models of health care in terms of:

(a) *macro* factors (for example, regulations around scope of practice, liability and funding issues);

(b) *meso* factors (such as education and organisational arrangements); and

(c) *micro* factors operating within teams (including interpersonal relations between team members and their experiences with teamwork).

These authors highlighted the importance of coordinated action by professional, managerial and governmental bodies across these multi-level factors. While concurring
with Bourgeault and Mulvale’s categorisation of levels of influence (as macro, meso and micro factors), I framed these levels of influence in relation to agentic\textsuperscript{57} individuals: that is, people working at governance and policy level (macro or broad context); people involved in discipline socialisation and education level (meso or health care setting level); and people working at interpersonal level to deliver collaborative health care (micro or team situations). I explored texts to interpret how people at these different levels of influence supported/impeded collaboration and how agency for such influence was framed.

\textit{i) Governance and policy (broad policy context of health care)}

A short feature article in an Australian medical indemnity insurance company newsletter provided an example of influence on collaboration at a legislative regulation level that recognised collaborators as having agency over their actions and decisions. In this article the CEO/Managing Director (MD) indicated her conceptual support for patient-centred collaboration in the statement “we understand the importance of effective collaboration in the delivery of high-quality patient care” (Anderson 2010, p.1). Besides this general support were some “practical tips” provided by this CEO/MD addressing pragmatic issues from a litigation perspective, such as reminders of the importance of taking responsibility for situationally appropriate actions, of working within the legislated scope of practice, and of being clear about communication expectations and role obligations. These practical tips included recognition that collaboration differed from situation to situation, for example “[consider] what will happen in the event that either you or your collaborator are absent for any reason, (...) [and consider] the challenges that [communicating] over distances represents”. Anderson recognised that these practical tips were “not an exhaustive list, but it is a useful starting point”. By incorporating the different needs of particular types of health care (such as general practice and midwifery health care settings) and situations (in relation to considering particular health professionals’ circumstances and individual patient’s needs) this legislative level text framed support for collaboration as an interplay of issues related to “inflexible” legislation and “flexible” people working with personal agency in particular settings and situations.

\textsuperscript{57} Bandura’s social cognitive theory outlined in 4.3.2 how people control these actions and shape their environments.
Governance and policy support for collaboration was evidenced in many publications by the NSW Department of Health, with a number of these publications referring to or implying the importance of multifaceted support. For example, the NSW Department of Health’s (2007) policy directive for collaboration in delivering human services explicitly outlined (a) mandatory requirements for formal agreements between different sections of the NSW health care context (including the NSW Department of Health, Area Health Services and Ambulance Service of NSW, Divisions of General Practice and Public Health Units), (b) principles of collaboration that emphasised the importance of relationships, communication and shared understandings in each of the numerous collaborative situations within health care, and (c) practical guidelines for collaboration that focused on continuous improvement of collaboration.

Within the broad scope of this policy directive, unresolved tensions between different intentions were identified. Tension was evident between the intention to achieve flexibility, situational responsiveness and patient-centredness and the expectation of measurable efficiency. The directive stated that “a ‘test’ of collaboration is whether ‘front line’ staff are empowered and resourced to work flexibly across agency boundaries so services are customised to meet client and community needs” (2007, p.3) but also stated that “performance indicators [are] to be used to determine how effective the collaboration is” (p.6). Suitable performance indicators to evaluate collaboration were not suggested, nor was it clear whether the focus of evaluation should relate to staff (such as the extent of their empowerments) or the services provided (such as the extent they met the needs of clients and community). Furthermore, a number of issues relating to the complexities of collaboration remained unexamined and unresolved, such as the time taken to develop relationships in contrast with the expectations of efficiency associated with measurable efficiency. This text demonstrated good intentions by policy setters in terms of supporting collaboration. Yet despite the directive’s good intentions there was scope for understanding more deeply the impact of these policies on those who were collaborating, such as the effect of predetermined performance indicators on collaborators’ agency to provide situationally appropriate patient-centred collaborative care.

**ii) Discipline socialisation and education (education and health care settings)**

There was evidence of different levels of influence on collaboration and varied scope for collaborative agency in many texts dealing with the education and socialisation of health
professionals. A physician training program\(^{58}\) (The Royal Australasian College of Physicians 2009) provided an example of how discipline leaders could support education and socialisation for patient-centred collaborative practice in health care settings. In this program the learning objectives reflected the goal of preparing physicians for communicating effectively in multidisciplinary teams. The trainee physician was expected to be able to:

- manage “time pressures, environment and personal factors that may affect communication”;
- identify and mediate “differences between health care workers, patients and carers”;
- use “conflict resolution skills to facilitate team interactions”; 
- give “clear verbal and written communication”; and
- manage “barriers to effective communication” (p.26).

The vast body of literature relating to interprofessional education commonly recognised the importance of (a) support for collaboration from educational organisations and discipline bodies, and (b) interactions between educational programs, discipline governance issues and individuals’ various capabilities. For example, Barr’s (2003) stance that interprofessional education provided an important means of preparing health professionals for collaboration in health care teams was widely acknowledged and valued across the literature. Underpinning this stance was an awareness of the need for standards and regulation of health professional disciplines, and for educational programs to be suited to their particular situations. Barr (2003, p.276) highlighted the importance of having a range of educational approaches available: “No one approach (to interprofessional education) has all the answers; together they offer a promising repertoire.” Barr (2003, p.267) also cautioned that sound individual capabilities and suitable discipline body governance were integral to the development of health professionals’ reciprocal attitudes towards one another:

> The risk remains that exposing one group to another may serve only to confirm prejudices and stereotypes. Attitudes and behaviours unacceptable to others, deficits in knowledge and skill, weakness in professional codes and disciplinary process, all or any of these may be exposed with implications for the governance

\(^{58}\) In Australia, specialist qualifications for medical practice are undertaken through colleges governed by the profession, the largest of which is the Royal Australian College of Physicians.
of the professions, their regulation and education, which students and teachers can do little or nothing to resolve.

In recognising the importance of supporting collaboration at educational and discipline governance level in an interrelated people-centred manner, Barr also raised the issue of educators’ and students’ minimal agency over discipline governance, and the resulting vulnerability for collaboration. This minimal agency highlighted the scope for, and importance of, discipline leaders recognising the impact of discipline governance on education for collaborative patient-centred care.

**iii) Interpersonal interactions (responding to specific situations)**

The importance of opportunities to develop situationally appropriate relationships and meaningful interpersonal interactions was explored in earlier sections of this chapter. For example, in Section 4.3.2, time, relationships between team members and sound communication were highlighted as important for collaboration. Subtle interplays between different levels of influence on collaboration are needed to ensure the provision of adequate staffing and resources (that is, policy and management support) and facilitation of interpersonal skills (that is, educational and management support) for developing such relationships and communication capabilities.

In support of the notion of relationship-centred care,⁵⁹ Safran, Miller and Beckman (2006) recognised clinician-colleague (including administrators) influence on patient-centred collaborative care. Administrators were viewed as real people and as individuals, rather than just position-holders or part of a faceless entity. The authors emphasised the need for the following qualities in interactions between administrators and clinicians:

- **mindfulness** (awareness of self and others);
- **diversity of mental models** (valuing multiple ways of knowing);
- **heedful interrelating** (being aware of how one works in relation to others);
- **a mix of rich and lean communication** (for example, combining elaborate face-to-face communication with simple emails);
- **a mix of social and task related interactions** (blending work and non-work related conservation);

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⁵⁹ The body of literature explaining and exploring relationship-centred care (based on Tresolini and the Pwe-Fetzer Task Force 1994) emphasises the importance of networks of relationships in health care.
• mutual respect (characterised by “honesty, tactfulness and valuing of each other’s contributions”); and

• trust (represented by judging that others are capable and committed) (2006, p.S12).

Personal agency and scope for developing relationships between people working at different levels of health care are assumed characteristics in this text.

The importance of time in patient-centred care reflects the challenge practitioners face in balancing the needs of efficient health care and satisfying/fulfilling health care experiences. For example, a patient’s poignant quote from the research of Mangset, Erling Dahl, Førde et al. (2008, p.830) exploring elderly stroke patients’ satisfaction with rehabilitation highlighted the importance of staff’s busyness not precluding time to interact with and care for their patients:

I’d say they don’t listen to us. Not at all. They shut their ears when they pass by: “I haven’t got time now, I’ve got to do this and now I’ve got to do that.” It’s as though they look back on us when they have passed [and say]: “Oh, thank God, she didn’t ask me for anything.” We’ve laughed at that many times. Then she’d walk past without saying anything or she passed me without me saying anything. (Patient 3, first interview). (italics in original)

There was no sense in this quote of patients being at the centre of health care; rather, they seemed to feel that interactions with them were not prioritised. Further, the apparent absence of compassion demonstrated by practitioners for their patients in this scenario highlighted its importance to patient-centred health care. However, without their points of view being represented in this publication, it was difficult to understand staff members’ perceptions of this apparently non-compassionate (and hence I propose non-patient-centred) style of health care.

Shea and Lionis (2010, p.2) grappled with the complex issue of compassion in health care. They considered some of the interrelated influences on compassion, particularly contextual and educational issues. In relation to rural areas (but perhaps equally relevant to other health care settings), they highlighted the importance of, and challenges to, health care team members being compassionate to each other and their patients, and proposed:

To provide compassion requires support and receipt of compassion oneself, at a “team-work” level and at an “organisational” level in addition to clinical and communication skills. ... It is perhaps not surprising in the light of a changing
world ... coupled with time pressure, organisational structures, and resource issues, that the attention to basic human needs, and preservation of human dignity can be overlooked.

These texts appealed for a valuing of the people involved in providing health care and their relationships with each other and with their patients.

**iv) Reflecting on organisational influences**

Not unexpectedly, organisational influences on collaboration were identified in the literature as broad in scope and multifaceted and interrelated in nature. The texts explored in this section highlight the broad responsibility of organisations for ensuring that organisational structures and social environments are supportive of patient-centred collaboration. This responsibility need not just lie with practitioners working directly with patients and carers; it needs also to include other people working across the health care system and related education organisations.

**b) Introducing ordered and organic modes of collaboration**

<table>
<thead>
<tr>
<th>Question Box 4.8</th>
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<tbody>
<tr>
<td>The questions informing this dialogue (with the second text set) were:</td>
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<tr>
<td>“What modes of collaboration are practised and/or supported?”</td>
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</table>

On examination of my interpretations of the PPPP dimensions (from text set one) in terms of the scope for multifaceted and interrelated organisational support for collaboration, I observed that collaboration was portrayed in the literature as having:

- varying degrees of acknowledgement of the clarity of the collaborating structure and embeddedness of collaboration in its wider social environment (*place*);
- different views regarding whether individuals, collectives and their related organisational and discipline entities were the enactors of collaboration (*people*);
- a range of complexities within the reasons for and function of collaboration, in terms of how collaboration was initiated (external or internal instigators) and the different degrees of synergy and multiple outcomes sought (*purpose*);
- different views on the roles of communications structures (to direct or facilitate interactions) and the degree to which relationships were integral to communication (*process*).

I noted that features within these dimensions tended to have an *ordered* or an *organic* nature, reflecting the various authors’ frames of reference and models of
Features that leaned towards an organic nature (that is, individuals collaborating through evolving relationships in contextual continua for synergic purposes) corresponded to my view of collaboration as an internally motivated and motivating process. Recognised in organic collaboration were the notions of variability, agency and need for particularity of people, processes and purposes. Also recognised was the embeddedness of people, actions, goals and outcomes in places that were more than inert and depersonalised locations and sets of resources. Organic modes of collaboration enable the uncertainties of health care to be embraced and provide scope for dealing with different collaborative needs that arise from patients’ various situations. They allow for genuine respect, trust and mutuality to develop between the collaborators, and for collaboration to be volitional and situationally relevant. It could be argued, however, that this organic collaboration might benefit from some preparatory and systematic structure as well as resources (such as time and opportunities to communication) to facilitate the development of relationships between collaborators.

Those elements with an ordered tendency (that is, externally decreed collaboration occurring between collective entities through structured processes in demarcated territories for the purpose of coordinating or integrating differences) relied on a different concept, in which people’s complexities were not at the forefront and conformity was expected. It appeared that ordered collaboration tended to suit situations where predictable organisational support was sought. Processes and purposes could be pre-planned, and could be explicitly evaluated and resourced for teams with clear structures. People were seen primarily in relation to the disciplines (or organisations) they represented. Support for ordered collaboration involved identifying expected outcomes for collaboration and facilitating the development of delineated teams and ways for representatives of discipline groups to interact in those teams to achieve the expected outcomes. Yet this mode of collaboration may be insufficient for collaboration to be embedded in and connected to the collaborators’ workplace situations and cultures.

To draw on the strength of both modes (and avoid the extremes of either), I argue that optimally supporting collaboration for patient-centred health care requires widespread consideration. All who have the potential and capacity to influence collaboration need to be aware of the different intentions and practice realities inherent in ordered and organic collaboration. People are not obliged to conceptualise or approach collaboration in the same way, but they need to be aware of the implications of their approaches to collaboration for those at the centre of health care, that is, the health professionals and
the patients. Through my interpretation of text set two, I identified the potential for people working at different levels of influence within health care organisations to support patient-centred health care by being aware of the contributions made by both ordered and organic modes of collaboration.

The PPPP dimensions of collaboration provided a useful framework for contextualising and understanding the modes of collaboration in health care and the support they required. In recognising the importance of people being able to respond appropriately to their particular context or place in health care I concur with Higgs, Hunt et al. (1999), who argued that we need a social ecology strategy for health care that places “people concerns, holistic care and preventive health at the centre of the healthcare agenda”. They contended that:

healthcare does not and cannot operate in isolation from the many local and global forces impacting on people’s lives and environments (...) [social ecology] recognises the particular shortcomings of the ubiquitous economic rationalist approach, overlaid by a medical model with a managerial mode of healthcare, or “social market” approach in addressing local or global health problems. Instead, social ecology is based on the premise that we have to focus on the relationship between humanity, community and the environment to achieve optimal social outcomes (p.21).

Giddens’ theory of structuration (1986, 1993) also underpins my stance that collaboration is influenced by the structures and systems within which people work as they manage, provide and receive health care. Giddens claimed that social structures and actions of individuals were created and reinforced by their social environments, and that humans were bounded by unconscious and unacknowledged or unintended reproductions of these systems and structures. Consistent with this notion, in my next dialogue with text set two I explored the modes of collaboration embedded within the systems and structures in which people work. These modes were evident in the ways collaboration was framed and explored, rather than necessarily explicitly promoted and endorsed by particular people or groups of people within the health care system.
c) Contextualising modes of collaboration in relation to PPPP dimensions

Question Box 4.9
The questions informing this dialogue (with the second text set) were:

“What are the implications of different modes of collaboration (in relation to organisations and teams) for providing patient-centred health care?”

In the following sections I explain the findings of my exploration of health care and rehabilitation literature in terms of the PPPP dimensions of collaboration, and describe the implications of working within ordered and organic modes of collaboration. Different intentions for driving collaboration are highlighted. These intentions include achieving efficiency in health services, maintaining discipline territories, complying with policy directives, facilitating personal and professional development and seeking to work in meaningful patient-centred ways. Practice realities involve complying with the need for financial accountability and legislated scopes of practice, and dealing with staff shortages, hierarchies, discipline territories, challenging individuals, dynamic contexts and time pressures. These intentions and practice realities shape the different modes of collaboration that are sought, supported and practised: that is, explicit, predictable and measurable ordered modes, and evolving and responsive organic modes.

The PPPP dimensions of collaboration provide the context for the interpretation of modes of collaboration; that is, people (as disciplines and individuals representing those disciplines), places (in terms of delineated and evolving groups within their wider societal and organisational contexts), processes (the communication opportunities and their underpinning structures and relationships), and purposes (both the internal and external instigators driving collaboration and the coordination and synergy that are sought).

i) Place: Delineated teams and evolving networks

Question Box 4.10
The question informing this dialogue (with the second text set) was:

“In relation to practising and supporting patient-centred collaborative health care, what are the implications of framing the place of collaboration (in terms of varying clarity of team structures and embeddedness in the wider social and organisational contexts)?”
The *place* dimension relates to where collaboration takes place: in *delineated teams* as a managed entity and/or in more ambiguous, less visible *evolving networks* and *groups*. Although management support for *ordered* collaboration is important for providing the organisational structures that promote collaboration, *organic* modes widen the “stage” of collaboration to include groups and evolving networks, and in doing so contribute important insights into the complex ways of people working together in health care and how they can be supported to do so.

In relation to team structures, *ordered* collaboration has particular value for developing and resourcing teams with visible boundaries and stable membership. Lasker and the Committee on Medicine and Public Health at The New York Academy of Medicine (1997, p.42) explained, “it is difficult to put collaboration into practice without organizational structures that can bring together the perspectives, resources, and skills of diverse health professionals and organizations”. However, in health care practice collaboration is not necessarily confined to the organisational structures of teams. By expanding collaboration past the confines of *ordered* health teams structures, *organic* approaches enable collaboration to occur in multiple places beyond formally structured teams, such as informal groups, partnerships and networks. In this way, the personal agency and capabilities of particular health professionals to develop collaborations can be elucidated and facilitated.

**Place: Delineated teams**

Evident in the texts were a number of frameworks, models and theories for policy-makers and managers to facilitate *ordered* modes of collaboration. *Ordered* modes commonly focused on establishing clearly defined teams and creating structures that promoted delineated roles and effective teamwork. Common management strategies that I identified for facilitating teams with such roles and teamwork reflected those presented in a range of texts such as Firth-Cozens 1998; Latella 2000; Hutchings et al. 2003; Hyrkäs & Appelqvist-Schmidlechner 2003; Harris, Harris & Johnstone 2006; Blankenship & Elsworth 2006. These strategies included:

a) effective leadership to encourage non-hierarchical relationships for open communication, establish shared purposes, deal with conflict and facilitate shared decision-making;

b) an adequate mix of people to take on different team roles; and

c) sufficient time for interactions, such as regularly scheduled team meetings.
The identification of key requirements for effective teams provides management guidelines for establishing and resourcing health care teams. One example of a set of requirements is shown in Table 4.5. Requirements included defining goals, developing clinical systems, dividing up roles and tasks, providing training, and setting up structures for communication. This example illustrates typical requirements for components of teams to be sustainable, visible and able to be imposed.

Table 4.5 Key team requirements for effective health care teams
(Summarised from Grumbach & Bodenheimer 2004, p.1249)

<table>
<thead>
<tr>
<th>Defined goals</th>
<th>Overall organisational mission statement (e.g. improvement of patient’s health and staff satisfaction)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Specific measurable operational objectives (e.g. length of time before appointment, achieving explicitly defined goal for personal development)</td>
</tr>
<tr>
<td>Systems</td>
<td>Clinical systems (e.g. procedures of informing patients of results)</td>
</tr>
<tr>
<td></td>
<td>Administrative systems (e.g. policies on how decisions are made)</td>
</tr>
<tr>
<td>Division of labour</td>
<td>Definition of tasks</td>
</tr>
<tr>
<td></td>
<td>Assignment of tasks (e.g. which people perform which roles)</td>
</tr>
<tr>
<td>Training</td>
<td>Training for specific roles</td>
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<tr>
<td></td>
<td>Cross-training for substitution for vacations or times of heavy demand on one part of team</td>
</tr>
<tr>
<td>Communication</td>
<td>Communication structures (e.g. routine paper and electronic communication flow)</td>
</tr>
<tr>
<td></td>
<td>Communication processes (e.g. giving feedback and conflict resolution)</td>
</tr>
</tbody>
</table>

Individual team members’ different roles in supporting team dynamics and function, such as team roles as outlined by Belbin\(^{60}\) (1993), were identified in the literature as contributing to effective teamwork (e.g. Leathard 2003; Martin & Rogers 2004; Harris et al. 2006). A number of texts (e.g. Farrell, Schmitt & Heinemann 2001; Hope, Lugassy, Meyer et al. 2005; Ivanitskanya, Glazer & Erofeev 2009) used the oft-cited stages of team development (proposed by Tuckman 1965 and updated in 1977 by Tuckman & Jensen) as a basis for enabling newly formed teams to become cohesive in their purposes and ways of working. These five stages were *forming, storming, norming, performing* and *adjourning (or mourning)*.

- In the *forming* stage, the purpose and rules of the group are established and team members become known to each other, and roles are assigned.

\(^{60}\) In the 1970s Dr Meredith Belbin described nine clusters of behaviour or “Team Roles”, that influenced team dynamics, with individuals displaying different team roles to varying degrees. Team roles’ labels and characteristics were: plant (creative problem solver), resource investigator (extrovert, enthusiastic communicator), co-ordinator (mature, confident chairperson), shaper (team member who thrives on pressure and challenges), monitor evaluator (strategic discerning team member), teamworker (co-operative, perceptive diplomat), implementer (reliable, efficient team member), completer finisher (conscientious perfectionist), and specialist (single-minded, dedicated team member).
- In the *storming* stage, purposes, team rules and roles are challenged and hidden agendas are revealed.
- In the *norming* stage, the team develops a sense of identity and clarity of roles and consensus emerges.
- In the *performing* stage, previous stages are completed and the team moves to optimum performance and achievement of purpose.
- Once the team has achieved its purpose it enters the *adjourning* (or mourning) stage.

Although stages of team development were applied or advocated in a number of texts (including Farrell et al. 2001; Hope et al. 2005; Ivanitskanya et al. 2009), the fluidity of team membership and core and expanded groups within teams (noted by Latella 2000; Lingard et al. 2004; Harris et al. 2006) challenges the relevance of these stages for all teams. Thus, although it could be argued that active promotion of team development is a worthwhile pursuit for newly formed health care teams, these notions might not be as useful in clinical practice where teams may lack particular starting dates, stable membership and clear boundaries. In such teams, expectations for progression past the stage of *forming* during their development might often be optimistic. Lingard, Gotlib Conn, Russell et al. (2007) responded to the need for team members to get to know each other in situations with high staff turnover by implementing a protocol for learning team members’ names, roles and scopes of practice. This example of a structured protocol with potential to facilitate personal interactions was required due to the teams’ numerous (re-)beginnings.

It became evident during ongoing interpretation of text set two literature that the implementation of frameworks and guidelines for effective teamwork might not be straightforward or even applicable to all health care teams. Even within delineated teams, many health professionals work within time pressures and staff shortages which can limit their capacity to work together optimally (Hutchings et al. 2003; Reeves & Lewin 2004). With shortages of health professionals, particularly in rural areas (Wilson, Couper, De Vries et al. 2009), the goal of ensuring adequate discipline representation in teams can be problematic for some team managers. Health professionals in teams may also have divided loyalties to their organisation, team and discipline (Enderby 2002; Smits, Falconer, Herrin et al. 2003) which can limit their team participation (e.g. attendance at meetings).
In health care teams, the influence of organisational cultures, structures and processes on team members’ status and legitimised ways of working (Scott & Thurston 2004), including the medical profession’s dominance within health care systems (Murphy & McDonald 2004; Irvine, Kerridge, McPhee et al. 2002; Willis 2006; Bourgeault & Mulvale 2006) could limit the leader’s ability to establish non-hierarchical relationships (Harris et al. 2006). Further, Clark, Cott and Drinka (2007 p.596) proposed that “if the values of the organization are heavily weighted toward short-term economics, resources will not be directed at those factors critical for effective teamwork”.

A tendency was noted in a number of texts to overlook the ambiguous, dynamic nature of health teams, erroneously simplifying their nature. The framing of teams by many researchers (including Hyrkäs & Appelqvist-Schidlechner 2003; Leggat 2007) did not incorporate the aspect of teams having transient members. Some researchers chose to explore only the stable components of teams. For example Baggs et al. (2004) studied the stable “core” team of decision-makers within a patient care team. Others (e.g. Bower, Campbell, Bojke et al. 2003; Carpenter, Schneider, Brandon et al. 2003; Petersson 2005; Sheehan et al. 2007) did not clarify whether their conceptualisation of team referred to an entity of disciplines or the individuals who comprised it. Carpenter et al. (2003, p.1997) and Sheehan et al. (2007, p. 20) explored “well-established teams” but omitted to clarify if this meant that all team members had been working together throughout that time, or if the team entity had been in existence for a period of time with individual team members moving through it. Harris and colleagues (2006, p.139) provided guidelines for managing groups with “legitimate standing”, rather than informal groups, which they claimed were aimed at meeting the needs of individual group members.

Proponents of the systems theory model of inputs, processes and outputs61 (e.g. Mickan & Rodger 2000b; Harris et al. 2006; Strasser, Uomoto & Smits 2008) and authors focusing on organisational characteristics (e.g. Boaden & Leaviss 2000) tended to concentrate on teams’ complexity in terms of their contexts and requirements, rather than teams’ stability and boundaries. In their health care team management guidelines, Harris and colleagues (2006, p.148) acknowledged problems with lack of team stability, but offered no strategies for dealing with these scenarios apart from the suggestion “that managers should avoid disturbing membership, once settled, if at all possible”.

61 A diagram representing systems theory is shown in Appendix 1.
However, as the aim of avoiding team instability was not dominant in these authors’ text, it is difficult to ascertain whether they overlooked this aspect of health care teams or whether it was beyond the scope of their guidelines.

*Ordered* collaboration can support patient-centred health care by providing structures and frameworks for bringing people together (particularly those who might not otherwise have the opportunity) to address the needs of particular patients. However, those who focused on health care teams as visible stable entities with *ordered* modes of collaboration tended to overlook the dynamic and flexible nature of teams in health. In order to adequately resource and support the range of collaborative structures encountered in health care, *ordered* modes of collaboration need to encompass broader ideas of teams.

**Place: Evolving groups and networks**

Indeterminate networks and informal groups (or entities considered to go beyond the conventional managerial notions of teams) were evident in the literature. Although these groups might be obvious to those collaborating within them, it can be argued that their informal and transient nature can render them less visible (than teams with clear designations and boundaries) to policy-makers, discipline and health care management. Thus, support and resourcing for such informal groups and networks could be overlooked by people working at these levels of influence and might rely primarily on health professionals’ capabilities to use *organic* collaboration.

There were a number of different examples of non-delineated health care teams in text set two. Some authors dealt with complex team boundaries by incorporating the notion of networks extending from teams. These networks tended to have a temporal and opportunistic nature. For Benner (1984), a nursing team could extend temporally into the next shift. An observer in her research noted “when the team relationship among shifts is established, the next shift can be relied on to help out when the current shift can longer cope” (p.151). In the multidisciplinary team described by Kvarnström and Cedersund (2006) membership was opportunistically expanded when certain types of expertise were required. Being a member of a team also opened access to others’ professional networks (Cook, Gerrish & Clarke 2001).

Readily identifiable teams did not appear to be the predominant focus of explorations of collaborative practice. A number of authors focused on the practice and experience of collaboration rather than specifically labelling the collaborative entities they were
studying (e.g. Sullivan 1998b; Way, Jones, Baskerville et al. 2001; Sohlberg et al. 2001; Schaible, Thomlinson & Susan 2004; Todahl et al. 2006). Partnerships between health professionals rather than teams were the focus of authors such as Coombs (2003), Scott and Thurston (2004) and Sinclair et al. (2009).

Some texts did highlight the potential value of management’s involvement in transient collaborative entities formed to address particular patients’ issues. For example, Willumsen and Skivenes (2005) recommended the use of formal guidelines to facilitate effective participation in groups where membership changed to meet clients’ specific needs. In contrast to this reliance on established management-style team facilitation, some authors promoted a broader view of managers’ and policy makers’ roles for teams. Reeves and Lewin (2004) challenged the relevance of the teamwork as promoted in health care policies. They suggested that “normative models of teamwork need to be replaced in health care policies by forms that are responsive to local ‘cultures’ of collaboration and to the shifting and contested relationships between professional groups” (Reeves & Lewin 2004, p.224). Allen, Lyne and Griffiths (2002, p.301) posed a challenge for policy makers and managers “to create a climate which capitalizes on front-line staff’s willingness to work flexibly in the delivery of services while providing some safeguards against the vulnerabilities of this kind of system”.

Broadening policy and managerial understandings of collaborative entities beyond the conventional notion of teams can provide a platform for supporting and resourcing collaboration in a range of health care situations. Valuing the situationally relevant nature of informal collaborative groups and networks provides scope to be responsive to patients’ needs and recognises the personal agency and capabilities of health professionals to develop such collaborations. By overlooking these groups, organisational policy and management risk de-emphasising role of individual initiative and the importance of flexibility for patient-centred care.

Key features of the modes of collaboration in relation to the place dimension identified from the literature are summarised in Table 4.6.
Table 4.6 Relating modes of collaboration to PPPP dimensions – Place

<table>
<thead>
<tr>
<th>Dimensions of collaboration</th>
<th>Ordered modes of collaboration</th>
<th>Organic modes of collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Place:</strong> delineated teams and evolving networks</td>
<td><strong>Organisational level:</strong> Management can support patient-centred health care by providing structures and frameworks for bringing people together (particularly those who may not otherwise have the opportunity) to address the needs of particular patients and their situations. <strong>Team level:</strong> Collaboration in stable teams with clear boundaries can be facilitated by understanding how teams are formed and developed, and how individuals function effectively in teams.</td>
<td><strong>Organisational level:</strong> Evolving networks may be less visible to management than delineated teams. Support for evolving networks requires management to recognise the complex and flexible ways people work together as they respond to various patients’ needs and situations. <strong>Team level:</strong> Collaboration occurs in many places such as teams, evolving networks, and informal groups of varied nature. These collaborative forms are influenced by the opportunities, practices and cultures of the wider societal contexts. The personal agency and capabilities of particular health professionals to develop collaborations are elucidated and facilitated.</td>
</tr>
</tbody>
</table>

ii) People: Disciplines and individuals

**Question Box 4.11**

The question informing this dialogue (with the second text set) were:

“In relation to practising and supporting patient-centred collaborative health care, what are the implications of framing the people who are collaborating as “particular individuals” and “collective (discipline) entities”?”

Consideration is given in this section to the risk that a focus on disciplinary power differentials in ordered modes of collaboration in health care teams might eclipse the voices of the particular people representing the disciplines. The reason for this concern is that individual practitioners bring to collaborations their unique perspectives (including their attitudes towards, and need for, power), capabilities and experiences (including past experiences of team work); dispositions and qualities that can contribute to, or detract from, collaborative practice. I found in the literature that the value of examining ordered collaboration (in relation to discipline contributions) lay primarily in the capacity provided to explore the impact of power differentials between disciplines, and the guidance generated to address those socialised differentials. However, the degree of complexity within power differentials was not consistently identified, and at times there was a tendency for generalisations about disciplines to overlook the
interpersonal relationships between people in teams and how these relationships can contribute to the functioning and patient-centredness of the team.

I contend that sole reliance on ordered modes of collaboration that encourages a purely disciplinary focus in collaboration can result in situations where there is lack of valuing of the diversity of meanings, ways of working and needs that individuals bring to collaborative situations. Organic modes of collaboration can provide insights into the interplay between discipline and individual in collaborative practices. They also illustrate that some of the power differentials between team members relate to personal (including experience and capability) rather than discipline characteristics.

**People: Discipline affiliation and representation**

Differences between disciplines’ socialised characteristics underpinned many explorations of collaboration in health care teams (e.g. Booth & Hewison 2002; Martin-Rodriguez, Beaulieu, D’Amour et al. 2005; Suter, Arndt, Arthur et al. 2009). Viewing the people involved in collaboration predominantly in terms of their discipline affiliation and representation was common in ordered modes of collaboration.

The importance to collaboration and teamwork of team members’ discipline affiliations and representation roles was evident from the common “discipline-labelled” categorisation of teams (e.g. multidisciplinary and interprofessional). This categorisation related to typical ways that members of the same discipline worked with members of other disciplines and was noted across both ordered and organic modes of collaboration. Various terms were applied to these discipline-related ways of working in the health literature. The terms included multidisciplinary, multiprofessional, interdisciplinary, interprofessional, transdisciplinary and transprofessional. An example of characteristics within these “discipline-labelled” team categorisations is provided in Table 4.7. Although these terms were often used in an imprecise, ambiguous manner with different meanings attributed by different authors (McCallin 2001; Choi & Pak 2006), their use frequently served to maintain focus on collaboration between disciplines. At times this was at the expense of a focus on the individuals and the experience they brought to their discipline roles. Having to deal only with discipline characteristics potentially decreased the complexity of “who” collaboration involved.
Members of different health professions were reported or portrayed as bringing different meanings and models of health to collaboration. These various meanings and models of health were often credited as providing the rationale for collaboration (e.g. Vinicor 1995; Irvine et al. 2002), whereas discipline-related power imbalances, particularly in relation to medical dominance, hierarchies and autonomy issues, were portrayed as impeding collaboration (Rothberg 1981; Baggs & Schmitt 1997; Dowswell, Forster, Young et al. 1999; Gair & Hartery 2001; Irvine et al. 2002; Coombs 2003; Murphy & McDonald 2004; Apker, Propp & Zabava Ford 2005; Reynolds 2005). Scott and Thurston (2004) proposed that the nature of relationships between collaborating partners can be influenced by the hierarchy of status and authority in organisations, the allocation of resources and communication strategies.

Baggs and Schmitt (1997) claimed that power disparity between nurses and doctors could influence perceptions of collaboration; for example doctors saw their brief explanations of decisions as being collaborative whereas nurses saw the doctors’ “talk” as giving orders. It appears that health professionals with lower status (e.g. nurses) and
non-biomedical language and models of practice (e.g. occupational therapists), could be
marginalised, or could perceive themselves to be marginalised, in collaborative practice.

A number of solutions for overcoming these power imbalances were proposed in the
literature, including:

- critiquing factors that perpetuate power imbalances, such as legislated scopes of
  practice, differential funding of disciplines and institutional incentives or
disincentives for collaborative practice (e.g. Bourgeault & Mulvale 2006);
- implementing interprofessional education to increase understandings of others’
  roles (e.g. Hojat, Gonnella, Nasca, Fields et al. 2003; Howarth, Holland & Grant
  2006), taking care not to reinforce the traditional power relationships (Baker,
  Egan-Lee, Martimianakis et al. 2011);
- increasing professional confidence to enable participation (e.g. Kenny 2002);
- basing authority on expertise and knowledge rather than role (Henneman et al.
  1995; Robson & Kitchen 2007)
- ensuring effective team leadership to accommodate power differentials to
  achieve congruence across different professional disciplines. (e.g. Hutchings et
  al. 2003);
- facilitating role clarity to prevent territorial disputes (e.g. Rotheberg 1981); and
- implementing discipline-specific strategies to encourage collaborative practice,
such as Apker and colleagues’ proposal (2005, p.111) that “if physicians truly
  wish for nurses to be more collaborative, they need to communicate those
  expectations more directly when interacting with nursing staff”, and Morse’s
  (2010) claim that doctors needed to have more humility in terms of recognising
  their role in relation to others’ roles.

The numerous solutions for overcoming power issues indicated the multifaceted nature
of power imbalances and hinted at the difficulty as well as the possibility of addressing
them and overcoming them.

Besides the challenges to collaboration provided by medical dominance, I argue that
complexities of power relations are further complicated by (a) the notion that autonomy
needs to be set aside to work with others, (b) hierarchies identified within disciplines
that may require some team members to negotiate within their own profession as well as
with other professions, and (c) differences between individuals within disciplines in
relation to their contexts and in relation to how they relate to and involve other
disciplines.
Autonomy was a discipline-related issue of interest in many texts. Autonomy was presented in the literature as a complex component of interprofessional power relations, and a paradox related to autonomy was evident within texts: discipline autonomy (in relation to scope for independent practice) needed to be present so that it could be set aside for collaborative practice (in which individuals were responsible for implementing their roles in relation to collective decisions). As an attribute of independent practice (Freegard 2006), autonomy was considered a necessary part of collaboration (e.g. Bailey & Armer 1998; Haig & Le Breck 2000; Sheehan et al. 2007). Bailey and Armer (p.229) explained that autonomy in collaborative practice ensured “that individuals are empowered to carry out the plan of care within their respective scopes of practice”. However, Molyneux (2001) highlighted the need to defer professional autonomy when working within blurred discipline boundaries. Working in this way might require health professionals to be “sufficiently confident in their own roles and in their own professional identity” (Molyneux 2001, p.33, citing Laidler 1991) and not too focused on their professional autonomy (Clewley & Bowen-Clewley 2005) in terms of “claiming” the entirety of their scope of practice. Thus it could be argued that while discipline autonomy was brought to collaborations, collaborative practice was reliant on individual health professionals working collectively for the collaboration rather than individually to claim and maintain discipline territories.

Hierarchies within disciplines were identified by a number of authors (e.g. Duffy 1995; Leipzig, Hyer, Ek et al. 2002; Wicke, Coppin & Payne 2004; Apker et al. 2005). Leipzig et al. (p.1146), for example, described the clear chain of authority between doctors in teams from the lower rank of the “medical student, to the interns, the resident, the junior attending physician and senior attending physician”. This challenge to a homogeneous view of disciplines was further reinforced by evidence of differences within disciplines regarding the involvement of other disciplines in decision making. For example, Hall’s (2005 p.191) generalisation that “physicians will not easily listen to a patient’s problem from a nurse or a social worker, but will extract hard data quickly to solve a patients’ problem” was not supported by Abramson and Mizahi’s (2003) findings that some physicians did share responsibility and decision-making with other professional groups, or by a rehabilitation physician’s account of rehabilitation team meetings where “establishing the patient’s viewpoint is an important part of the assessment ... it is often the nurse who can obtain this information most easily and efficiently” (Wade 1999,
Piquette, Reeves and LeBlanc (2009) also claimed that hierarchical styles of interprofessional interactions could be tolerated during times of crisis.

The research of Gair and Hartery (2001) contributed another insight into individual and contextual influences on power imbalances. Recognising medical dominance as a structural feature of health care systems, Gair and Hartery explored this dominance in multidisciplinary teams in a geriatric assessment unit. They identified a “lower than expected degree of medical dominance” despite “the location of the unit (i.e. in a hospital) and the legal accountability of consultants for patient care and safety” (p.9). They wrote (p.9):

The evidence from the study shows that the senior doctor exercised a disproportionate degree of power and influence on certain counts, namely in the chairing of the meeting, but not on other counts, namely overall amount of contribution, types of issues raised and – perhaps most significantly of all – responses to discharge proposals.

Gair and Hartery (2001, p.9) proposed that “interpretations of medical dominance are relative to context and expectations” and provided two main reasons for the lower degree of medical dominance in this context: (a) that “the consultants respected and valued each profession’s contribution, and showed this in their behaviour at team meetings”, and (b) that the team’s stability meant that team members “were comfortable working with one another, valued each other as individuals as well as professionals and were tolerant of disagreement”. Thus, while understandings of discipline power differentials can provide a basis for facilitating interprofessional interactions, care needs to be taken that generalisations about disciplines do not colour collaborative expectations and in turn become self-fulfilling prophecies.

Texts focusing on discipline related issues in collaboration often sought ordered and sustainable/predictable means of addressing autonomy and power differentials. Addressing discipline issues could, however, erroneously imply that collaboration occurred primarily between disciplines, and that individuals were interchangeable members of their disciplines. This implication was problematic. For example, poor communication and lack of clarity of roles were reported as resulting from situations where team members rotated through teams on an interchangeable basis. Miller and Freeman (2003, p.125) outlined collaboration problems caused by (so-called) interchangeable team members: “Nurses on the ward did not know when other professionals would arrive on the ward, nor who they would be ... [and] with the shift
rotation of nurses and the use of ‘bank’ staff, visiting professionals did not know who to go to for advice or information”.

When team members were presented as interchangeable members of disciplines, the influences of professional experience on clinical reasoning and decision making in teams tended not to be acknowledged. For example, Lincoln, Walker, Dixon et al. (2004) noted variations in levels of input from different disciplines in the rehabilitation teams they studied, but did not report if these variations were associated with different levels of experience. Further, when team members were viewed as interchangeable, discipline and individual characteristics tended to be blurred. It could be argued that lack of distinction between discipline and individual characteristics might result in confusion as to solutions to power-based collaborative problems (that is, whether personal qualities or the profession’s scope for autonomy should be addressed), and may also de-value the role of particular people’s collaborative relationships and the role of such relationships to optimal team functioning.

**People: Particular individuals**

Texts with interpreted *organic* modes of collaboration highlighted a variety of individual characteristics that accompanied discipline representation. These *organic* modes of collaboration discussions recognised that, in addition to their socialised discipline perspectives, individuals brought personal meanings and experiences of health to collaborations, along with different ways of interacting, stages of professional development, and temperaments. These differences were reported to increase the potential for diversity within collaborations and influenced the ways in which particular people interacted with each other, their clinical reasoning and decision-making processes. Whittington (2003, p.42) highlighted differences that individuals brought to collaboration in his claim that “people experience and represent themselves as having characteristics and a biography which is not denoted adequately by their professional self alone, or by their membership of a team or organisation”. Gibb, Morrow, Clarke et al. (2002, p.348) framed individuals’ diversity positively and proposed that pooling the diversity of knowledge, skills and practice experiences in teams could be a “resource for team members to draw on to enhance their individual practice or the activity for the whole team”. Appreciating such diversity was claimed to provide a foundation for developing respect between individuals within collaborations (Hutchings et al. 2003).
The beneficial influence of experience was recognised by a few authors, including Dielman, Farris, Feenby et al. (2004), who reported that team members perceived that experience in teams led to better understandings of other disciplines’ perspectives and roles in health care. The notion of different levels of experience is not well dealt with in ordered modes of collaboration. This notion of developing collaborative practice through individuals’ first-hand experiences was supported by Blount, DeGirolamo and Mariani (2006). The influence of individual interactive characteristics on collaboration practice was also recognised by some authors. For instance, Todahl and colleagues (2006) noted that collaboration between therapists and physicians was inhibited by particular therapists being reserved and hesitant, and Ødegård and Strype (2009 p.293) claimed that “individuals vary quite a lot regarding how motivated and willing they are to collaborate”. Long, Kneafsey and Ryan (2003, p.672) found that team members must “want to collaborate”.

Thus, it is argued that by involving discipline and individual factors, collaboration requires both ordered and organic modes of operation. An interplay between these factors was evident in Hudson’s (2007) claim that discipline differences (in such areas as knowledge, status, power, accountability and culture) were inhibitors of interprofessional team work, whereas individual characteristics and experiences (such as value systems, reflective practice, co-location with other disciplines, and working through complex cases with others) could overcome these collaboration barriers or limitations. This view was echoed by Lee (2010, p.55), who stated that “the units are staffed by people with good intentions, but they all have turf to defend – and in the mainstream of American medicine, threatening someone’s turf is a quick path to destructive conflict”. By presenting the individual as having inherent “goodness” and disciplines as being obstructive, these views disregarded the notion of disciplines being constructed by people and under the control of people.

Key features of the modes of collaboration in relation to the people dimension identified from the literature are summarised in Table 4.8.
Table 4.8 Relating modes of collaboration to PPPP dimensions – People

<table>
<thead>
<tr>
<th>Dimensions of collaboration</th>
<th>Ordered modes of collaboration</th>
<th>Organic modes of collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>People</td>
<td>Organisational level: Professional identities and norms of practice can be shaped to facilitate collaboration. Disciplinary power issues can be addressed. Team level: Teams can develop rich understandings of patients’ needs and situations through the different meanings and models of health that disciplines bring to collaborations. The power differentials between disciplines can impede collaboration.</td>
<td>Organisational level: Focus on discipline characteristics can lead to the importance of interpersonal relationships being overlooked. Team level: Collaboration is undertaken in teams (and other collaborative places) by unique individuals. These individuals are socialised into their discipline’s ways of knowing and working, but they also bring their different ways of interacting and their professional and personal experiences to the collaboration. Individual differences can contribute to or impede collaboration.</td>
</tr>
</tbody>
</table>

iii) Purpose: Expected and evolving outcomes

**Question Box 4.12**

The question informing this dialogue (with the second text set) were:

“In relation to practising and supporting patient-centred collaborative health care, what are the implications of framing the purpose/s of collaboration as externally or internally instigated, and as seeking synergistic or integrative outcomes?”

In this section I argue that policy-makers’ and management’s needs for explicit measurement should not overshadow the less visible collaborative outcomes such as innovation (including the development of unique situation-relevant strategies) and learning (arising from the collective decision-making and situational learning that contributes to professionals’ development). *Ordered* modes of operation facilitate collaboration through their focus on measuring service outcomes and integrating different discipline perspectives. These factors reflect policy and structural support for collaboration. In contrast, texts demonstrating *organic* modes of collaboration were more aware of innovation and learning through collaboration (which were often less visible and more difficult to measure) and recognised that some collaborations could be internally initiated.

*Organic modes of collaboration* tended to be more open to exploring implicit intricacies of patient-centred teamwork. For example, Abreu, Zhang, Seales et al. (2002, p.701) explored how the “social fabric and social drama” of interdisciplinary team meetings influenced team members’ perceptions of patients. I propose that including the
flexibility and situational responsiveness inherent in organic modes of operating leads to rich understandings of collaborative purposes and requirements that can inform a sound framework for the pursuit of collaboration in patient-centred health care.

**Purpose: Integration of services and disciplines**

Policy and management directives (external instigators) were commonly identified in the literature as providing the impetus for teamwork (e.g. Kenny 2002, Allen et al. 2002; Reeves & Lewin 2004; Harris et al. 2006; Howarth et al. 2006; Kvarnström & Cedersund 2006; Baxter & Brumfitt 2008). The predominant purpose of policy and management directives for teams and interprofessional practice was reportedly to bring people together to integrate services and discipline perspectives (e.g. McGrath 1993; Smits, Falconer, Herrin et al. 2003). Such integration was presented as a solution to many problems facing health care, including barriers created by professional specialisation, complex patient needs, rising health care costs, and demands for involvement of patients (Suber 1996; Irvine et al. 2002; Levin-Scherz 2010).

Policy and management directives to support collaboration were identified as providing leverage to implement the change needed for increased collaboration. Financial incentives to work with others (e.g. Coleman & Fox 2004; Bourgeault & Mulvale 2006), and meeting and communication protocols (e.g. Haig & LeBreck 2000) have been implemented to provide support for collaboration. Such support, however, needs to contextually and clinically relevant. In evidence of this, Shortus, McKenzie, Kemp et al. (2007) found that despite financial incentives for collaborative care plans for patients with diabetes, health professionals did not perceive that collaboration improved the quality of care the patients received.

Management’s support for collaboration was often reportedly accompanied by a need for explicit evidence that this support was worthwhile. Despite recognition that team complexities are difficult to research (Wieland et al. 1996; Schofield & Amodeo 2004), a number of researchers sought to identify and measure explicit modifiable factors of teamwork (e.g. Haig & LeBreck 2000; Schmitt 2001; Smits, Falconer, Herrin et al. 2003; Strasser et al. 2005; Feldman, Weitz, Merli et al. 2006; Blazeby, Wilson, Metcalfe et al. 2006). However, simplistic views of collaborative processes were common in such research. For example, in their study of multidisciplinary decision-making in cancer teams, Blazeby et al. (2006) measured implementation of team decisions, rather than types of knowledge used or reasoning processes inherent in decisions. Thus it could be
argued that the many tacit qualities of professional practice and the numerous permutations of collaborators, purposes and patient-centred outcomes risk being overlooked where team effectiveness is understood only in terms of measurements.

**Purpose: Synergy, innovation and learning**

A number of texts (e.g. D’Amour & Oandasan 2005) framed collaborative practice as a patient-centred response to specialisation and the division of knowledge between health professions, and justified teams in terms of their contributions to patient care (e.g. Wieland et al. 1996; Wade 1999; Willumsen & Skivenes 2005). The notions of synergy, innovation in relation to decision making, and professional development that arise from learning from others were common ideas in such texts and reflected an organic mode of collaboration.

Collaboration facilitates the provision of different material from which to synthesise and implement new knowledge, ideas and possible courses of action (Opie 1997; Cook et al. 2001; Carpenter et al. 2003, Chatalalsingh & Regehr 2006; Kvarnström and Cedersund 2006) and develop critical and holistic thinking (Irvine et al. 2002). Sullivan (1998b) emphasised that collaboration was underpinned by the notion of transforming. She proposed that collaboration involved a “commitment to change” (p.13) where “disciplinary interests or personal agendas are secondary to the shared goals of the collaborators in a transforming partnership” (p.14). I argue that these outcomes of synergy, critical thinking and transforming are more complex than integration and more difficult to measure. Furthermore, underpinning such collaboration is the importance of health professionals’ agency and desire to transform and learn.

Multidisciplinary team meetings (described by Gagliardi, Wright, Anderson et al. 2007) provided opportunities for professional development through reflective practice. In that research surgeons compared “their proposed treatment with that of the group, and through exposure to decision making for many more cases than they would see in their own practices, … [and] said they developed clinical expertise that could be applied to future cases” (pp. 217-218). Openness to learning was claimed by Dieleman, Farris, Feenby et al. (2004) to be important for collaboration. Tacit qualities of professional practice (as related to professional development and clinical reasoning in teams) were evident in texts focusing on innovation and learning from collaborations. As these qualities can be difficult to measure, I contend that (a) the importance of tacit qualities of professional practice in achieving synergistic outcomes for collaboration needs to be
recognised and (b) a range of strategies to determine team effectiveness in all its complexities is required.

Key features of the modes of collaboration in relation to the *purpose* dimension identified from the literature are summarised in Table 4.9.

Table 4.9 Relating modes of collaboration to PPPP dimensions – Purpose

<table>
<thead>
<tr>
<th>Dimensions of collaboration</th>
<th>Ordered modes of collaboration</th>
<th>Organic modes of collaboration</th>
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<tr>
<td><strong>Purpose</strong>: integration of services and synergy/innovation</td>
<td>Organisational level: Policy support for collaboration is accompanied by a need for explicit evidence that such support is worthwhile. Team level: Teams are formed and resourced by management for explicit purposes.</td>
<td>Organisational level: In seeking measurable outcomes (to justify supporting collaboration) management can overlook the importance of patient-centred outcomes (that are specific for each patient). Team level: Internally instigated collaborations in teams (and other collaborative places) tend to be specific for particular people and situations. Synergistic, innovative and evolving outcomes can be sought.</td>
</tr>
</tbody>
</table>

iv) Processes: Prescribed interactions and chosen communication

**Question Box 4.13**

The question informing this dialogue (with the second text set) was:

“In relation to practising and supporting patient-centred collaborative health care, what are the implications of framing collaboration **processes** in terms of prescribed and chosen communication?”

In this section I argue that the “doing” of collaboration requires (a) that people bring appropriate personal qualities to collaboration and have sufficient opportunities to develop capabilities for interpersonal communication during collaboration, and (b) that organisations should provide appropriate guidance for structured, systematic interactions while also enabling people to determine situationally responsive ways of communicating. Texts describing *ordered* modes of collaboration tended to focus on prescribed structured processes, whereas those reporting *organic* modes of collaboration chose and adopted flexible interactions and communication that supported evolving relationships.

Inherent within the different modes of collaboration are the notions of impetus and control. In *ordered* modes of collaboration the impetus and control for collaborative processes tend to be external to the collaboration. In *organic* modes, the communication
processes and relationships that occur are not necessarily developed on command; rather they are chosen and/or evolve through shared experiences. I argue that a broad view of prescribed interactions, chosen communication processes and evolving relationships, developed through meaningful interactions, is necessary to understand the scope of the processes involved in collaboration in health care teams.

**Processes: Prescribed interactions and structured communication**

Texts portraying *ordered* modes of collaboration commonly emphasised the need for capabilities for effective communication, leadership competencies and prescribed, expected, structured communication processes. No text disputed the relevance of communication in collaboration and teamwork, and support for the importance of communication in collaboration was abundantly evident. This support tended to be explicitly provided. For example, a number of authors deemed training of communication skills important for collaboration and teamwork (e.g. Shumway 2004; Thomas, Sexton & Helmreich 2003; Blount et al. 2006; Harris et al. 2006; Eldar, Marineck & Kullmann 2008; McIntosh 2009). Simulated team communication training (Harris et al. 2006; McIntosh 2009), a structured team training intervention (Stevens, Strasser & Uomoto 2007) and training of team leadership skills were proposed as strategies to improve team performance (Feldman et al. 2006; Alleyne & Olawale Jumaa 2007; Higgs, Ajjawi, McAllister et al. 2008).

Prescribed interactions and structured communication processes during team meetings were also claimed to be effective strategies to encourage participation, to ensure that all critical areas of concern were covered, and to enhance collaboration (e.g. Haig & LeBreck 2000; Roelofsen, The, Beckerman et al. 2002). Participants in the research of Mullins, Balderson, Sanders et al. (1997) suggested that an increase in the number of team meetings would improve teamwork. Other formal opportunities for team communication, such as ward rounds, were also recognised. For instance, Weber, Stöckli, Nübling et al. (2007) concluded that explicitly structured communication helped overcome the chaotic manner in which information was presented during ward rounds and enabled patients to participate more readily.

A focus on prescribed interactions and structured communication processes, accompanied by a preference for visible, measurable procedures and resources that could be managed and monitored, was evident in literature related to managing health care resources (e.g. Joint Commission Resources 2008). This interest in explicit,
measurable procedures often extended to integrated care pathways as a model for collaborative practice. The multidisciplinary focus of these pathways was deemed to promote teamwork, encourage communication between disciplines, and (importantly for management), provide “complete accessible data collection for multidisciplinary audit as an integral part of clinical care, which encourages changes in practice” (Whittle & Hewison 2007, p.301). Not all studies, however, supported the use of integrated care pathways to improve collaboration. Atwal and Caldwell (2002) explored the improvement of interprofessional collaboration through an integrated care pathway for people with hip fractures, and found that “although integrated care pathways led to improved outcomes for the health trust there was little evidence to suggest that interprofessional relationships and communication were enhanced” (p.360). This finding highlighted the risk of relying solely on structured communication for collaborative practice. The contribution of integrated pathways for the team’s valuing of patients as individual with will, agency and preferences was unclear.

Awareness of the benefits of unstructured opportunities for communication was also evident within some texts describing ordered modes of collaboration. For instance, along with resources such as time for meetings, procedures for information flow, clerical assistance, technological support to solicit and share information, and financial resources to support team decisions, some managers recognised that the human side of teamwork also needed consideration: “periodic social time, and personal contact should be planned when resources are allocated” (Joint Commission Resources 2008, p.32). It could be argued that managements’ need to measure and control is inappropriate for organic social interactions in workplaces.

Processes: Chosen interactions and evolving relationships

The importance of chosen interactions and evolving relationships alongside prescribed opportunities for communication was highlighted in many texts with a predominant focus on organic modes of collaboration. Ellingson (2003, p.93), for instance, identified “dynamic communication outside of meetings among dyads and triads of team members in a web-like organization” in an interdisciplinary geriatric oncology team. Similarly Todahl et al. (2006, p.54) noted that “collaboration is most often spontaneous (e.g. in the hallway when time allows)”. The power of informal systems for exchanging information

62 Health trust refers to health care services provided in the UK by the National Health Scheme (http://www.nhs.uk)
about patients and making decisions was also highlighted by Baxter and Brumfitt (2008). Similarly, Sheehan and colleagues (2007) identified the value of team members’ sharing of patient information in regular team meetings, informal morning meetings and frequent discussions in the corridors.

A key difference was noted, however, between ordered and organic modes of collaboration. In ordered modes, the control for interactions and communication processes tended to be located externally: others took responsibility for prescribing, training and structuring. In contrast, team members in organic modes were portrayed as having agency and responsibility to choose communication processes and to ensure that those processes suited the needs of their own and their patients’ current situations. Integral to teamwork, for example, were the “organic development and constant adjustment” of opportunistic interactions (Ellingson 2003, p.110) and “salient shifts in the standard or explicit process of information work between members of different health care professions” (Lingard et al. 2007, p.664).

Besides informal communication processes, the development of relationships, trust and respect tended to be portrayed in the literature as unstructured and evolving. These universally valued attributes were underpinned by individuals’ willingness to work with others. For example, Allen et al. (2002, p.300) identified the importance of the “willingness of providers of health and social care to work together to manage intra- and interprofessional and interagency boundaries”. Martin-Rodriguez et al. (2005, p.145) stated that “collaboration [for patient-centred care] is essentially an interpersonal process that requires the presence of a series of elements in the relationships between the professionals in a team. These include a willingness to collaborate, trust in each other, mutual respect and communication”. It could be argued that the quality of willingness relates more to individuals’ internal impetus than management’s external impetus, and thus needs to be enabled rather than decreed.

Many authors articulated the importance of relationships in collaboration (e.g. Tresolini & the Pew-Fetzer Task Force 1994; Sullivan 1998b; Cook et al. 2001; Molyneux 2001; Allen et al. 2002; Hyrkäs & Appelqvist-Schmidlechner 2003). Scott and Thurston (2004, p.499) emphasised that “collaboration was shaped by relational practice” and Braithwaite, Iedma and Jorm (2007, p.356) claimed that “trusting relationships and open communication [are] the normal glue that makes well-performing organisations work”. Relationships were also presented as fragile entities that developed through time,
appropriate social climate and opportunities to work together (e.g. Blue & Fitzgerald 2002). Social interactions facilitated relationship building between nurses and doctors in rural areas (Blue & Fitzgerald 2002). Dieleman, Farris, Feenby et al. (2004, p.78) found that collaboration entailed “taking the time to be comfortable with other enhanced communication”. Sinclair and colleagues (2009, p.1200) noted in the rehabilitation team they studied that “with fewer staff rotating in and out, deep relationships seemed to develop between professionals, supporting trust-based interactions”.

For many authors, trust, mutuality and respect were intertwined with relationships. Daniel (1998, p.220) proposed that trust in professional disciplines was “a rational feeling which helps us deal with uncertainties, difficulties and dangers”. Clark and colleagues (2007, p.593) claimed that individuals had an obligation “to develop knowledge of oneself and competency in one’s own discipline as the basis for mutual respect among the professions on the team”. It could be argued that trust between individuals in health care collaborations might begin with a view of trust in team members’ professions, but trust between individuals develops through communication, time and shared experiences. In support of the notion of trust not being a given, Hutchings et al. (2003, p.129) proposed that, rather than being requirements of how one person should behave towards another, trust and respect needed to be established, and that demonstrating respect towards team members and patients entailed “valuing the many different ways colleagues may frame and interpret a problem or propose a clinical intervention”.

Kvarnström and Cedersund (2006) noted teams’ use of the pronoun “we” to indicate a notion of trusting support. Sheehan and colleagues (2007, p. 28) proposed that “team attitude” was a distinguishing feature of collaborative teams, and that such attitudes can be “developed, maintained and strengthened at least partly through language and communication patterns within the team”. Further, they proposed that collaborative teams might need to be “experienced to be appreciated” (p.29) and that without experiencing collaboration there may be little awareness of this way of operating. Sullivan’s (1998b, p.14) emphasis on relationships was evident from his claim that in collaborative practice “people like each other”.

Yet relationships do not need to be harmonious to be constructive. For example, McDaniel and Lanham (2009, p.217) cautioned managers to “resist the temptation to foster a climate of consensus as tension and conflict can be sources of creativity” and
suggested that diverse points of view could “seed informed conversations”. Further, not all relationships within teams are necessarily constructive. Sinclair et al. (2009, p.1198) identified alliances within teams that developed through closer relationships between some team members than others, noting one participant’s view that “these alliances also created divisions, such as the distinction between clinicians focused on treating the physical needs of patients and those whose focus was more on psychosocial needs”.

Although informal organic communication, relationships, trust and respect are not easy attributes to train or measure, I argue that they are inherently important to collaboration, and this importance should not be overlooked. Without the guidance of prescribed structured processes to frame collaboration, however, it could be argued that team members with less status in the team due to their discipline or experience, or who may not have developed strong relationships with other team members, may have fewer opportunities to participate in decision making. Thus I propose that effective communication for collaboration requires (a) a balance of prescribed and organic communication and (b) opportunities to develop relationships.

Key features of the modes of collaboration in relation to the processes dimension identified from the literature are summarised in Table 4.10.

Table 4.10 Relating modes of collaboration to PPPP dimensions – Process

<table>
<thead>
<tr>
<th>Dimensions of collaboration</th>
<th>Ordered modes of collaboration</th>
<th>Organic modes of collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processes: prescribed interactions and chosen communication</td>
<td>Organisational level: Predetermined, trainable, reproducible and/or measurable communication strategies can be explicitly and systematically developed. Team level: Team members receive training in communication for prescribed interactions. Structured opportunities for communication can facilitate team members’ participation.</td>
<td>Organisational level: The nuances of informal communication may not be recognised by management’s focus on explicit reproducible strategies. Team level: Interpersonal relationships provide an important basis for communication. Communication and relationships tend to (a) evolve in teams (and other collaborative places) through shared experiences and (b) be chosen (in order to be situationally specific). Interpersonal relationships provide an important basis for communication.</td>
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</table>

**d) Working within ordered and organic modes of collaboration**

**Question Box 4.14**

The main question informing this dialogue was:

“How can different modes of collaboration contribute to patient-centred rehabilitation?”
From the contextualisation of the PPPP dimensions in health care and rehabilitation in this interpretation of text set two, it was apparent that both the *ordered* and *organic* modes of collaboration had the potential to contribute positively to patient-centred collaboration. Yet inherent within these modes were competing interests and motivations that could simultaneously detract from collaborative practice.

**i) Value and limitations of different modes of collaboration**

I found that *ordered* modes of collaboration typically demonstrated organisational commitment and support in terms of structures, frameworks and resources. However, a predominant interest in the measurable and predictable aspects of health care shown in *ordered* modes collaboration could lead to support for mechanistic systems in which individuals were largely unrecognised. *Ordered* approaches to shaping professional identities and norms of practice had the potential to decrease the structural embeddedness of biomedical dominance and to facilitate the involvement of a range of different professions in collaborations. Yet concentrating on discipline characteristics could overshadow the individuality of the particular contextualised people within the discipline, and seeking to protect professional territories could narrow the collaborative focus. By maintaining the focus on individuals and their interpersonal relationships, *organic* modes of collaboration provided a frame of reference for people who wanted (and pursued) choice and agency to interact and work responsively with each other, while seeking and evolving outcomes for mutual benefit (including patient-centred care and professional development). However, a sole focus on individuals could risk collaboration becoming meaningless to wider organisational purposes, being inadequately resourced, or having an undue focus on the “wrong” people (such as staff at the expense of patients).

From my interpretation of text set two, I argue that collaboration is facilitated by:

- *ordered* modes of collaboration providing (a) a frame of reference for organisational support and commitments that enable people to work constructively together, and (b) the basis for valuing and encouraging people’s different contributions in terms of their discipline’s socialised understandings of health and ways of working together;

- *organic* modes of collaboration ensuring that (a) patients’ changing situations and needs are at the centre of the collaboration, (b) the individuals providing health care are recognised for their individuality and embeddedness in the cultural context, and (c) relationships between collaborators are valued.
Neither mode appeared sufficient alone for patient-centred collaboration in health care, but a potential tension arising from an oppositional relationship between the modes was apparent. This tension was realised when ordered modes overpowered organic modes of collaboration. I argue that an intertwining of both modes is key to collaboration being situationally responsive and patient-centred.

ii) Collaboration for patient-centred care in rehabilitation teams

Using rehabilitation teams as the setting for collaboration, this section explores how intertwining ordered and organic modes of collaboration can contribute to patient-centred care in rehabilitation teams. I begin by critiquing texts with a predominant focus on ordered (and measurable) modes of collaboration. The obvious “fit” of management’s needs for measurement and accountability with the scope provided by quantitative research for delivering numerical information is noted. Following a brief discussion of this predominantly singular approach, I contrast this approach to the intertwined approach. An intertwined approach was evident in texts describing how people collaborating worked within both ordered and organic modes of collaboration to deliver patient-centred care. Qualitative research provided appropriate strategies for exploring the complexities of collaboration without being constrained by the need to use numbers. The implications of single and intertwined modes of collaboration are discussed.

Management’s need for order and measurement may be served at the expense of understanding the complexities of organic collaboration. This was evident in the research projects seeking to understand team functioning (by measuring team attributes) and identify attributes of collaboration (so that their presence could be measured, explicitly taught and evaluated). In these instances, complexities of interpersonal interactions, relationships and patient-centredness tended to be simplified for the sake of measurement, yet the suitability of measuring complex attributes was not addressed.

Quantitative research methods appeared to be well suited to management’s need for ordered modes of collaboration. Mullins et al. (1997, p.283), for example, noted “the lack of a well-established measure of team functioning” and designed their own tool. They did not explore the reasons for this lack. Then, although noting that their tool’s

63 As outlined in Chapter 1, people require rehabilitation for a range of reasons e.g. cardiopulmonary rehabilitation and rehabilitation for mental health and behavioural difficulties. The focus in this thesis is neuromusculoskeletal rehabilitation. I noted that many texts on person-centredness related to mental health rehabilitation, and some of those texts are also included in this section.
survey measurement format was a limitation of the study, they concluded that further evaluation with this tool was needed. This uncritical reliance on measuring resonates with Mazlow’s well-known quote, “When the only tool you have is a hammer, every problem begins to resemble a nail”.64

More recently, other researchers have shown a similar uncritical reliance on measurement for understanding collaboration. For example, in their proposal for 29 elements to be used as a guideline and checklist for teams and empirical research related to collaboration, Nijhuis et al. (2007, p.197), identified “power, commitment, conflict, time” as some of the key elements, yet did not critique their abstract nature in relation to their suitability for measurements. Similarly ignoring limitations of measurement, Strasser et al. (2005) attributed the quantitative non-significance of the measures of innovation, leadership and interprofessional relationships in part to the limitation of the measurement tools they developed. Haig and LeBrack (2000) also concluded that further research was needed when their Teamwork Assessment Profile produced few statistically significant results. Through their emphasis on measurement, these texts framed health professionals and patients in a non-embedded, non-particularised manner. The focus on measurement appeared to limit the potential for deep understanding of collaboration, particularly organic modes of collaboration.

While not disputing the need for efficient and effective health care services (including rehabilitation), I do not support the relentless and unchallenged quest for numerical reduction of teamwork and collaboration that was evident in these texts. I contend that (a) it is also important to acknowledge that individuals and their agentic interactions are important to collaboration, and (b) not all aspects of their interactions and relationships are necessarily measurable. Although deliberation on the influences of quantitative research as the hegemonic research paradigm and management’s needs for measurable attributes of collaboration is beyond the scope of this research, the link between the two is noted. I argue that for management to successfully engage with complexities of collaboration, managers must consider “how they know” about collaboration. Consideration of these factors might enable them to understand the implications of their numerical focus and clarify discrepancies between the rhetoric of seeking patient-centredness and the practical realities of achieving it.

64 Abraham Maslow from http://www.abraham-maslow.com/m_motivation/Maslows_Hammer.asp (accessed 22/03/10). Original date of quote is not provided.
Texts describing how team members used both ordered and organic modes of collaboration provided important insights for supporting collaboration for patient-centred care in rehabilitation teams. Through the interpretation of these texts I highlight the benefits of a reciprocal relationship between patient-centred health care and team members interacting with and responding to each other as individuals (and as inherently complex dynamic beings). By responding to each other at an interpersonal level, health professionals can (perhaps unknowingly) intertwine ordered (facilitated by management’s structures and resources) and organic (required to work in dynamic and unique patient care situations) modes of collaboration and provide patient-centred care.

The PPPP dimensions and collaboration modes identified in Study A were evident (though not identified or alluded to) in the research undertaken by Sinclair et al. (2009). This insightful ethnographic research explored the “team structures, team relationships, and elements of organizational culture” that related to interprofessional collaboration in a rehabilitation setting (p.1196). I found no evidence in their research of an “either/or” situation; that is, collaboration was not either ordered or organic. People did not use either formal or informal structures, relate to each other either as disciplines or people, work in either clearly delineated teams or evolving groups, or seek either measurable or evolving outcomes. Rather, both modes of collaboration were apparent in all PPPP dimensions of collaboration identified. The authors described both formal structures of communication (ordered mode of collaboration) and informal communication and relationships (organic mode of collaboration).

The complexity of team boundaries was described by Sinclair et al. (2009), particularly in relation to the researchers’ identification of a core team and additional temporary staff and clinicians with responsibilities to other teams. Discipline power relations were noted in relation to particular individuals within disciplines:

No single member of the team was designated as the leader, although some members of the team, by dint of seniority or clinical role, were treated as having more decision-making authority than others [in relation to patient-related decisions]. (p.1198)

Shared measurable goals provided the basis for learning about what others were doing in the team. At the interpersonal level, both modes of collaboration were required and they were seamlessly intertwined.
In the text by Sinclair and colleagues, patient-centredness was regarded as important for collaboration. The following quote from their research described how formal goals setting (relating to an *ordered* mode of collaboration) could form a foundation for informal communication (relating to an *organic* mode of collaboration) and contribute to patient-centred practice:

The use of patient goal setting aided this collaborative behaviour because it allowed team members to consider how they could use their skills to contribute to achieving a measurable, shared goal rather than thinking of themselves as working in isolation. This not only allowed the entire team to focus on the patient’s goals, but allowed the team to learn about what one another were doing, and encouraged members of the team to work together to deliver patient care simultaneously and collaboratively. (...) All of the team members indicated that working from a patient-centred, goal-focused approach made it easier for the team to exchange information, track patient care, and work collaboratively.

(Sinclair et al. 2009, p.1198)

Their interactions were driven by the need to be responsive to particular patients’ needs.

The rehabilitation team described by Sinclair and colleagues seemed to routinely take advantage of chance meetings in the hallway, in the nursing station, and in shared therapy spaces to exchange information and develop as-needed strategies. Intertwined *ordered* and *organic* modes of collaboration were also evident in other texts. For example, in relation to collaboration between neuropsychologists and speech pathologists in rehabilitation settings, Wertheimer et al. (2008) highlighted the importance of formal team meetings and structured communication together with opportunities for informal meetings and developing collegiality. Although not explicitly addressed, the contribution of patient-centredness to collaboration was implied in the following participant quote:

It is important to exchange information and to tap different knowledge bases. We can benefit from differences in discipline/staff experiences in various treatment settings, training, and team dynamics. (p.278)

Abreu et al. (2002) analysed team meetings where health professionals discussed patients with brain injuries. They claimed that structure promoted order and efficiency, whereas humour improved communication and problem solving. In contrast to the findings of Sinclair et al. (2009) and Wertheimer et al. (2008), these authors emphasised that being collaborative in meetings did not necessarily mean being patient-centred: “The meetings
are intended to be client-centred; in reality, they enacted more professional collaboration than client-staff collaborations.” (p.700). Building on this caution, however, they emphasised the value of patient-centredness in providing opportunities for collaborating with other health professionals: “Collaboration in the meetings was viewed as an opportunity for partnership. The partnership was diminished because the client’s voice was not always present or encouraged.” (p.700).

Thus although intertwining ordered and organic modes was important for patient-centred collaboration, not all texts discussed patient-centredness or presented it as the purpose for collaboration among team members. For some authors a concept of collaboration that sought quality health care was clear, without specific designation of the goal and model of health care being patient-centred. I argue that valuing the patient as a unique individual at the centre of collaboration informs and is informed by the intertwining of different modes of collaboration by particular embodied health professionals.

iii) PPPP model of collaboration
A diagrammatic representation of the PPPP model of collaboration is shown in Figure 4.6. In this model the organic mode of collaboration is represented by the inner, subtly coloured triangles and black font for labels, and the ordered intention is depicted by the more definite colours of the outer triangles and white font for labels.

By making the dimensions of collaboration and modes of collaboration explicit, this model provides a basis for developing patient-centred collaboration at the level of patient care, as well as informing organisational support for such collaboration.

4.3.4 Critical appraisal of Study A
In this section I provide a critical appraisal of this study. I consider the value of the findings, the limitation of the project, and the contribution of my chosen frame of reference. Questions for future research are also suggested.
Figure 4.6 PPPP dimensions in relation to *ordered* and *organic* modes of collaboration
The value of the findings of my Study A relates primarily to the “framework for understanding” they provide for (a) those researching collaboration and critiquing the literature, and (b) team members’, managers’, discipline leaders’ and policy-makers’ reflection on how their understandings, decisions, actions and practice influence patient-centred collaboration. In my initial engagement with the diversity of collaboration in the literature (in Section 4.3.1) I noted the elusiveness of understandings of the entire phenomenon. I used the metaphor of the blind men describing an elephant to portray how the literature commonly described different aspects of collaboration without reference to the “whole”. By seeking to be open to different meaning of collaboration throughout this philosophical hermeneutic interpretation (to challenge my beginning horizon of understanding) I developed the PPPP model of collaboration. The value of this model is that it enables a view of the “whole” of collaboration and in doing so provides a reference point for understanding and critiquing “what is being described” in the various accounts of collaboration in the extensive literature.

For example, the set of principles and a “toolbox” of ideas provided by Briggs (1997a) to guide team members’ interactions focused on the process dimension in ordered modes of operating. Although her encouragement for team members to assemble their own toolbox implied a need for an intertwined ordered and organic mode of collaboration, the value of this text lay in its support for structured ways of communicating and working together. The scope and richness of the Wood and Gray (1991) indicators for collaboration could be appreciated when they were critiqued against the PPPP model. By providing a framework that made explicit these authors’ predominant (but implicit) focus on organic modes of collaboration and their implied reference to ordered modes of collaboration, the PPPP model provided another characteristic of collaboration that users of Wood and Gray’s model might like to consider.

A key aspect of my project related to my decision to dialogue only with texts constructed from the literature. Key advantages of this strategy included:

- the capacity of the approach to draw on the multiple studies, interpretations and findings of many, many authors to produce a rich and multi-layered new interpretation; and
- the opportunity that this approach provided to analyse ideas and theorisations within my chosen theoretical frames of reference to dialogue with these texts against the questions posed.
The focus on literature texts in Study A was complemented by Study B, which deals with the experiences of health professionals as collaborating team members. The focus on particular literature texts was influenced by feasibility (although I wanted to explore a broad selection of literature I needed to ensure that text sets did not become too large to engage with deeply).

Despite the advantages of my Study A strategy, accessing team members’ experiences through literature reports resulted in my interpretation of accounts of patient-centred collaboration being based on “second-hand” rather than first-hand descriptions. Furthermore, by sourcing texts from published literature only, influences on the collaboration of policy-makers, managers and discipline leaders were interpreted from the literature rather than being directly explored. The risk that quantitative methods (commonly recognised as the hegemonic research paradigm) might lead to over-representing of ordered modes of collaboration was tempered by the inclusion of qualitative research and policy documents (and other non-research documents) in the text sets. The relevance of these limitations needs to be considered by those using the “framework of understanding” to more deeply recognise and realise the nature of collaboration and how it can contribute to patient-centred collaboration.

Throughout this philosophical hermeneutic interpretation, my theoretical frame of reference of social ecology theory, structuration and social cognitive theory guided my compilation of text sets and questions for dialogue. The value of social ecology to my emerging horizon of understanding was that it oriented me to the interplay between social, institutional and cultural contexts and people’s responsibility for shaping those contexts. The value of structuration theory included the standpoint it provided to see organisational structures and processes as created by people (and hence capable of being changed). Through the perspective of social cognitive theory I was aware of people’s agency in relation to how they shaped their contexts and relationships. This frame of reference enabled me to successfully embrace the complexity of collaboration, immerse myself in different meanings and representations of collaboration and reach a new horizon of understanding.

During my interpretative dialogues my frame of reference, together with the use of a broad range of texts, attuned me to instances in the literature where the notions of complexity, agency, responsibility and interrelated influences were not embraced. These
negative instances challenged my initial horizon of understanding and triggered my insights into the different modes of collaboration developed in this study.

Study A was framed by a number of decisions that I made as researcher. These included the scope of the literature to be examined, the theoretical framework and major theories that were used as part of my interpretation, and the depth and volume of discussion. Other researchers could well have taken the same literature, used different theoretical lenses to frame their interpretation of collaboration, or used a different depth or scope of discussion. Furthermore, other people might have different perspectives and different interests that they wished to examine via this literature, such as a managerial focus on efficiency (including examining economical ways of collaborating), a focus on staff development (such as exploring how organisational developers or staff developers could use this literature to frame different organisational change processes or staff development issues), or a focus on patients’ rights and roles in rehabilitation (for example how patients’ voices are represented in rehabilitation decisions and actions). These perspectives and interests were not a primary focus of my research. I chose to explore collaboration between employed team members, and particularly those in rehabilitation teams. One of the contributions of this research is to draw future researchers’ attention to this scope of literature and to encourage them to pursue different frames of reference for their interpretation.

As well as providing a “framework for understanding” and encouraging further exploration from different perspectives, my research findings from Study A can also inform future research using different frames of reference. The following questions arising from this research are worthy of further investigation:

- How do people working at different levels of health care understand their influence on collaboration?
- What do people working at different levels of health care understand by ordered and organic modes of collaboration, and what do they see as the contributions and limitation of both modes?
- How do team members view the influence of policy-makers, discipline leaders and managers on their collaboration?
4.4 Conclusion

In this study I broadened my initial horizon of collaboration by fusing my entry perspectives with horizons of understanding I interpreted from the literature. The key points of the new horizon of understanding I gained are used in Chapter 6 where I merge the findings of Study A with those of Study B.

I began this study viewing collaboration as the intentional process of sharing knowledge, thoughts and perceptions between people (through decision making and actions) to achieve a common purpose that was underpinned by effective communication and group facilitation skills. My new fused horizon incorporated a deeper understanding of different ways in which collaboration can be conceptualised, operationalised and supported. Two contrasting modes of collaboration were identified in health care and rehabilitation team literature: *ordered* modes of collaboration, supporting visible, viable integrated structures for collaboration and clarity of the value of discipline contributions, and *organic* modes of collaboration, dealing with respect for people’s different interests and approaches, and with the uncertainty and ambiguities inherent in patient-centred health care. Collaboration can contribute to patient-centred health care when it is both *ordered* and *organic*.

A potential tension between these modes of collaboration was identified where the *ordered* mode was in danger of overshadowing the *organic* mode of collaboration. This tension was addressed by the positive patient-centred attitudes and flexibility of those collaborating. Based on this interpretation I highlighted the need for collaboration to be explicitly supported by policy-makers, discipline leaders, health professional educators, managers of health care teams, and team members. The PPPP dimensions of collaboration (*place, people, purpose and processes*) provide a valuable framework for ensuring that organisational support encompasses the different dimensions of collaboration and values the contributions of both *ordered* and *organic* modes of collaboration.
CHAPTER 5
STUDY B: COLLABORATING IN REHABILITATION TEAMS – A HERMENEUTIC PHENOMENOLOGICAL EXPLORATION

“I feel very comfortable and proud to be part of the team.” [P19]

“You’ve got to have that team cohesiveness to actually be able to cope with [complex] patients.” [P3]

“The rehab team is the unit of currency of rehab, if you don’t have a good team you get lousy results.” [P48]

5.1 Overview of Chapter 5: Methods and findings

This chapter explains the strategy used to explore the phenomenon of the experience of collaborating in rehabilitation teams and presents the findings of this study. The methods section of this chapter builds on Chapter 3 in which I described the interpretive research paradigm and provided an overview of research choices. In the findings section I introduce and explain the eight interdependent dimensions of the experience of collaborating.

5.2 Overview of phenomenology

Hermeneutic phenomenology, located in the interpretive research paradigm, was chosen to illuminate the experience of collaborating in rehabilitation teams.

5.2.1 Phenomenology as a philosophy

Husserl (1859-1938), often called the father of phenomenology, contended that we experience objects and others as they are constituted for us by our consciousness, rather than experiencing them as sense or empirical data (Hughes 1990). According to Husserl, human activity was a conscious experience in which the orientation towards an object, or intentionality, was only available retrospectively to consciousness, and could only be understood by going back to things themselves (van Manen 1997).

65 [P19] refers to Participant 19. Participants were randomly allocated numbers to protect their anonymity. This convention is used throughout the chapter.
While Husserl’s focus was on consciousness, Heidegger’s (1889-1976) focus was on *Being*. Heidegger proposed that our fore-structure of understanding is pre-given by history and influences the meaning we make of the world (Grondin 1994). For Heidegger, interpretation was closely related to the explicit elucidation of these fore-structures. Heidegger’s Being, our being-in-the-world and our care about this being, is also related to everyday understanding of the world. Being, its concern for itself, is the “more or less unconscious hook that gives understanding its purchase on things” (Grondin 1994, p.95). Heidegger contended that the world and the individual are constructed by each other (Munhall 1994) and that phenomenology was “the study of Being, the study of our modes-of-being or ways-of-being-in-the-world” (van Manen 1997, p.183). For Heidegger, pre-understandings were the meanings of a culture that are present before the individual understands them: they are part of being in the world (Laverty 2003).

Building on the ideas of Husserl and Heidegger, Merleau-Ponty (1908-1961) proposed that the interrelated existential life world themes of corporeality (lived body), relationality (lived human relation), spatiality (lived space) and temporality (lived time) were a means of understanding our world (van Manen 1997). For Merleau-Ponty the existential theme of the lived body related to embodied understandings the world, with embodiment being part of being and knowing (Todres 2007). Relationality, as an existential theme, was concerned with the experience human beings have of each other (van Manen 1997). Merleau-Ponty (2006, p.412) explained: “it is precisely my body which perceives the body of another, and discovers in that other body a miraculous prolongation of my own intentions, a familiar way of dealing with the world”. Within the theme of spatiality, Merleau-Ponty (2006, p.284) conceived space “not as the setting in which things are arranged, but the means whereby the position of things becomes possible ... the universal power enabling them to be connected”. His theme of temporality viewed time as arising from our relation to things (Merleau-Ponty 2006).

As my living present opens upon a past which I nevertheless am no longer living through and on a future which I do not yet live, and perhaps never shall, it can also open on to temporalities outside my living experience and acquire a social horizon, with the result that my world is expanded to the dimension of that collective history which my private existence takes up and carries forward (Merleau-Ponty 2006, p.503).
Schutz (1899-1959) developed key ideas of the eminent social scientist Weber (1864-1920) and sought a phenomenological grounding for social science. He proposed that the social world experienced by individuals includes the realm of directly experienced social reality, the realm of contemporaries and the realm of predecessors.

This social world is by no means homogeneous but exhibits a multiform structure. Each of its spheres or regions is both a way of perceiving and a way of understanding the subjective experiences of others (Schutz 1967, p.139).

The work of these influential philosophers informed my understanding of phenomenology. These understandings formed a basis for choices made in relation to implementing hermeneutic phenomenology as a research method.

5.2.2 Phenomenology as a research method

Although philosophers introduced phenomenological ways of understanding, the role of defining this movement as a research method tended to fall to others (Cohen & Omery 1994). This section outlines issues associated with the practical application of phenomenology as a research approach.

Phenomenology “calls into question what is taken for granted” (Crotty 1998, p.155) with researchers being “open to new meaning and the revitalisation of existing meaning” (p.154). Phenomenological research uses other peoples’ experiences as a starting point to more deeply understand the meaning of the experience in order to establish “accounts of experienced space, time, body and human relation as we live them” (van Manen 1997, p.184). The focus of the research lies with “what ‘manifests’ itself in experience rather than that which the subject has made of it” (Crotty 1996, p.57). Authentic phenomenological research illuminates phenomena, rather than subjectively describing experiences (Crotty 1996). Thus, phenomenological methods emphasise the meaning of lived experience: they distinguish between the meaning that may be made of an experience before reflection on that experience, and the meaning that can be made after phenomenological reflection on the experience (such as reflection made by researchers) (van Manen 1997).

In phenomenology, humans are viewed as social beings engaging in dialogue with each other, sharing an understanding of background practices in culture, language, skills, activities and meanings, and interpreting events and phenomena around them (Plager 1994). Portraying a particular phenomenon commonly involves precisely determining and clearly framing thephenomenon to be investigated; putting aside (or acknowledging
the influence of) everything we usually associate with this phenomenon, to look at it as though it is being seen for first time; describing what comes into view; ensuring that the description is the phenomenon as it is experienced, rather than reflecting researchers’ preconceived ideas about it; and determining through reflection the elements or aspects of the phenomenon that make it what it is (Crotty 1998).

Giorgi (1985 p.24) claimed that with phenomenology evolving and changing since its inception, a “consensual, univocal interpretation of phenomenology is hard to find”. Phenomenological methods may be pre-dominantly descriptive, by showing how things appear, and letting them speak for themselves (van Manen 1997). They can also be deeply reflective, by meaningfully interpreting the experience and reporting the interpretation. Interpretation of the experience involves identifying essential, rather than incidental themes, that is, “aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is” (van Manen 1997, p.107).

Different orientations of phenomenology are based on different contentions and emphases. For example, according to van Manen (1999b):

- transcendental phenomenology (as practised by Giorgi, 1871-1950) focuses on analysing and describing how things are constituted in and by our consciousness;
- existential phenomenology (as described by Merleau-Ponty, 1908-1961) is more an attitude than a method and is concerned with the lived experiences of embodied humans in the concrete world;
- linguistic phenomenology (as conceptualised by Derrida 1930-2004) emphasises the importance of language in consciousness and intention;
- ethical phenomenology (as described by Levinas 1906-1995) focuses on understanding human reality in the light of the face of others;
- hermeneutic phenomenology (informed by Heidegger, Gadamer and Ricoeur) contends that meanings are not transparent, rather they need to be interpreted.

The orientation of phenomenology I chose in this research was hermeneutic phenomenology. Van Manen’s (1997) descriptions of this orientation informed my implementation of this approach.
5.3 My strategy for utilising hermeneutic phenomenology

Hermeneutic phenomenology provides a way for researchers to grasp and make explicit the “internal meaning structures of lived experiences” (van Manen 1997, p.10). By making meaning structures explicit the nature and significance of particular experiences can be grasped in an new way (van Manen 1997). This research approach was a credible choice for interpreting the lived experience of collaborating. I was able to explore collaboration as an aspect of patient-centred interprofessional practice, embrace its complexities and articulate my interpretation of its meaning structures.

Rather than being a prescriptive method, hermeneutic phenomenology requires the “ability to be reflective, thoughtful, sensitive to language and constantly open to experience” (van Manen 1997, p.xi). For van Manen, orienting to the phenomenon, collecting experiential material, analysing experiences and illuminating the essence of the phenomenon through writing are integral to the exploration of human experiences through hermeneutic phenomenology. An overview of my strategy for using hermeneutic phenomenology is shown in Figure 5.1. Evident in this strategy are recognition of my role as the researcher and the iterative relationships between orientation to the phenomenon, data collection, analysis and writing.

5.3.1 Orienting to the phenomenon

Throughout the research I aimed to be “steadfastly oriented to the lived experience” I was researching and continually mindful of my research question (see van Manen 1997, p.42). Orienting to the phenomenon involves being strongly aware of the phenomenon and animated by it, yet able to step back and look at the total phenomenon in light of the emerging interpretations/meaning structures (van Manen 1997). My continued interest in, and curiosity about, the phenomenon I was researching enabled me to be animated by it. Stepping back to look at the parts of my emerging understanding in relation to the whole was a deliberate process.

Being conscious of the preunderstandings I brought to the research was also a deliberate process in my orienting to the phenomenon (my preunderstandings are outlined in Chapter 1). Bringing researcher subjectivity to the foreground of research provides a platform to “begin the process of separating out what belongs to the researcher rather than the researched” (Finlay 2009, p.12) and enables the researcher to engage in...
Orienting to the phenomenon:
I acknowledged my "lifeworld" experiences and preunderstandings of collaborating.

Collecting experiential accounts: I collected and engaged with participants’ experiences throughout 3 phases of the research that involved 9 rehabilitation teams, 66 health care staff, and 11 patients and carers.

Interpreting meaning structures:
I interpreted these experiential descriptions for meanings, insights and themes from which I determined the experiential structures of the phenomenon.

Illuminating the phenomenon:
I transformed lived experiences of collaborating in rehabilitation teams into textual expression that evoked a sense of the experience of the phenomenon.

Figure 5.1 My strategy for using hermeneutic phenomenology in Study B
“dialectic movement between bracketing preunderstandings and exploiting them reflexively as a source of insight” (Finlay 2009, p.13). I undertook this dialectic movement through an ongoing dialogue between my preunderstandings as a source of insight and their role in my emerging understandings.

5.3.2 Collecting experiential material
Data collection in this research project involved gathering experiential material from observations of team meetings of nine rehabilitation teams and interviews with 66 team members including medical, nursing, allied health staff and 11 patients and carers. (Specific details of the research participants and particular methods of data collection are provided in Sections 5.6 and 5.7). Throughout the process of collecting experiential material phenomenological researchers need to remain “oriented to asking the question of what is the nature of this phenomenon ... as an essentially human experience” (van Manen 1997, p.62). Being oriented to the phenomenon throughout the collection of experiential material enabled me to avoid what van Manen (1997 p.67) described as “an over-abundance of poorly managed interviews [which] may lead to either total confusion or despair”. As I collected, analysed and interpreted the experiential accounts of collaborating I repeatedly returned to my research questions to focus my interpretations.

5.3.3 Interpreting meaning structures
Reflection on and interpretation of the data are necessary to make explicit the elusive element of lived meaning (van Manen 1997). Interpretation is “the process of ascertaining the meaning(s) and implications(s) of a set of materials” (Kritzer 1996, p.2). In this project interpretation of data enabled me to move from my pre-reflective lived understanding of the experience of collaborating to a reflective grasp of meaning structures, i.e. the phenomenological structure of the lived meaning of the experience of collaborating.

A number of themes and sub-themes were identified in this research as I moved to higher levels of reduction during my ongoing analysis and interpretation of the lived experiences of my participants. A theme is “a simplification … the form of capturing the phenomenon one tries to understand” (van Manen 1997, p. 87). Themes always involve “a reduction of a notion”, and arise from the desire to make sense of the phenomenon (van Manen 1997, p. 88). They enable the researcher to “get at the notion
… give shape to the shapeless” (van Manen 1997, p.88). The essence of the meaning of a phenomenon is multi-dimensional and multi-layered, and cannot be grasped by the identification of a single structure or theme (van Manen 1997). Through the identification of themes I developed insights into the experience of collaborating in rehabilitation teams. I labelled the final set of themes as meaning structures to differentiate them from earlier evolving themes and to highlight their hermeneutic phenomenology origins. Van Manen (1997, p.79) described meaning structures as “the experiential structures that make up that experience”.

5.3.4 Illuminating the phenomenon

Phenomenological writing is a very important component of hermeneutic phenomenology. The experiences of the phenomenon can be richly illuminated through writing (van Manen 1997). In this research my orientation to writing was inspired by van Manen (2007, p.26):

> Perhaps a phenomenological text is ultimately successful only to the extent that we, its readers, feel addressed by it — in the totality or unity of our being. The text must reverberate with our ordinary experience of life as well as with our sense of life’s meaning. This does not necessarily mean that one must feel entertained by phenomenological text or that it has to be an “easy read.” Sometimes reading a phenomenological study is a truly laborious effort. And yet, if we are willing to make the effort then we may be able to say that the text speaks to us not unlike the way in which a work of art may speak to us even when it requires attentive interpretive effort.

In describing my interpretations of participants’ experiences with collaborating in rehabilitation teams, I intended that my text would “speak” to the reader and provide meaning of the phenomenon. A blend of metaphorical writing and participants’ quotes that were grounded in experience provided an appropriate avenue for such “speaking”. While not wanting reading my findings to be a *truly laborious effort*, I did not want to overly simplify and trivialise what was an inherently complex interpersonal phenomenon. Guidance for achieving this balance with phenomenological authenticity was provided by Todres’ (2007) considerations of dilemmas of phenomenological writing and its structure.

The dilemmas of *writing*, as explored by Todres (2007), arose from, and were guided by, concepts from Dilthey, Heidegger and Merleau-Ponty. Using Dilthey’s concepts,
Todres noted that phenomenological writing needed to retain continuity with what is already experientially evident and familiar to us as “commoners”. He cited Dilthey’s simple message “to write in a language that aims to elicit empathy and participation in the reader” (Todres 2007, p.10). In addressing this dilemma I chose quotes that evoked the experience I was describing, thus making it accessible to the reader. Todres proposed that Heidegger’s message was that mood was intimate to understanding. This proposal requires us to use language in a way “that communicates the mood of a situation of experience” (pp.10-11).

I endeavoured to convey a mood of the multifaceted, dynamic nature of collaboration by weaving overlapping and interrelated ideas. For Todres, the challenge posed by Merleau-Ponty was to “write our descriptions in such a way that they are able to communicate a bodily sense of being-there” (Todres 2007, p11). To achieve this I aimed to create a sense of different perspectives of the same issue that were coherently and purposely related. Todres’ dilemma of structure concerned the challenge of maintaining the structure of the experience while keeping its individual nature, in order to “find a level of participation that is neither impersonal nor only personal” (Todres 2007, p.13). In addressing this challenge I used a planning table to provide an overview, with headings as signposts to convey key elements in the structure of the experience of collaborating. The words of the participants conveyed the individuals within this structure.

Throughout my analysis I reflected on the implementation of my strategy. Examples of questions I used to guide my reflection are shown in Table 5.1 These reflections, grounded in van Manen’s (1997) descriptions of hermeneutic phenomenology, kept me focused on implementing hermeneutic phenomenology as a research method. Through such reflection I also intended that my research would achieve what van Manen (2007, p.26) referred to as the “various formative relations” of phenomenology of practice:

- informing (by enabling thoughtful consultation with the phenomenon);
- reforming (through the demand made by phenomenological texts on our understandings);
- transforming (by prompting in us “a new becoming” in relation to the way we practise).
I consider that through eliciting meaning structures of the experience of collaborating to inform thoughtful consultation I achieved the first component of this aim. Such consultation also has the potential to reform understandings and, through reflection, to transform practice.

Table 5.1 Examples of my ongoing reflections (informed by van Manen, 1997)

<table>
<thead>
<tr>
<th>Orientation to experience of collaborating</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Am I aware of my personal assumptions?</td>
<td></td>
</tr>
<tr>
<td>Have I “confronted and dislodged” unexamined assumptions?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collecting experiential material</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Am I open to the experiences of others?</td>
<td></td>
</tr>
<tr>
<td>Am I engaging with participants’ lived experiences?</td>
<td></td>
</tr>
<tr>
<td>Am I collecting their experience of collaborating?</td>
<td></td>
</tr>
<tr>
<td>Am I viewing collaborating as it is for the participants, not as I already interpret it?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analysing experiences</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Am I holding my own preunderstandings and presuppositions aside?</td>
<td></td>
</tr>
<tr>
<td>Am I grasping the complexities of collaborating?</td>
<td></td>
</tr>
<tr>
<td>Am I making the essence and meaning of collaborating explicit?</td>
<td></td>
</tr>
<tr>
<td>Are my data collection and analysis interrelated and concurrent?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Illuminating the essence of the phenomenon through writing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Am I evoking a sense of the experience of collaborating?</td>
<td></td>
</tr>
<tr>
<td>Is my text “speaking” to the reader?</td>
<td></td>
</tr>
</tbody>
</table>

5.4 Overview of data collection processes and research participants

This section provides an overview of data collection processes and research participants (see Table 5.2). The study was conducted in three sequential phases:

- Phase 1, which involved rehabilitation team members (team meetings were observed and interviews undertaken);
- Phase 2, which involved rehabilitation team members from teams participating in Phase 1 who were invited to continue their participation (team meetings were observed and interviews were undertaken);
- Phase 3, which involved patients and carers sourced from the patient base of Phase 2 teams (interviews were undertaken).

The sequential nature of these phases enabled issues identified in Phase 1 to be followed up in relation to particular modes of collaborating (in Phase 2) and then be explored from patients’ and carers’ perspectives (in Phase 3). For teams involved in ongoing phases, the time frame between their participation in Phases 1 and 2 was from 12 to 14 months, with Phase 3 beginning about 2 months after the completion of Phase 2 data collection.
Table 5.2 Overview of data collection and profiles of participants

<table>
<thead>
<tr>
<th>Data collection</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teams participating in phase</td>
<td>Teams n = 9</td>
<td>Teams n = 4</td>
<td>Teams n = 3</td>
</tr>
<tr>
<td>Location of teams</td>
<td>Rural = 2, Regional = 3, Metropolitan = 4</td>
<td>Rural = 1, Regional = 2, Metropolitan = 1</td>
<td>Rural = 0, Regional = 2, Metropolitan = 1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Type of service provided by teams</td>
<td>Community-based (predominantly outpatients) = 2</td>
<td>Community-based (predominantly outpatients) = 1</td>
<td>Community-based (predominantly outpatients) = 1</td>
</tr>
<tr>
<td>Within an acute hospital (in-patients only) = 3</td>
<td>Within an acute hospital (in-patients only) = 2</td>
<td>Within an acute hospital (in-patients only) = 1</td>
<td></td>
</tr>
<tr>
<td>Non-acute location (in-patients only) = 4</td>
<td>Non-acute location (in-patients only) = 1</td>
<td>Non-acute location (in-patients only) = 1</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>9</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Team meetings observed</td>
<td>Team meetings n = 9</td>
<td>Team meetings n = 4</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Number of participants in team meetings</td>
<td>6-12 TOTAL = 82</td>
<td>8-10 TOTAL = 36</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Roles of team meeting participants, Number (percent)</td>
<td>Allied health (^a) = 43 (52)</td>
<td>Allied health = 20 (56)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Medical (^b) = 19 (23)</td>
<td>Medical = 9 (25)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing (^c) = 12 (15)</td>
<td>Nursing = 3 (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (^d) = 5 (6)</td>
<td>Other = 3 (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown = 3 (4)</td>
<td>Unknown = 1 (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL = 82 (100)</td>
<td>TOTAL = 36 (100)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interviews (total of 77 participants)(^e)</td>
<td>Health care staff n = 50</td>
<td>Health care staff n = 26</td>
<td>Patients &amp; carers n = 11</td>
</tr>
<tr>
<td>Role of interview participants Number (percent)</td>
<td>Allied health = 25 (50)</td>
<td>Allied health = 13 (50)</td>
<td>Patients = 9 (82)</td>
</tr>
<tr>
<td>Medical = 11 (22)</td>
<td>Medical = 6 (23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing = 11 (22)</td>
<td>Nursing = 5 (19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other = 3 (6)</td>
<td>Other = 2 (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL = 50 (100)</td>
<td>TOTAL = 26 (100)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender Number (percent)</td>
<td>Female = 35 (70)</td>
<td>Female = 17 (64)</td>
<td>Female patients = 5 (46)</td>
</tr>
<tr>
<td>Male = 15 (30)</td>
<td>Male = 9 (36)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL = 50 (100)</td>
<td>TOTAL = 26 (100)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff years in team Number (percent)</td>
<td>0-5 years = 32 (64)</td>
<td>0-5 years = 15 (58)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>6-11 years = 5 (10)</td>
<td>6-11 years = 3 (12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-17 years = 10 (20)</td>
<td>12-17 years = 3 (12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-23 years = 1 (2)</td>
<td>18-23 years = 3 (12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsure/unspecified = 2 (4)</td>
<td>Unsure/unspecified = 2 (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL = 50 (100)</td>
<td>TOTAL = 26 (100)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Including physiotherapy, occupational therapy, speech pathology, social work, neuropsychology, dietetics and students  
\(^b\) Including specialists, registrars, residents, interns and students  
\(^c\) Including nursing unit managers, clinical nurse consultants, ward nurses and students  
\(^d\) Including non-clinical team manager, rehabilitation assistants, a wardsman and a clerical worker  
\(^e\) Phase 2 included ten team members from Phase 1
Nine rehabilitation teams in rural, regional and metropolitan NSW were involved. Interviews were conducted with 77 health care staff, patients and carers from these teams. These teams represented rehabilitation services for inpatients in acute hospitals and outpatients in community settings. All teams participated in Phase 1 of the study. From these teams, four were selected to participate in Phase 2.

Phase 2 teams were recruited from teams participating in Phase 1. The four teams invited to continue to participate in Phase 2 all accepted this invitation. The invitations were based on purposive sampling of geographical locations (rural, regional and metropolitan), type of service (inpatient and community-based services) and team characteristics (which were identified in Phase 1, including clarity of team boundaries, of membership and of leadership\textsuperscript{66}). Phase 2 teams were then used to source patients and carers for Phase 3. Through this purposive sampling I accessed a diverse range of teams. More details of team selection and participant recruitment are provided in Section 5.6.

I observed 82 team members interacting at team meetings in Phase 1 and 36 team members interacting in Phase 2. Although the teams in Phase 2 participated in Phase 1, the team membership had changed between the phases for all teams. For example, in one team fewer than half of the team members present at the Phase 1 team meeting attended the Phase 2 meeting (i.e. one of three doctors, four of eight allied health staff and no nurses). The attendance at the team meetings for Phase 1 ranged between 6 and 12 health care staff, with the range for Phase 2 being between 8 and 10. Team members with various roles participated in these team meetings (including allied, medical, nursing and administrative staff).

Sixty six health care staff and 11 patients and carers participated in interviews. Due to the team membership changes only 10 participants from Phase 1 were re-interviewed in Phase 2. The predominance of female health care staff interviewed reflects the higher numbers of females in nursing and allied health care professions. Interviews in each team were conducted after observation of their team meeting. This provided orientation for the research about how the team operated, and contextualised the interviews.

Most team members who were interviewed had been observed interacting in team meetings. Not all team members observed at meetings were available to participate in

\textsuperscript{66} As these characteristics relate to research findings their relevance is described in Section 5.12.
interviews (some people were transient team members, others were students observing the meeting, and others' availability was limited by their rosters and allocated days off). Similarly not all team members interviewed participated in team meetings. For example, some administrative and ward-based staff interviewed did not attend team meetings. Further, due to the large attendance at team meetings it was not feasible to interview all those attending team meetings. Interview participants in Phases 1 and 2 represented a range of health care and administrative roles.

Patients and carers were recruited for Phase 3 from the patient base of teams participating in Phase 2 (i.e. teams purposively sampled to represent a diverse range of team characteristics). I interviewed seven patients individually, and two patients with their carers. In this phase a similar number of male and female were interviewed, but both the carers that I interviewed (being wives) were female. Although patients and carers from rural geographical locations were not interviewed (due to unexpected recruitment difficulties in one team) diversity was still evident in relation to types of service (as shown in Table 5.1) and in relation to other team characteristics.

The profile of teams and participants in this research indicates that I achieved reasonable diversity of roles, years of experience (for health care staff) and gender (see Table 5.2). The different opportunities and constraints for collaborating presented by the diversity of the teams and participants within the Area Health Service Region chosen as the location for this research provided a good starting point for exploring the complexity and challenges of collaborating with teams.

5.5 Ethical considerations

The ethical considerations of informed and voluntary consent, anonymity, confidentiality and dealing with inadvertent access to private health information were key to my ethical behaviour in this study, and are explained in this section.

5.5.1 Informed consent and participant recruitment

Informed consent is concerned with ensuring that the participants’ decision to participate in the research is voluntary (without coercion), based on their full understanding of the nature and purpose of the research, as well as the nature and potential risks of their involvement. Data collection in this study was undertaken in three phases, with informed consent from participants obtained separately for each phase.
A challenge for this research was to ensure that team members, patients and carers had sufficient opportunities to make informed individual decisions rather than being coerced to be involved in the research by me, institutional “gatekeepers”, other team members or health care staff. Ethical behaviours that enabled me to ensure individuals made informed decisions to participate in this research were:

- providing potential participants with separate information sheets and consent forms outlining the research purpose, methods and requirements for involvement for each phase of the research (information sheets and consent forms are included in Appendix 2);
- balancing my access to teams through one team member (gatekeeper) per team, with the provision of opportunities for all team members to ask me questions about their prospective participation, and decide independently;
- ensuring that only those who had signed consent forms participated in the research (as participants in the meetings I observed or in interviews).

I also responded to individuals’ concerns about particular ethical issues (for example, I did not tape a meeting I observed due to one team member’s concern for the privacy of patients’ health information\(^ {67} \)). Further, in Phase 3 I ensured that staff who approached patients to participate in the research were aware of the importance of not coercing and of inviting only patients with suitable cognitive and communicative abilities. The steps involved in obtaining written informed consent are detailed below.

**a) Phases 1 & 2: Recruiting for observations of team meetings and staff interviews**

Initial approaches to gain access to teams were made via introductory letters sent to rehabilitation or medical specialists in rehabilitation teams. These letters explained the research and were followed up by telephone calls to discuss the project further with them and answer any questions. At this time practical information about the team was elicited (including how many people were in the team, when and where they met, how stable the team was, how team decisions were made, whether there was an appointed team leader and who to contact for further information). The process involved in eliciting this information also allowed me to begin to understand team compositions and processes and plan how to ensure that all individuals attending team meetings would

\(^{67}\) This meeting was observed but not recorded, and my field notes formed the basis of analysis.
receive information sheets and consent forms for Phase 1 if and when the team accepted the invitation to participate.

Following our initial discussions, team leaders, medical specialists, or nursing unit managers\(^{68}\) then discussed the research project with team members at team meetings. After the team as a whole agreed to be involved (i.e. they decided that it was appropriate for individuals to be invited to participate), nominated co-ordinators within each team distributed Phase 1 forms, and notified me of dates the forms were distributed, the team members’ names and their positions. I provided stamped addressed envelopes so that participants could return their consent forms direct to me, thus providing them with opportunities to discuss the research individually and, if they so decided, to individually decline participation without the knowledge of the rest of the team.

I was aware that lack of informed consent by any team member attending the team meeting would prevent my attending that meeting. However, although a number of team members asked questions about the research, no team member declined to participate\(^{69}\) and all invited teams participated.

Two processes were used to ensure that all the information sheets were distributed and consent forms were received in advance of the planned meeting attendance. First I checked the team’s distribution information against the consent forms received and clarified whether each person was still a member of the team. Second, a day or two prior to each observed team meeting I checked that new team members knew about the research project, had received information sheets and consent forms and had had opportunities for questions. Those attending the team meeting (as observers) without advance notification (such as medical students) had the research explained to them on the day of the team meeting observation.

Team membership changed between Phases 1 and 2. Therefore, separate information sheets and consent forms for these phases enabled participants to make informed decisions about their ongoing participation, without any obligation to continue.

\(^{68}\) In the teams with no appointed team leader positions, the medical specialist or the nursing unit manager tended to take the role of explaining the research project.

\(^{69}\) However, one team member’s agreement was limited to observation of the team meeting only and did not include agreement to be interviewed.
An unanticipated situation occurred in one team. During my attendance at the team meeting, I found that, following a staff discussion, each patient attended part of the team meeting in turn. As I had not obtained consent from patients prior to the meeting I left the room when most of the patients were in attendance. However the staff identified and approached two patients who were interested in participating and were capable of giving informed consent. Following a discussion of the research, and adequate time for the patients to consider their participation and ask questions, these two patients consented for me to be present during their discussion with the team.

b) Phase 3: Recruiting for interviews with patients and carers
As many patients in rehabilitation have communication and cognitive difficulties, care was taken to ensure that only those who were capable of providing informed consent were approached to participate. As it was not appropriate for me to make direct contact with patients to explain about the research, I liaised with four rehabilitation team members (one from each team) to source potential participants for this phase of the research. These staff members used their judgement of patients’ willingness to participate, availability, good cognitive ability, and ability to understand and speak English to identify suitable patients and provide them with information sheets and consent forms. Care was taken by staff to avoid any coercion to participate. Since the patients were not being asked to comment on the quality of their care there was no implication that their participation or lack of participation in the research would influence their future care. My contact with patients and carers began after they had indicated to the staff their interest in participating. As the focus of the research was on team member interactions, information about patients’ conditions was not explicitly sought.

5.5.2 Ensuring anonymity and confidentiality
Anonymity refers to the protection of the research participant’s identity (Powers & Knapp 1995). To ensure anonymity, identifying information was not disclosed. Teams were allocated general labels and participants were assigned pseudonyms.

Maintaining confidentiality involves not revealing information about the participants (Powers & Knapp 1995). Participants’ comments were not shared with other participants, and were de-identified before being made public in the form of quotes in presentations, the thesis or publications. All data collected were stored in locked filing
cabinets or in password-protected computers, and were accessed only by the researchers.

5.5.3 Inadvertent access of health information without patients’ consent
Health information about patients not consenting to be involved in the research was inadvertently accessed during my attendance at rehabilitation team meetings. However, the Human Research Ethics Councils approving my research determined that the public interest from increased knowledge outweighed the public interest in the protection of privacy for the following reasons: (a) the access to health information was incidental to the collection of the information about team collaboration, (b) the health information would not be used or disclosed, and (c) the resulting increased understanding about collaborating in rehabilitation teams could be valuable in educating and preparing health professionals for effective teamwork. No health information about patients was used in any research reports or presentations.

5.6 Selection of teams and recruitment and participants
For this research, a team was considered to be rehabilitation team if:

- the group’s major service function was rehabilitation of individuals with neuromuscular or musculoskeletal conditions acquired or developed through trauma or disease;
- the group comprised a minimum of three different health professional disciplines;
- the group held “regular” team meetings;
- the group had a self-expressed identity of being a “rehabilitation team”.

5.6.1 Selection of institutions to recruit participants
One Area Health Service Region in the state of New South Wales (NSW) was chosen as the location from which rehabilitation teams were sourced. This choice was based on the different geographical and demographic areas within the region (rural, regional and metropolitan areas), diversity of teams within the region (inpatient and community-based services) and the feasibility of accessing these teams (all of which were located within a 4½ hour drive of my home base). As each Area Health Service Region in NSW has its own human research ethics committee, locating the research in one region also limited the number of ethics committees required to approve this research.
As no register or list of rehabilitation teams was available from the Area Health Service, the nine teams were initially identified by a rehabilitation specialist located in the area. All teams were invited to participate in the research, and all accepted the invitation. During the data collection process, another two teams with rehabilitation roles were identified by participants. Although feasibility was the major deterrent to inviting these teams to participation, I determined that their inclusion would not contribute significantly to team diversity as there was some team member overlap between these teams and the ones already participating.

5.6.2 Recruitment of participants
The interview research participants were predominantly health care staff, and a small number of patients and carers. The means by which teams and participants were recruited to achieve diversity (and fulfil the requirement of one ethics committee that all team members had a chance to participate) is explained in this section.

a) Recruitment of participants for Phases 1 & 2
Participants for Phases 1 and 2 were recruited primarily on the basis of their attending the team meeting on the day of the scheduled meeting observation. All attendees were required to sign a consent form before I could proceed with the meeting observation. As all but one team meeting attendee in Phases 1 and 2 indicated that they were also willing to participate in an individual interview I had a large volunteer pool from which to source participants for interviews. Moreover in some teams, team members suggested particular team members to be interviewed who were not in the team meeting observed (e.g. wardsman and ward nurses).

It was not feasible to interview all team members who were willing to be interviewed, due to the overall number of team members and the need to make the research manageable. Thus interview participants were recruited using purposive sampling. Purposive sampling is a process used to select a range of participants that are typical of the setting of the researched phenomenon (Maxwell 2005). This process enabled me to interview a broad and representative range of participants across the various teams and disciplines.

Through purposive sampling I was able to include for each team at least one representative from each discipline group (with the exception of teams whose medical

70 Consent forms included permission for me to observe their team meeting and request an interview.
specialists I interviewed in conjunction with roles in other teams, or teams which did not have nurses caring for inpatients), team leaders (where appropriate and feasible), and team members with a range of experience in the team (with the exception of a newly formed team whose team members were all relatively new to the team). Due to scheduling difficulties during my visit to a particular rehabilitation team, one interview was conducted over the phone. Due to staff workload in another team, one team member was interviewed outside my scheduled visit. All other interviews were conducted face-to-face during my visit to the rehabilitation team centre.

Although the original intention had been to re-interview participants of teams invited to continue their participation into Phase 2 (based on their geographical location, type of service and team characteristics), rapid staff turnovers, rosters, holidays, and staff workload at the time of interviews reduced the number of potential re-interviews in these teams. Thus recruitment for Phase 2 interviews also involved purposive sampling of team members to ensure a range of discipline representation and team experience. As the most stable professional group was the medical specialists, this was the most represented group in the re-interviews. At least one person in each team from Phase 1 was interviewed in Phase 2. This re-interviewing provided links and insights about changes to the team since my previous visit.

In Phases 1 and 2, a total of 77 interviews were undertaken with 66 participants across nine teams. Ten participants were interviewed in both phases. The largest number of team members interviewed in a team was 13 (across both phases), and smallest was 4 (in one phase).

b) Recruitment of participants for Phase 3

Patients and other carers were recruited from the patient base of the rehabilitation teams participating in Phase 2. I interviewed nine patients and two carers across three teams in this phase. The relatively small number of patients and carers in the study was not considered to be a problem since the focus of the study was on collaboration between staff.

Participants in this phase represented a range of involvement with rehabilitation services and teams. Some had no previous interactions with rehabilitation services, some were familiar with services through professional or carer roles, and others had had extended personal involvement with rehabilitation teams over many years. Some required rehabilitation following the sudden onset of a disabling condition, for others
rehabilitation related to long-term conditions. This varied involvement provided access to a wide range of patients and carer experiences. Their interview questions focused on the collaboration between staff that they observed or experienced.

5.7 Data collection

Multiple data gathering methods were chosen, to explore the phenomenon of the experience of collaborating from different views and perspectives, and to ensure the rigour of the study. Observations of team meetings (in Phases 1 and 2) and semi-structured interviews with individual team members (in all phases) were supported by extensive use of field notes and analytical and procedural logs.

5.7.1 Observation

Observation enables actual behaviour rather than reported behaviour to be accessed by allowing researchers to “see for themselves” (Kellehear 1993, p.6). Rehabilitation team meetings were chosen as the context for observing collaborating, because team members from all disciplines commonly participated in those meetings. To gain an orientation about how a team operated, and to contextualise the interviews, I undertook observation of the team’s case conference before interviewing team members. At these meetings I observed at first hand team contexts, team processes and interactions between individuals. Insights gained from team meeting observations were explored further in individual interviews and reflected upon in my analytical journal.

Researchers as observers can be active and involved in the researched phenomenon, discreet and non-involved, or hidden (Kellehear 1993). The observer’s purpose can be explicit or non-disclosed (Llewellyn 1996). I determined that my role as observer would be discreet and non-involved, and my purpose would be explicit. I sat to the side of the room where the case conference was being held and observed each entire meeting, including the arrival and departure of team members. The meetings of eight of the nine teams were audio recorded and descriptive field notes were written. One team declined to have the meeting taped. For that team, data collection was limited to field notes made before, during and after the meeting.

The focus of my observational field notes varied, as shown in Table 5.3. This shift in focus enabled meetings to be viewed from different perspectives. When used in conjunction with the recordings these field notes provided rich data about the nature of collaborating at the meetings.
Table 5.3 Focus of team meeting observation field notes

<table>
<thead>
<tr>
<th>Focus of observation</th>
<th>Style of field notes</th>
<th>Type of interactional characteristics observed</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contextual characteristics of venue and individuals</td>
<td>Free-style notes (initially noted for 10 minutes, then as indicated by team actions)</td>
<td>Contextual characteristics of meeting and team interactions</td>
<td>Characteristics of room and meeting set-up; people arriving and leaving, interruptions from outside; team members' non-verbal interactions and actions (writing, reading, notes being passed, eating and drinking)</td>
</tr>
<tr>
<td>Who interacts with whom</td>
<td>Sociogram-style sheet (5 mins per sheet, every 15-20 mins)</td>
<td>Direction and types of communication and people involved</td>
<td>Direction of communication (directed and/or non-directed, questions and/or comments); who contributed (discipline roles and/or personal experience); one main focus or aside conversations</td>
</tr>
<tr>
<td>Flow and purpose/intent of interactions</td>
<td>Free-style notes (blocks of 10-15 minutes)</td>
<td>Segments of interactions in terms of communication processes and what was discussed (e.g. reporting assessments, questioning and clarifying information, making suggestions, and deciding/confirming goals)</td>
<td>Who began the interaction; how it was begun; who contributed; what it was about; what was contributed; how long each contribution lasted; how the contribution ended; who spoke next; overlapping or turn-taking input</td>
</tr>
<tr>
<td>Overall impressions</td>
<td>Free-style notes (as required during the meeting)</td>
<td>Reflective observations about the nature of the meeting</td>
<td>The feel and mood of the meeting, e.g. &quot;The meeting had a calm feel to it – no obvious time pressure – words were gentle, inviting participation – there was time to explore new ideas that led to emerging synthesis and synergy&quot;</td>
</tr>
</tbody>
</table>

5.7.2 Semi-structured interviews

Semi-structured interviews with individual participants allowed in-depth exploration of the experience of collaborating in rehabilitation teams. A range of topics can be discussed with participants in interviews, including meanings of events and experiences, processes by which they occur, and the physical and social contexts (Maxwell 2005). Semi-structured interviews provided scope for broad exploration of issues central to the topic of the experience of collaborating (including working together, role clarity and purpose), with opportunities for more specific focus and probing where required. Questions were posed to elicit open-ended responses. I aimed that the interview had the feel of “personal sharing of a confidence with a trusted friend” (based on Morse & Field 1995, p. 90).

Although I used an interview schedule of pre-prepared questions related to these central areas as a guide to elicit discussion I did not necessarily use the exact wording or order of the questions (see Minichiello et al. 1995). This schedule, developed from my initial understanding of the phenomenon, also evolved throughout the data collection process as my understanding of the experience of collaborating developed. Some questions were replaced as the research progressed, to allow new issues to be explored. During the
Interviews I typically followed participants’ leads in relation to the order in which topics were explored, and when relevant I used their words to frame prompts for clarification and expansion. Examples of central issues and their corresponding prepared questions used in Phase 1 are shown in Table 5.4.

Table 5.4 Interview guide: issues and questions

<table>
<thead>
<tr>
<th>Central issues</th>
<th>Examples of questions developed to guide interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working together</td>
<td>What would you say about the way this team works together? (prompt for atmosphere, attitudes to others, team leadership, decision making and policy making and communication)</td>
</tr>
<tr>
<td></td>
<td>Would you say that the team has a particular philosophy or approach to the way the way it works?</td>
</tr>
<tr>
<td></td>
<td>Does the team, as a group, do anything, apart from team meetings?</td>
</tr>
<tr>
<td></td>
<td>Could you tell me how your meetings work?</td>
</tr>
<tr>
<td>Role clarity/understanding</td>
<td>How would you describe your role in rehabilitation?</td>
</tr>
<tr>
<td></td>
<td>How important is it, do you think, for team members to know about each other’s roles and how you all work?</td>
</tr>
<tr>
<td></td>
<td>How does the team deal with gaps and overlaps in the team?</td>
</tr>
<tr>
<td></td>
<td>What role do patients and their carers have in this rehabilitation team?</td>
</tr>
<tr>
<td>Purpose</td>
<td>What do you see as the main purposes of rehabilitation team meetings?</td>
</tr>
<tr>
<td>Orientation to the team</td>
<td>What was it like joining this team?</td>
</tr>
<tr>
<td></td>
<td>Tell me about the written rules/guidelines or unspoken rules for the team.</td>
</tr>
<tr>
<td>Team development</td>
<td>How has the rehabilitation team developed in the time you have been part of it?</td>
</tr>
<tr>
<td></td>
<td>How does the team deal with changes to the team membership?</td>
</tr>
</tbody>
</table>

Interviews were transcribed to facilitate my engagement with the participants’ experiences during analysis. Due to technical difficulties with recording equipment, two interviews could not be transcribed entirely. For those interviews I utilised notes taken during and after the interview.

5.7.3 Field notes

Field notes were compiled primarily during team meetings, and before and after interviews. The varied content and purposes behind my interview field notes are shown in Table 5.5 (details of field notes compiled during team meeting observations were provided in Section 5.7.1). My recollection of specific interviews was facilitated by my notes about particular contextual characteristics and my general impressions. By making notes of conversations that continued after the recording stopped (or the reasons for turning the tape back on again), I ensured that that all the participants’ experiences shared during the interview were available for analysis.
Table 5.5 Content, purpose and examples of field notes from interviews

<table>
<thead>
<tr>
<th>Content</th>
<th>Purpose</th>
<th>Example of researcher’s field notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context of interviews</td>
<td>To enhance recollections of specific interviews to facilitate engagement with transcriptions during later data analysis</td>
<td>“Interview room was like a bunker – quite airless despite air-conditioning – did not hear thunderstorm – created a pressure feel to the interview.” “Interview constrained by [participant’s] time pressures.”</td>
</tr>
<tr>
<td></td>
<td>To document constraints to participants’ explorations of interview topic</td>
<td></td>
</tr>
<tr>
<td>Impressions of interview</td>
<td>To document features of interviews to assist recalling the “feel” of interview that might have later relevance during analysis</td>
<td>“Quick, short, ‘pat’ answers, seemed busy and not very in depth about teams, but was able to move to more depth and elicit insights later in the interview with probing.” “I felt we often didn’t get past the ‘right’ words and rhetoric.”</td>
</tr>
<tr>
<td>Points made by participants during interviews</td>
<td>To highlight key contributions to inform data interpretation</td>
<td>“[Participant] described feeling intimidated at meetings – said that she was unsure of her role – didn’t really have an orientation to the team, just picked it up as she went.”</td>
</tr>
<tr>
<td>Participants’ post interview comments</td>
<td>To capture information provided by participant after the tape recorder was turned off</td>
<td>“[Participant] brought up a new point about ...”</td>
</tr>
</tbody>
</table>

5.7.4 Analytical and procedural journals

The notes made in my analytical journal following each interview provided a means to analyse contextual characteristics, reflect on impressions of the interview, identify common threads between interviews (or clashing concepts), and record key insights developed from the interview. Examples from my analytical journal are provided in Table 5.6. By highlighting participants’ key points and my emerging insights I integrated interview data collection with data analysis. Reflecting on my interview technique was integral to enhancing interview effectiveness.

Table 5.6 Content, purpose and examples of analytical journal

<table>
<thead>
<tr>
<th>Content</th>
<th>Purpose</th>
<th>Example of researcher’s field notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insights from interview comparisons</td>
<td>Record my emerging ideas as interpretation of data</td>
<td>“[Participant’s] comment at the end of interview ’It really gets me thinking about things I know I should be thinking about’ is very different from [previous interview participant] who said ’Is it really helpful to think about this?’ – Note to self: I need to think more about why people have different levels of awareness of the notion of team and collaborating.”</td>
</tr>
<tr>
<td>Reflection on interview technique</td>
<td>Develop personal interview style and skills</td>
<td>“I felt I tried to explore stories too early in this interview – should have left this until [participant] gave me a lead into it”</td>
</tr>
</tbody>
</table>
My procedural journal enabled me to record timeline and research events, prepare for meeting observations and interviews, record decisions I made in relation to the processes of the research and make notes about unexpected occurrences. The combined effect of my field notes, analytical and procedural information enabled me to be well prepared (from procedural and conceptual perspectives), facilitated a “whole” view of the team and, as well, provided me with a basis for reflection in preparation for the next interviews, and for developing coding categories for thematic analysis.

5.7.5 **Means of ensuring data quality for observations and interviews**

I implemented a number of strategies during the team meeting observations and interviews to ensure that the data I collected were credible in relation to the collaborating experiences of team members.

**a) Limited impact during observations**

To minimise my impact on team dynamics I aimed for people to be comfortable with my presence and my recording equipment. When possible I set up the recording equipment well before the meeting so that it was part of the scenery rather than a (foreign) disruption as people arrived. To lessen team members’ awareness of my presence I chose to sit back from the meeting table, in a position from which I could observe all interactions. I did not interact with the team during the meeting. The free flow of discussion during the meeting, the range of issues covered, and the nature with which they were dealt, together with comments of “I forgot that you were there” and “the meeting just flowed like normal” confirmed my impression of having minimal impact on the teams’ meetings.

**b) Engagement in interviews**

Through the data gathering process I was aware of the need for ensuring the collection of quality data. Engaging with participants is an important aspect of producing quality interview data in hermeneutic phenomenology. Van Manen (1997, p.66) explained that “the interview may be used as a vehicle to develop a conversational relationship with a partner (interviewee) about the meaning of an experience”. In aiming to develop conversational relationships I was aware that the degree of engagement between interviewer and participant is influenced by a number of different elements. These elements include the interviewer’s characteristics and roles, the participant’s understanding of what is involved in the interview, the accessibility of required information by the participant, rapport between participant and interviewer, and the
participant’s motivation to engage with the interviewer (based on May 1993). I used these elements as a guide for engaging with my participants, and thus as a means of ensuring the production of data quality.

- **Interviewer’s characteristics and roles**: I was aware that my previous interactions with some participants socially (or through other community roles) could lead to awkwardness in our role transitions from friend and/or community member to interviewer and participant. I was concerned that such role awkwardness could impact on the freedom with which participants shared their experiences. Therefore prior to the commencement of the interview I acknowledged our changing roles and our new situations through informal chat about shared experiences. At the completion of the interview I took cues from the participant regarding the need to step from our current roles back to our previous roles.

- **Participant’s understandings of what is required**: Information sheets and consent forms are an essential component of the informed consent required for ethical research. Yet the interview is also a social encounter, and “rules” for this encounter need to be established and clarified to ensure that participants have a clear understanding of what is expected of them (May 1993). At the beginning of the interview I clarified expectations and established rules for the interview, to enable participants to focus on the issues we were discussing rather than being concerned whether they were “doing the right thing”.

- **Accessibility of information**: Researchers need to ensure that the information they seek from the participants can be understood by the participants (May 1993). Parameters for collaborating, identified from my personal experience and through my initial overview reading of the literature, guided the development of the initial questions. Non-abstract questions phrased in conversational terms enabled the interviewees to readily understand and answer the questions. Probe questions were also developed to explore meanings and elicit more in-depth information. To facilitate access of information during the interviews I used the participants’ words for questions and probes where possible, rather than following the prepared interview guide prescriptively. The participants’ flow of ideas directed the order in which topics were covered. Different categories of question, such as basic descriptive questions, example questions, simple clarification questions, and conceptual questions (based on Janesick, 2004), were used as appropriate with participants.
- **Establishing rapport:** By providing a foundation for trust between interviewer and participant, good rapport facilitates honesty and depth of responses. In this research, establishing rapport with participants involved attending to a number of factors, including reassurance of confidentiality (which was confirmed in the information sheets and reiterated at the beginning of each interview), recognition of social and/or community contact, flexibility with participants’ time constraints, and use of non-judgemental language. I also reinforced that I was interested in understanding rather than judging what was right or wrong. By avoiding agreement or disagreement with their contributions I sought to prevent channelling information towards what I expected to hear and to remain open to hear their experiences as it was for them.

- **Motivation to engage with the interviewer:** Although the participants had already agreed to participate in the interview, I also needed their continued motivation to participate and engage with me throughout the interview. Maintaining eye contact, giving “encouragement cues” as appropriate, relating questions to participants’ own words or described experiences, and rephrasing questions for easier understanding were the main means by which I signalled the value of their contributions. Being flexible with the interview schedule and questions enabled me to adapt interview questions to particular interview situations while still covering all topics.

I verified the accuracy of transcriptions by checking them against the interview recordings and field notes. Transcriptions of interviews were not returned to participants for checking as I expected their ideas and experiential accounts to alter in response to exploring issues during interviews. I sought to access their experiences at the time of interview rather than subsequent experiences or their post-interview reflections on collaborating. This decision was informed by the notion of meaning-making in the interpretive paradigm being an ongoing process rather than a place to be reached. I took the responsibility of double-checking that all the tapes were transcribed accurately.

### 5.8 Methods of data analysis

Data analysis involved deep reading and re-reading of the three data sets (interview transcripts, case conference observations and field notes). Identification and critical appraisal of emerging themes across these sets enriched the understanding of each set as well as the emerging whole interpretation of the sets of data. To facilitate the interpretation of themes and meaning structures I needed a system for managing the large amount of data collected. I chose the software program NVivo as a tool for
collating, accessing and searching the data. NVivo was designed to support qualitative data analysis by facilitating data recording, storing, sorting, linking and retrieval (Bazeley 2007). Following transcription and de-identification, all interviews were converted to NVivo data files. I was then able to move easily between interviews, create coding labels for data, link data to these labels, access quotes and information related to these labels, and recode as necessary. Handwritten observation field notes were used in conjunction with NVivo by adding relevant information from these documents to the software program. This information was then coded and accessed in the same manner as the interview transcripts.

The process of data analysis for this project began during data gathering as I reflected on each interview and team meeting observation, developed insights for emerging ideas and made notes in my analytical journal. Following the completion of each phase of data collection, I listened to the tapes, read the field notes and transcriptions, re-oriented myself to the team meeting observations and interviews, and then began coding in NVivo. In NVivo data are coded to nodes developed by the researcher; a node is the term referring to the place where the software system stores related bits of information (Richards 2005). Coding can be considered to be organisational (facilitating the organisation of data), substantive (describing the data) and conceptual or theoretical (conceptualising the data) (Maxwell 2005). Organisational coding tends to occur early during analysis and conceptual coding occurs later as the researcher makes sense of the data (Maxwell 2005). Although I was an outsider to the specific research contexts (in that I had not worked, nor I was working, in the rehabilitation teams participating in the research) I brought a broad insider understanding to interpretation of the data through my health professional background.

Reflection is an important technique for qualitative analysis, and making notes while analysing data not only captures insights but also stimulates thinking. The use of procedural and analytical journals guided ongoing reflection on the congruence between research questions, data collection and analysis, and ensured that reasoning behind decisions, insights and findings could be articulated in a transparent, rigorous and trustworthy manner. Moreover, regular reporting of the research to the research training group and at conferences provided significant feedback that prompted reflexivity and challenged me to review and justify the research process and emerging findings. Throughout these activities the findings were refined and enriched rather than rejected. Feedback provided very positive support for the emerging and final findings.
Table 5.7 Relating different types of coding categories (based on Maxwell 2005) to my research

<table>
<thead>
<tr>
<th>Type of coding category (based on Maxwell 2005)</th>
<th>Characteristics of coding category</th>
<th>Examples of nodes from my research</th>
</tr>
</thead>
</table>
| **Organisational codes**                      | • Tend to relate to topics of interviews  
• May be anticipated prior to interviews  
• Act as “bins” for sorting data for future analysis  
• Facilitate the return to particular topics | • Case conference  
• Team processes  
• Beginning in the team  
• Patient/carer focus (by team)  
• Own role  
• Roles of others  
• Role clarity  
• Role gaps and overlaps  
• External influences |
| **Substantive codes**                         | • Tend to describe what is being said  
• Cannot necessarily be known in advance  
• Begin to make some claim about the phenomenon being studied  
• Can be participant’s or researcher’s descriptions  
• Beneficial for large amounts of data to ensure that ideas are captured as they emerge  
• Can be used as a stepping stone to develop a deeper understanding of the data | • Interrelated team membership  
• Orientation to team processes  
• Opportunistic communication  
• Team member’s sense of:  
  o agency  
  o personal development  
  o interpersonal aspects  
  o team interactions  
  o patient direction  
  o external contexts |
| **Conceptual or theoretical codes**           | • Represent researcher’s concepts of what is interpreted from the data  
• May represent an abstract framework | • Engaging with others  
• Envisioning together patients’ rehabilitation pathways  
• Effecting change |
The initial coding was organisational and substantive. However, as I immersed myself in the data and began recoding the initial nodes, I was able to move towards conceptual nodes and higher levels of abstraction and reduction. Characteristics of the coding categories are shown in Table 5.7 together with examples of nodes.

My analytical journal supported my analysis by providing a basis for, and record of, my ongoing engagement with my data. The process of writing was integral to the iterative process of analysis. Analysis continued through to the coding and re-coding of transcripts, and was completed when the questions I chose to ask my data were answered, the essence of collaborating was grasped, fusion of horizons had been achieved, and writing completed. The questions that guided my engagement with data included:

- What is the nature of the lived experience of collaborating in rehabilitation teams?
- What dimensions of collaborating are evident in team members’ experiences?
- How can collaborating (by rehabilitation team members) contribute to patient-centred health care?
- How does organisational support for rehabilitation teams’ collaboration contribute to patient-centred health care?

In aiming to illuminate the experience of collaborating I engaged with data I obtained about the complexities and challenges that team members faced in collaborating with others in their team, then dialogued with questions related to this data and the emerging themes of collaborating. I sought to understand the experience of collaborating more from an interpersonal perspective than from the various disciplinary perspectives, and to identify characteristics of the experience of collaborating evident within the diversity of teams and team members. Thus I did not seek to understand the experience of collaborating in terms of common experiences of each discipline involved. Instead my focus was on the interpersonal nature of the experience of collaborating. Through this dialogue I identified the meaning structures of the phenomenon.

5.9 Conclusion of methods section

The description of the method used in Study B, the hermeneutic phenomenology study of this research, and described in this part of the chapter built on the explanation of research choices presented in Chapter 3. The findings of this study are presented in the remainder of the chapter.
5.10 Introduction to findings

Understanding more deeply the experience of collaborating enabled me to bring individuals and their lived experiences to the forefront of the study. Through these experiences I explored what it is like to collaborate and how collaborating is influenced by rehabilitation goals and organisational contexts. Before presenting my detailed exploration of the dimensions of the experience of collaborating, I introduce and describe emergent conceptualisations of teams in relation to their arenas of collaborating and team members as people with particular patient care roles. These notions provide the context for the experience of collaborating in rehabilitation teams and contribute a focus for exploring organisational support for and barriers to collaborating. I identified these conceptualisations through my analysis of peoples’ descriptions of collaborating.

5.11 My use of participants’ quotes

This phase of the research involved 9 teams and 77 participants. From participants’ interview transcriptions, quotes were chosen to provide a sense of the experience of collaborating. The particular discipline and team of the person whose quote I have used is not stated for two reasons: (a) quotes were chosen to represent themes of interpersonal experiences rather than experiences typical of particular professional disciplines or specific teams, and (b) anonymity of participants could not be guaranteed if their discipline and team were identified (participants could potentially discern team codes from their own quotes and use this information to identify others in their teams). The numbers associated with the quotes correspond to their randomly allocated identity code, and the “P” (for participant) indicates that quotes relate to the participant’s lived experiences. Where the participant’s identity could possibly be determined from the content of the quote, “X” replaces the participant code number.

Preference was given to quotes that clearly and concisely described the particular idea I was seeking to explicate. My choice of quotes was also influenced by my aim to give voice to all participants and to represent interpersonal activities and experience of collaborating. The experiences of all the participants were used to identify concepts and themes.
5.12 Re-conceptualising teams and team members

Teams and team members provide the context and vehicles for collaborating. In the literature, health care and rehabilitation teams are often presented as concrete entities with stable structures, and team members are often referred to in relation to their discipline roles, such as nurse, physiotherapist or doctor. My re-conceptualisations of teams and team members arose from my analysis of the participants’ experiences of collaborating in rehabilitation teams, and enabled me to be open to experiences that transcended team and team members’ discipline role categorisations.

Through this re-conceptualisation I developed the notion of *arenas of collaborating*, which provided a framework in which I could explore experiences in rehabilitation units where team membership and team processes lacked clarity and stability (or alternatively exhibited flexibility and fluidity), as well as situations where team membership was more stable in character and where there were clear leadership guidelines and team process. By focusing on *arenas of collaborating* rather than explicit, readily identifiable *teams* I more clearly represented and acknowledged the variety of team structures and modes of operating that I encountered, and the fluidity and interrelatedness of team membership.

The focus on participants’ discipline roles within teams was similarly re-conceptualised by broadening the focus on roles to encompass the nature of the contribution to patient care rather than team members’ discipline title, socialisation and allegiance.

5.12.1 Teams in relation to their arenas of collaborating

Through the process of re-conceptualising teams it became evident that some of the characteristics commonly regarded as highly useful for teams (e.g. clarity of team boundaries and membership) were not necessarily present in or required for all contexts. In particular, during Phase 1 data analysis, I noted that the complexities and ambiguities of teams evident in my data contradicted the predominantly straightforward conceptualisations of identifiable teams commonly presented in the literature. In my research, some teams were diffuse entities with no readily discernible boundaries, whereas others were discrete entities with clear team boundaries and membership. Team membership in some teams had a transient nature. The different structural nature of teams became apparent during my preparation for observing team meetings, as evidenced by comments from my procedural log:
Despite my discussion with A I am not quite sure who is in charge in this team or who will be at the team meeting. I will use B as a contact and I will check a few days before the meeting that the information sheets and consent forms have been distributed to the people expected to be at the meeting. [Procedural log]

Spoke with Dr X – Y is team leader. (...) Spoke with Y – she will distribute information at next team management meeting – appears to be a stable team - she was able to tell me who would be at meeting. [Procedural log]

During interviews participants described “teams within teams”, interrelated team memberships, memberships of multiple teams, competing team loyalties:

You’re kind of part of two teams, as in the team on the ward (...) and your case conference [team]. [P63]

Team members (...) have responsibilities with other teams at the hospital. [P53]

[I am] part of the management team of the hospital and (...) and the medical rehab team (...) and every now and again there is a conflict. [PX]

There were differing views of the entity that was the team:

The rehab team is very sort of vague here [but it] consists of all of those who come to the meetings, (...) and other people [who] float in and out. (...) It’s not a defined boundary. [P72]

I think there is a core team, (...) people that have been there for a long time who probably know how the unit runs and who probably keep the unit ticking over I guess, and the others come and go. [P62]

There are different levels to the team. (...) [There is the] clinical team, but of course the infrastructure [team] is an important part in ensuring the clinical part works well. [P37]

Furthermore, some teams had no specifically designated leader, allocated budget, or authority to appoint members or clear processes:

I don't really feel that there's anyone who sort of stands out as being the leader of the team [P71]

In terms of how the team’s actually funded and who the team members actually report to for administrative matters, it’s quite separate because (...) team members are funded by their department. (...) [P17]

There are not a lot of structured processes [P17]

In contrast, other teams had a budget, clear leadership, and authority to appoint team members and direct team processes:

We have a budget [p19]

We have a manager who leads our team [P21]

[When recruiting new team members] we do ask quite a few questions in the interview about working in teams. [P75]
I try not to be autocratic, I (...) encourage people to talk about it, to let them feel free to voice their opinions and to disagree with me if they want. I think my leadership style is one of leading from about the middle, not from behind or in front. [P5]

The physical layout where the teams worked also differed:

We do all work within close proximity of one and other. [P17]

We’re a rehab unit but we’re setup on the acute medical floor. We don’t have the infrastructure really in place to be a proper rehab unit. (...) [The] gym area is on another floor. [PX]

In this research I sought to explore the experience of collaborating in the reality of rehabilitation teams rather than in what I, as researcher, deemed or saw in advance to be the team. Therefore I chose to embrace the complexity and ambiguity inherent in these teams, and in doing so I developed the model of arenas of collaborating (as shown in Figure 5.2). I identified modes of structural diversity within the arenas of collaborating and labelled those modes as integrated, intersecting and hybrid. The labels for these modes were chosen to reflect a feeling of stability and completeness (integrated) or a sense of ongoing change and movement (intersecting). In echoing the alliteration used to describe other findings (e.g. the P’s in Chapter 4), the repetition of the ‘i’ flags these terms as research findings. I listed each team according to how it fitted into this spectrum of structural diversity based on observed and described organisational and team characteristics.

Figure 5.2 Arenas of collaborating

215
Arenas of collaborating teams reflected the different organisational contexts of teams. From the data analysed, organisational components were identified as lying along a spectrum from centralised to dispersed. Teams with dedicated team budgets, whose members were employed specifically to work as part of the rehabilitation team and with opportunities to work in close proximity to one another, were identified as having centralised organisational components. Teams without a team budget, specific appointments to the team, and team member proximity were considered to have dispersed organisational components. In the latter situation, teams were also dependent on allocations from department or ward budgets, team members were rostered to work in rehabilitation by their various discipline departments, and rehabilitation team members often worked in separate areas. A spectrum of team processes and leadership roles within the participating teams was also identified, with some teams having clear communication strategies, forums to discuss team issues and appointed team leader positions, whereas other teams were unclear about such processes and roles.

In the intersecting arena, team members tended to have discipline-specific orientations, learned team processes “on the job” and had to manage competing team and discipline loyalties. Without a dedicated budget, and being reliant on discipline department rosters for team member continuity, teams in this arena often faced challenges to the security of their service provision and resources. In contrast, teams in integrated arenas were more assured of having clear leadership and management, adequate staff positions, suitable space and ongoing access to facilities. Team members collaborating in this arena also tended to have an extensive team orientation by the team leader. This orientation shaped them to work within their teams’ accepted ways of practice. Teams within the hybrid arena contained a mix of characteristics.

These arenas provide a valuable means of conceptualising aspects of participants’ varied experiences, highlighted the diversity between teams that participated in the research and informed the choice of Phase 1 teams invited to participate in Phase 2. The geographical location of teams in relation to their arenas of collaborating is shown in Figure 5.3, with details of staff participant numbers provided in Table 5.8.

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71 See Section 5.14.
72 Phase 2 teams represented different arenas of collaboration, as well as different geographical locations and types of service.
Table 5.8 Numbers of interviewed staff participants and teams in arenas of collaborating in relation to geographical location

<table>
<thead>
<tr>
<th>Arena of collaboration</th>
<th>Rural staff participants (teams)</th>
<th>Regional staff participants (teams)</th>
<th>Metropolitan staff participants (teams)</th>
<th>Total staff participants (teams)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intersecting</td>
<td>10 (1)</td>
<td>-</td>
<td>11 (1)</td>
<td>21 (2)</td>
</tr>
<tr>
<td>Hybrid/Intersecting</td>
<td>-</td>
<td>5 (1)</td>
<td>10 (2)</td>
<td>15 (3)</td>
</tr>
<tr>
<td>Hybrid/Integrated</td>
<td>4 (1)</td>
<td>14 (1)</td>
<td>-</td>
<td>18 (2)</td>
</tr>
<tr>
<td>Integrated</td>
<td>-</td>
<td>8 (1)</td>
<td>4 (1)</td>
<td>12 (2)</td>
</tr>
<tr>
<td>Total</td>
<td>14 (2)</td>
<td>27 (3)</td>
<td>25 (4)</td>
<td>66 (9)</td>
</tr>
</tbody>
</table>

5.12.2 Team members as people with patient care roles

In health care and rehabilitation literature, common conceptualisations of teamwork and collaboration view team members in relation to the disciplines they represent. In this research, however, I viewed collaboration primarily as occurring between individuals. In data analysis, individual participants’ experiences were the unit of consideration.

While acknowledging that team members’ involvement in collaborating was based on their health profession discipline role, I wanted to look through and past these roles to interpret collaborating as it was experienced on personal and interpersonal levels. I wanted to see collaboration from the inside out and explore what it was like for team members as individuals, rather than, for example, looking at participants predominantly as physiotherapists, nurses, occupational therapists or doctors. In doing so I was not
seeking to separate individuals from their socialised discipline roles; rather I was
looking for commonalities between individuals’ experiences of collaborating in
rehabilitation teams.

During analysis I noted that the discipline roles of team members did not necessarily
reflect the role the person played in patient care. For example, some nurses’ principal
roles in the team related to their specialist roles in patient education or discharge
planning rather than direct patient care:

I work on the wards as well as doing the discharge planning [PX]
I am a bit different in my role because although I have a clinical role to a certain extent
I’ve also got this remit of sort of coordinating care and being a liaison role and doing
education [P43]

One allied health professional’s primary role was a team manager:

[As a manager] I use my [allied health] skills all the time (...) I’m very much a clinical
manager in this role, I’m not just making budgets, meeting the bottom line [PX]

In some teams 24-hour patient care was not the domain of nurses, as rehabilitation
assistants were employed for this role.

I’m a rehab assistant (...) we’re seeing [the clients] at different times of the day and
spending a lot of time with them. [PX]

Further, for some teams, particularly those in the integrated arena of collaborating,
physiotherapists, occupational therapists, speech pathologists and social workers tended
to blur discipline boundaries when undertaking assessments and providing therapy:

I guess we are really expecting people to leave behind their “this is my territory” thing.
[P75]

We acknowledge that other people can also have input into a particular area, and
we’re willing to share those [areas]. It’s not like losing our role. It’s more like sharing
something and sharing our experience. [P21]

On the basis of these observations I reconceptualised people’s roles in teams in relation
to their patient care roles (see Table 5.9). Conceptualising rehabilitation roles in this
way reflected the experiences of team members and focused on contributions to their
patients’ rehabilitation rather than the framework of their professional socialisation. A
key feature of this conceptualisation is that team members’ contributions are broader
than their discipline roles.
Table 5.9 Patient care roles

<table>
<thead>
<tr>
<th>Patient care role</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of 24 hour care to a range of patients</td>
<td>Nurses, rehabilitation assistants and living skills assistants</td>
</tr>
<tr>
<td>Provision of assessments, treatments, and therapy to a range of patients</td>
<td>Physiotherapists, occupational therapists, speech pathologists, social workers, neuropsychologists, dieticians, medical specialists, registrars, resident medical officers and career medical officers</td>
</tr>
<tr>
<td>Provision of support for team members</td>
<td>Administrative assistants, managers, staff educators, discharge planners, wardsmen</td>
</tr>
</tbody>
</table>

Across the arenas of collaborating, the majority of team members interviewed provided assessment, therapy and treatment. Details of the team members’ patient care roles in relation to their arenas of collaborating are provided in Table 5.10.

Table 5.10 Patient care roles of staff in relation to arenas of collaborating

<table>
<thead>
<tr>
<th>Arenas of collaborating</th>
<th>Provision of 24 hour care</th>
<th>Provision of assessments, therapy and treatment</th>
<th>Provision of support to team members</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intersecting</td>
<td>4</td>
<td>14</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Hybrid/Intersecting</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Hybrid/Integrated</td>
<td>4</td>
<td>14</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Integrated</td>
<td>1</td>
<td>8</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>45</td>
<td>10</td>
<td>66</td>
</tr>
</tbody>
</table>

Because of their inherently different positions in rehabilitation teams, patients and carers needed to be distinguished from (staff) team members. Although patients were integral to the focus and shared purpose of rehabilitation teams, I realised that because of their limited involvement in team development and maintenance issues in the institutions I studied, they should not be considered as direct members of the team. Accessing their experiences with collaborating, however, informed and strengthened my interpretation of team members’ experiences.

73 Although there is some recognition in the literature of the complexity of patients’ position in rehabilitation teams (e.g. Suddick & de Souza 2006), uncertainty and lack of consensus surround this issue.

74 I note that in other settings (e.g. collaborative mental health programs where patients participate in decision making about their health care program) patients are clearly team members.

75 The voices of the, patient and carer participants will be focus of a paper exploring more specifically their roles in team decision-making. This paper, while arising from this research, is beyond the scope and core focus of this thesis.
Figure 5.4 *Experience* dimensions of collaborating: *Endeavour* (E’s) and *reviewing* (R’s) dimensions
5.13 Introducing the experience dimensions

This section briefly introduces the experience dimensions of collaborating, which are then detailed in Sections 5.14 and 5.15. Taking a view of collaborating as occurring between people (i.e. team members as individuals with varying patient care roles) who worked in different arenas of collaborating, I identified several interrelated themes or meaning structures from the data. These themes cut across the diversity of teams and rehabilitation roles involved in this study. I interpreted the themes or meaning structures of the experience of collaborating to be composed of eight experience dimensions. Five of the experience dimensions related to interpersonal endeavour and three were (meta) reviewing dimensions. These eight dimensions represent to me the essence of the experience of collaborating in rehabilitating teams. This accords with van Manen’s definition of the essence of a phenomenon being “the inner essential nature of a thing, the true being of a thing ... that what makes a thing what it is (and without which it would not be what it is)” (1997, p.177).

The five experience dimensions of interpersonal endeavour (E’s) identified related to: engaging with each other’s diversity, entering into the form and feel of the team, establishing ways of communicating and working together, envisioning together patients’ rehabilitation pathways, and effecting changes in people and situations. These dimensions were relevant to all team members (see Section 5.14).

Three experience dimensions were (meta) reviewing dimensions (R’s): reflexivity, reciprocity and responsiveness. These reviewing dimensions lie above, across and surround (i.e. are meta to) the endeavour dimensions and are responsible for regulating and revisioning the different levels and modes of collaborating. The term “reviewing” relates to the notions of thinking about and changing. More details about these dimensions and their relationships with the experience dimensions are provided in Section 5.15.

The words to label the dimensions emerged during on-going iterative interpretation and reflection. They were chosen to reflect the interpersonal nature of the collaborative experiences described by the participants, with the repetition of the beginning letters (E and R) serving as a heuristic device for conceptualising the dimensions and highlighting their interrelationship and interdependence (see Figure 5.4). In this figure the key role of engaging is portrayed as connecting to all dimensions, with the circular format and dimension “echoes” depicting the on-going and dynamic nature of collaborating. The
(meta-)reviewing dimensions (R’s) surround and inform the endeavour dimensions (E’s).

5.14 Explaining the **endeavour dimensions**

For team members, the dimension of *engaging positively with others’ diversity* reflects their openness to each other’s different perspectives and skills, as well as their goodwill and respect for others. This dimension related primarily to the positioning of *self* in relation to others; being positively attuned to others. *Engaging* was fundamental to other dimensions. *Entering into the feel and form of teams* involved making sense of teams’ expectations and team members’ capabilities. For some people *entering* a team was a gradual process whereas for others it was more abrupt. Changing team membership was the impetus underpinning this dimension. The organisational context influencing the nature of the team’s *arena of collaborating* was also relevant to shaping experiences within this dimension. *Establishing ways of communicating and working together* required intertwining a range of formal and informal systems of communication and adjusting to others’ ways of working. The focus of this dimension was the complex nature of interactions with others. *Envisioning together patients’ rehabilitation pathways* provided the basis of patient-centred collective for collaborative care. This process involved team members interweaving their clinical information with stories of patients’ situations and aspirations, to develop mutual understandings for patients’ rehabilitation directions and ways to achieve them. *Effecting* changes in people and teams required team members to help patients progress through rehabilitation within organisational constraints. This dimension related to working with others in organisational contexts. Descriptions of each dimension conclude with a free text poem that captures and expresses the rich experience of collaborating within the dimension. The aim of the free text poems is to evoke for readers the sense of participants’ experiences in relation to the interpersonal endeavour required for collaborating in rehabilitation. The poems arose from my deep immersion in the data; they reflect underlying messages, if not the precise voices of the participants.

Depicted in Table 5.11 are the **endeavour** dimensions of collaborating and elements within each dimension. These dimensions and elements are then discussed in greater detail.
Table 5.11 *Endeavour* dimensions of the experience of collaborating

<table>
<thead>
<tr>
<th><strong>Endeavour dimensions of the experience of collaborating</strong></th>
<th><strong>Elements within the dimension</strong></th>
</tr>
</thead>
</table>
| a) *Engaging* with other people’s diversity             | • being positively attuned to others  
| (self in relation to others)                             | • respecting others  
|                                                           | • valuing different contributions |
| b) *Entering* into the form and feel of the team         | • entering teams in slipstreams and as baton changes  
| (in relation to team membership changes and influences from the broader organisational context) | • easing into the team  
|                                                           | • coping with continual alterations to team membership |
| c) *Establishing* ways of communicating and working together (highlighting complexities of interacting with others) | • adjusting to teams’ ways of working  
|                                                            | • negotiating and developing roles with others  
|                                                            | • intertwining structured and organic communication |
| d) *Envisioning* together frameworks for patients’ rehabilitation (in relation to patient-centred collective decision making) | • sharing expectations and information  
|                                                            | • negotiating mutual understandings  
|                                                            | • portraying patients as people |
| e) *Effecting* changes in people and teams (highlighting working with others in organisational contexts) | • helping patients progress through rehabilitation  
|                                                            | • dealing with system requirements and changes  
|                                                            | • developing and sustaining teams |

5.14.1 *Engaging* with other peoples’ diversity

To engage: “to occupy the attention (of a person, etc.) ... to attract or please ... to interlock with ... become involved”

(Delbridge & Bernard 1992, p. 311)

We [health professionals] are supposed to be people people. [P57]

The dimension of *engaging positively with each other’s diversity* was based on the notion of “self” in relation to “other”. The term *engaging* was chosen to highlight interpersonal connectivity. Collaborating involved team members being positively attuned to others in the team, respecting them and valuing their differences, not just being in tandem or alongside each other. This dimension was underpinned by the awareness of what people could achieve when they brought their different perspectives, knowledge and skills to rehabilitation situations:

I just think you all have strengths and you all have weaknesses. And when you work as part of a team you can complement each other; you know, your knowledge, your personal skills, your professional knowledge, your life experience knowledge. [P11]
The participants demonstrated their awareness of the value of *engaging* with others by referring to more complete understandings of the *whole* person, not just the part of the person that is relevant to their particular discipline:

I really like working with other people and seeing the whole person. [P75]

Seeing the whole person required people to see beyond their own discipline to appreciate the roles of others:

I think people need to be able to step out of their own discipline and think a little bit more about where the other disciplines are coming from. [P53]

The dimension of *engaging* infused all other dimensions of collaborating. Yet *engaging* had a nebulous nature that rendered it somewhat hard to see and difficult to grasp; at times it seemed more noticeable when it was absent. Participants often used its absence as evidence of the importance of its presence. In the following descriptions of elements within *engaging* these nebulous aspects are brought into clearer focus. See Table 5.11a for an overview of the elements in this dimension.

**Table 5.11a Dimensions and elements of experience of collaborating**

<table>
<thead>
<tr>
<th>Dimension of experience of collaborating</th>
<th>Elements within the dimension</th>
</tr>
</thead>
</table>
| a) Engaging with other people’s diversity (self in relation to others) | • being positively attuned to others  
• respecting others  
• valuing different contributions |

**a) Engaging: Being positively attuned to others**

Within the dimension of *engaging* was the element of *being positively attuned to others*. This element highlighted ways in which, from an attitudinal perspective, team members positioned themselves openly towards each other and were prepared to interact on a personal level. Rather than being easily or explicitly articulated, being *positively attuned to others* was evident as a common thread within descriptions of team situations and atmospheres that were conducive to collaborating. In such circumstances team members valued being accepted and included by other team members:

There’s a sense of ease, there is a sense of, I don’t know, bonding or whatever between people, but it’s also open. [P4]

They’re just really easy to work with. Yeah, just a positive body language and you know, they make the time to listen to you if you need to talk to them. There’s a good level of humour as well, which kind of makes it more relaxed. [P24]

Within positive descriptions of team atmospheres the absence of negative emotions was often noted. Not being scared or intimidated provided a reference point for accentuating the significance of the more nebulous notions of acceptance and inclusion:
It’s great that you can be sitting down in that room with the rehab specialist and not be frightened to say anything. [P35]

Being respectful of each other and not trying to undermine each other [is important] and I think we do that well. I don’t ever feel intimidated. [P1]

We have the meeting and it’s not scary at all. I’m quite comfortable with everyone on the rehab team, which is helpful because it means I don’t start walking to work going “Oh crap I’ve got a case conference today”. [P72]

Although it was unclear if these emotions had actually been experienced by the participants in other situations, references to being frightened, intimidated and scared provided strong images of participants’ personal vulnerabilities and introduced the notion of fragility to collaborating.

The valuing of people was integral to team members being positively attuned to each other. Team members tended to be perceived by others in the team as being more than just competent representatives of their disciplines. Who they were as people in their personal contexts was important to others, particularly in relation to their contributions to patients’ rehabilitation:

I think to get the best out of your staff [for patients’ rehabilitation] you have to make them feel comfortable. You have to find out about them as people. [P17]

Incorporating food (such as chocolates and lollies) and morning tea into meetings appeared to help team members connect as people, and these connections appeared to contribute to their sense of collegiality:

The tea and coffee loosens up people, so it’s like a nice interaction. They share, cut pieces, so they look at each other when you give them and say thank you and so it’s like a starting of a friendly atmosphere. [P2]

In some teams there was also a sense of team members enjoying each other’s company:

Generally it’s a very social environment here, so there are lots of morning teas and people are very aware of when it’s someone’s birthday. (...) Because you’re working so closely you do develop relationships with each other and often quite close friendships. [P1]

I mean we are a team, but we are also mates that might go out at other times as well. [P31]

Thus for a number of rehabilitation team members, being able to interact positively with others augmented their primary role of providing rehabilitation services.

However, this was not always the case. While it seemed beneficial for team members to “get on”, team members did not necessarily need to be friends. In such instances the

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76 Mate is an Australian term denoting friend.
valuing of their contributions to patients’ rehabilitation might necessarily overshadow the importance of the relationship with the “person”:

She [a particular health professional] is known for being quite prickly and having her own opinions on things. I haven’t really had a problem with her, [but] at the same time there’s not really any friendship or any connection there. It’s a very professional. [She] has more fixed boundaries. She’d probably be the only person that I feel a little bit nervous about occasionally approaching. [P1]

Team members often had optimistic views of the team and team members. A sense of relational generosity was detected in the ways they approached their interactions with others. For them, the “team glass” was typically half full rather than half empty; there were possibilities rather than impediments, and people were viewed as having inherent potential to improve their relationships with others. Evident throughout the element of being positively attuned towards others was a sense of goodwill.

This sense of goodwill and optimism was evident within positive framings of “prickly” individuals and deliberations on how to improve situations. Many team members personally bore the responsibility for developing effective communication strategies as they sought solutions to interactional challenges. Their strategies often appeared to involve a large degree of caution for interacting with particular people and the alteration of their own styles of communication:

I haven’t really found my way with that person to be quite honest. I tend to think a lot about what I’m going to say before I actually go and talk to her about something. [P3]

I think it’s just the personalities in the team. I find [one of the team members] quite domineering, I’m not a very confrontational person, so I find that intimidating. So if I’ve got something to say I usually try and make sure I’m very clear on what I want to say and have the reasons behind it all worked out beforehand. [P13]

Embedded in these quotes is recognition of the importance of communication and the on-going effort that might be required to interact with particular people.

Communication about patients was viewed as too important to relegate to the “too hard basket”.

At times team members relied on their managers’ interventions to deal with situations where common ground between team members was difficult to obtain. Optimistic views (perhaps founded on previous positive experiences) of the manager’s ability to work with team members to improve the situation could be discerned within this seeking of outside assistance:

I’ve had some [team members] who I haven’t seen eye to eye with, and vice versa. But I tried. Yeah that’s why you have the manager, so if you’re having problems with
someone you need to be talking to her, so she can talk to that person and then talk to you, and try and find some even ground. [P30]

Optimistic views of team members’ potential for change were also evident in the explicit and proactive modelling of inclusive team behaviours to team members:

One of the best ways you can actually influence staff is by setting a good example. It’s not only what you say, it’s how you say it. It’s how you treat people. It’s non-verbal communication. It’s whether you appear interested or you don’t appear interested. (...) [It is how you] treat your other staff, not only your direct staff, you know, the physios, and the speech therapists, but talk to the cleaner and the ward clerk and the physio aide. [P17]

Being positively attuned towards others also required a balance between optimistic stances towards others’ potential and a pragmatic awareness of peoples’ capacity for change:

Some people you won’t change. I mean, you’ve got to understand for some people that’s their personality and you won’t change it, so it might be the other people getting used to what they do. [P59]

Team members were also pragmatic about the impact difficult individuals might have on others in the team, and despite wide acceptance for people’s challenging interactions, at times the solution involved not having particular people in the team. Tolerance of team members was not unconditional, particularly when the quality of patients’ rehabilitation was at risk:

It’s very important that you get people who can work in the team. You know, you can have a great [member of a particular discipline] but if they can’t work well with the team, it really permeates everything we do. And for me I’d prefer not have that person and have that [position] vacant rather than having someone [who doesn’t work well with others] because it’s actually detrimental [to providing rehabilitation]. [P75]

To have a vacant position provided this team with the option of seeking expertise from other sources, as well as the potential for the position to be filled by a person with ability to contribute to, rather than impede, the work of others in the team. This situation illustrates the detrimental effect one person can have on the work of others.

Being optimistic about people’s capabilities involved seeing their potential for change, and balancing this potential with an acceptance of what was possible and not possible. Although not all members of rehabilitation teams were positively attuned to each other to the same extent all the time, team members appeared predominantly to seek goodwill and openness to each other in their interactions. Being positively attuned to others involved being accepting of and responsive to other people’s diversity.
b) **Engaging: Respecting others**

Respect meant different things to people and was expressed in varied ways. For some team members, respect was a general notion associated with teams. Other team members differentiated between respect for disciplines and respect for individuals’ capabilities and experiences. Respect had directional elements: receiving respect from others (being respected) and providing respect for others (showing respect). Although there were many different nuances within this complex construct, the experience of respect was unanimously valued.

Being respected was perceived as having an enabling effect on team members’ contributions. *Respect was relevant to the notion of engaging positively with other’s diversity.* In a broad sense, respect helped team members to be positively attuned to each other, particularly in relation to contribution to patients’ rehabilitation:

> I think it’s important, showing your respect for their profession and their knowledge and their skill of helping, and helping each other. And I think we have to learn to respect each other and just work together. I mean I couldn’t come down here and do everything for those people on my own because I don’t have the skills that others have in their roles. They wouldn’t be able to walk in and do the things I do. [P23]

When receiving respect, health professionals experienced a sense of freedom to express different opinions and participate in healthy debate. Being listened to and heard was an important aspect of feeling respected:

> I guess debate happens when one person puts forward their professional views or ideas or whatever, and the rest of the team [have] different ideas, or different interpretations. I certainly feel comfortable discussing things openly [even those things] that may not directly agree with other members of the team (...) and [I find] that they will respect my opinion. It may not be what we go with but it’s certainly respected and considered seriously. [P21]

Such respect appeared to enhance people’s confidence and self-esteem in terms of their discipline roles and team contributions.

Respect was often interlinked with trust, and presented as a construct to be earned.

Knowing the other health professionals as *people*, as they performed their rehabilitation roles, formed a basis for gaining respect and trust:

> I think respect has to be earned, in that there is the obvious respect that you have for every human being and every person within their role. But to really trust someone and really respect their position or their job or their professional abilities or their social skills obviously you need to get to know them and observe how they work. [P1]
For some team members, respect for the discipline was different from respect for the person representing the discipline. In such situations, experience often counted positively in making judgements about respect:

I feel as though I have respect for each of the professions. I’ve worked with each of those professions for a long time. (...) I also respect the individuals on our team at the moment. [But a] new person coming in, do they have to win respect? I think they do. [P22]

I think people are very respectful of other peoples’ experience. I think at this point in time we have got a mix of quite senior [discipline roles], I think everyone’s quite respectful of people’s experience. [P62]

Being respected was not necessarily a taken-for-granted concept by many team members, particularly if they had previously experienced working in non-engaging hierarchical teams. These instances highlighted that respect for discipline contributions could not necessarily be expected automatically:

We’re pretty lucky to have [an approachable rehabilitation specialist], I haven’t actually had that in any other team where we’ve had the rehab specialist really respecting what his team says, and that goes a long way to having a nice team with that respect from those that you consider above you and the doctor. [P35]

Respect, in all its varied meanings and nuances, was undisputedly constructive. Engaging positively with others’ diversity required respect between team members. Respect engendered facilitatory attitudes towards the contributions of team members. Although team members valued being respected, the granting of respect was not necessarily assured. Granting respect to others often involved intertwined perceptions of the merit of others’ discipline roles and contributions to rehabilitation and judgements about the worth of individuals’ contributions.

c) Engaging: Valuing different contributions

Valuing different contributions from team members contributed to engaging positively with others’ diversity. Rehabilitation was consistently portrayed as being bigger than one profession, one person or one way of doing things. Team members recognised that “I” and “you” brought different qualities and characteristics to rehabilitation. These differences were commonly viewed as being integral to collaborating, and were valued:

From our backgrounds we have different ways of approaching, getting information or dealing with the information that [patients and carers] are giving us. It’s so nice to watch someone else at work. I think it’s just more effective. [P11]

You widen your approach [with rehabilitation patients], because you talk to the psychologist, you talk to the social worker, you talk to the occupational therapist, and so you get a better understanding of other approaches or things that can be managed for the person. [P47]
You know [we] are just so completely different, we’re not different with regards to ideals to have the best thing going, and we’re not different in terms of having an understanding what rehab is. But in terms of our personalities, the way we get jobs done, agendas, all different. And I think that’s fantastic. [P48]

Despite team members valuing others’ different contributions, incorporating others’ different perspectives was not always straightforward:

I think sometimes there’s a clash between a couple of groups [with] a different way of looking at some issues. [P71]

Many differences were brought to collaboration in rehabilitation teams, particularly in relation to team members’ perspectives and skills to understand and address patients’ and carers’ aspirations and situations. Through seeing self in relation to others, these differences were predominantly valued.

d) Engaging: Free text poem

A poem illuminating the dimension of engaging is shown in Free text poem 5.1.

e) Engaging: Comparison of findings with key aspects of the literature

The dimension of engaging highlights the importance of educating health professionals about each other’s roles. Although not providing the answer to how to educate professionals about the roles and contributions of other health professional disciplines, this dimension does emphasise the importance of appreciating the diversity that may be encountered in team situations, and in doing so supports the current interest in interprofessional education as a means through which health professionals can be prepared for working with others. This interest is evident in a number of publications (as described in Section 2.2) and organisational policies, including the World Health Organization’s Framework for Action (WHO 2010, p.7) which states: “interprofessional education is a necessary step in preparing a “collaborative practice-ready” health workforce”.

By highlighting the notions of appreciating diversity in others, the findings presented in my research also support the notion of collaborating as involving intensely interpersonal attunement and connectivity, as is evident in the claim of Barr, Koppel, Reeves et al. (2008, p.3) 78.

77 Interprofessional education is outlined in Section 2.2.4.

78 Texts describing interpersonal aspects of collaboration are also explored in Section 4.3.
ENGAGING
We are part of an emerging whole.
Each bringing
a piece of our differences.
Contributing
our sense of others,
and our willingness to connect.

Through our awareness of this emerging whole,
potentials and possibilities are
sought and valued.
Our openness to each other,
our multiplicity, our shared focus
presumed and comfortable within our synergy,
encompassed by a word –
“respect”.

Or not?
Are we indifferent to our differences?
Are we detached and disconnected?
Where new paths of understanding are
detoured by isolated individuals
hedged by dissonant disciplines
overgrown by habitual practice
our affinity for others
is fluorescent in its absence.
And these memories linger ...

So we may not fit comfortably ...
you might challenge and confront me.
But do I have time and inclination
for you?
Do you for me?
Then can we move
past the constraints that crowd
my outlook, your outlook?
And engage
with each other, 
about others.
We are part of an evolving whole.
Collaboration between professions is a two-way process, grounded in mutual respect for diversity and difference. On the one hand, it presupposes readiness to listen, to value what the other has to contribute, to be receptive to new ideas and information and prepared to change attitudes, perceptions and behaviour in response. On the other hand, it calls for generosity, openness and trust in a spirit of inclusion. More than mere mechanics, communication is at the heart of interprofessional relations.

However although the authors describe collaboration as being interpersonal, they stop short of identifying and labelling the interpersonal endeavour underpinning their claims. I propose that identifying and labelling interpersonal endeavour, as undertaken in this thesis, is a step towards being able explicitly to reflect on and develop interpersonal connectivity and awareness of self in relation to others.

Similarly, the importance of trust and respect for collaboration between health care professionals noted in the findings of my research has been noted by other authors. D’Amour et al. (2008), for example, claimed that trust in each other’s competencies is necessary for collaboration. This thesis frames these notions of trust and respect as complex elements, aspects of which can be developed through interpersonal endeavour rather than necessarily being precursors of collaboration. This is consistent with Williams’ (2004, p.154) claim that “when individual practitioners from different agencies meet often enough, they usually narrow the gaps between them and respect and trust grow”.

In my research, the interplay between trust and respect as precursors and outcomes was highlighted in terms of these qualities being (a) something to be expected, due to being a person with inherent value and a member of a discipline that brings different perspectives and skills to the collaboration, and (b) something to be earned, due to each person’s different levels of experience and capability, in relation to the context in which they are required. These findings indicate that while trust and respect are integral to collaboration, they can be developed through collaborating rather than just being qualities that must be present prior to collaborating.

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79 Texts discussing trust and respect were explored in Section 4.3.4.
5.14.2 Entering into the form and feel of the team

To enter: “to be admitted ... to make a beginning ... to join” (Delbridge & Bernard 1992, p.313)

I think we try and sort of ease [new team members] into what the expectations of the team might be. [P35]

The dimension of entering into the form and feel of the team arose from the participants’ experiences during alterations to their team memberships. The form and feel of the team do not create a fixed setting that newcomers need to reproduce or replicate, but rather an organic space or frame for the group. That space or frame reflects structural elements of the team in relation to its broader institutional context (particularly in relation to the nature of team entry), together with team members’ experiences, capabilities and expectations. In some instances team members had an abrupt team beginning, whereas in other instances the beginning involved a gentle slipping into the team. Sometimes a confident and experienced team member “fitted right in”, especially if the team was welcoming and had expectations of and tolerance for change and fluidity. At other times, team members had to use their experience and/or expertise in teamwork to ease themselves into the team. For less experienced team members, feelings of vulnerability about being judged by their new team members were common during this time.

In entering the form and feel of a team there was often a sense of entering a purposeful entity that was an active whole. This active whole sought to maintain its purpose of patient rehabilitation despite ongoing team changes. New team members’ contributions to this active whole were important for their acceptance into the team. This dimension of entering into the form and feel of a team highlights on-going changes to team memberships and the influence of different institutional contexts. Table 5.11b presents an overview of the elements in this dimension.

<table>
<thead>
<tr>
<th>Dimension of experience of collaborating</th>
<th>Elements within the dimension</th>
</tr>
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<tbody>
<tr>
<td>b) Entering into the form and feel of the team (in relation to team membership changes and influences from the broader institutional context)</td>
<td>• team beginnings as slipstreams and as baton changes</td>
</tr>
<tr>
<td></td>
<td>• easing into the team</td>
</tr>
<tr>
<td></td>
<td>• coping with continual alterations to team membership</td>
</tr>
</tbody>
</table>
a) Entering: Team beginnings as slipstream entries and as baton changes

Influences from the broader organisational context (particularly in relation to arenas of collaborating) and the notion of time were important for entering teams. Teams’ location within the arenas of collaborating spectrum played a significant role in the expected “speed” of team beginnings. In integrated arenas of collaborating, new team members tended to enter the team in the slipstreams of outgoing team members. A slipstream effect was created when incoming team members overlapped for a period of time with the team members they were replacing or when they were provided with ongoing mentoring. Thus new members had time and opportunities to learn about the team’s ways of practising and their roles within the team:

[The orientation] is lengthy, rather than being short and sharp. There was a checklist that you went through, but they also continued that mentoring process on (...) to anything else you were having difficulty with. Kind of a buddy system I guess. [P8]

Explicit handovers and orientations to teams’ expectations were valued components of team member overlaps in slipstream beginnings:

When I first started, the therapist that was here before me, – we had an overlap of about 3 weeks so I guess I got a lot of information from her. (...) I felt that that was really important in terms of getting a detailed client handover. And just knowing a little bit about the team, what my roles were to be, and getting that from the person who had actually been in the position beforehand, that was incredibly good. [P21]

Inherent within slipstream team beginnings was the expectation for collaborative practice to vary between different individuals’ and teams’ contexts. This system tended to facilitate smooth changeovers and gentle team entries.

However, slipstream beginnings did not belong solely to integrated arenas of collaborating. In other arenas of collaborating, a slipstream of familiarity was created when the incoming team member knew team members and the team personally prior to team entry:

It was just a gradual sort of process I suppose. I knew everyone before I came here. [P55]

The gradual nature of slipstream beginnings was appreciated by team members.

In intersecting arenas of collaborating, team beginnings resulting from discipline department roster changes resembled baton changes in a relay race (when one team member passes the baton onto another who continues the race). Rotating team members did not necessarily have overlapping time with team members they were replacing: they were expected to take the baton and run from the baton giver to continue the team relay.
Learning tended to happen “on the job” rather than being explicitly organised. In such situations smooth team entries were largely due to individual initiatives.

[Orientation] wasn’t organised for me; I had to seek that out myself. [P9]

For some team members the lack of clarity in relation to role expectations resulting from the baton change was confusing:

[Team members didn’t say] “you do this and this” and I often wish they did, because I didn’t feel like I had guidelines. [P25]

Others were content to find the way for themselves and be individually responsible for ensuring that they understood what was expected from their contributions to the team:

Throw me in the deep end, that’s the best way to go. [P72]

Within these two different natures of team beginnings, different expectations of responsibility for team orientations were evident. In slipstream beginnings, team leaders were responsible for ensuring that incoming team members were adequately oriented. However in baton change beginnings, individuals were expected to respond to the needs of the situation, and it was assumed that incoming team members would find out for themselves and be supported in this by continuing team members. In this latter situation there was a risk of overlooking orientation, leaving new team members inadequately prepared and supported for working in their new positions.

The influence of the organisational context is evident in this dimension. Team beginnings tended to be supported in organisations where team members’ positions were relatively stable and where resources allowed time or provided guidance to understand the team’s expectations. These “gentle” beginnings were particularly appreciated by less experienced members.

b) Entering: Easing into the team

Many team members (new and existing) experienced a period when the changed team entity eased into its new team membership and the team members eased into the team. For team members this period of easing required a balance between sensitivity for others’ expectations and experience, and concern for the ongoing functioning of the team. Easing into a team did not happen immediately for all the participants and teams, nor did the team stop functioning while new team members entered; like cyclists changing positions in pelotons, the team continued to move dynamically towards its shared destination of (multiple) patient discharge. During this forward movement, incoming team members became part of, and in turn, subtly shaped the form and feel of the team.
For many team members, this period of easing was a time of vulnerability. Feelings of nervousness and apprehension were common among incoming team members:

I was apprehensive to start with, because I thought “Oh, going into a new position with new people”. [P56]

Getting to know the system and how to approach people was a little bit daunting. [P40]

I was a bit concerned about fitting the shoes because the shoes have been here for many, many years. [PX]

Having to deal with multiple unknowns added to feelings of intimidation during team beginnings:

It is hard at first when you’re just very new and you feel very shaky in your knowledge base and you’re not used to working with these allied health teams. (...) I guess it was a bit intimidating when everyone was focused on you and you’re talking and you’re not used to that. Everyone is observing you, it can be a bit intimidating to start with. [P1]

Being welcomed in a friendly manner could assist in overcoming feelings of nervousness and apprehension. A friendly welcome was widely valued by people entering teams throughout the spectrum of arenas of collaborating. Being included was an important component of being welcomed.

I guess it was just a good team to come into because they were all very friendly and very eager to have your input. [P69]

Continuing team members also evaluated the contributions of incoming team members and judged their patient-related clinical capabilities.

Initially everyone was relatively welcoming, but it was the sort of team that you had to prove yourself to feel comfortable in. [P35]

I certainly remember the first couple of case conferences and having a lot of specific clinical questions fired at me. I did anticipate that as a testing of sorts as to how I would respond and whether I would be displaying enough expertise for this team. [P34]

Some team members anticipated these judgements:

I was interested to see how I would be read. [I] anticipated I would be tested, which tends to happen. [P66]

For others, judgements overshadowed the team’s friendliness:

I guess you feel like you’re being judged, and people are. Yeah, that was hard. [P3]

The new team member’s contribution to patient care was important for acceptance into the team:

If someone came in and they didn’t have a clue what Mr Bloggs was able to do and not do and when he might be able to go home, what their plan is to do next with him, then that wouldn’t be well received. [P55]
Thus the initial friendly welcomes, although appreciated, were not necessarily unconditional. Team members found that to be truly welcome in the team they needed to demonstrate the value of their contributions.

Incoming team members were not the only ones to be apprehensive about alterations to team membership. Farewelling valued team members often left a sadness that encompassed the “personal” farewells, the loss of their contributions to the team, and the anticipated effort involved in welcoming and adjusting to new people:

That’s always sad when they [team members] go, but I guess it’s just sort of a bit of flux. You just adapt as it goes and every person has a different personality and different approach, and it’s just working out how to best work together. [P1]

Some continuing team members were concerned about the potential for new team members to disrupt the team, particularly when they had experienced this in the past:

I think there was a few [of us] that were like “What’s he going to be like?”, because prior to me being here we had a couple of people (...) who had burnt out [in another team] and come here, and they weren’t very good. [P29]

One team member could not be substituted for another without the team needing to adjust in some way.

This element of feeling vulnerable and being cautious emphasises the human side of teams. Alterations to team memberships were times of vulnerability. Friendly welcomes helped overcome these vulnerabilities for team members as they eased into teams.

Contributing constructively to patients’ rehabilitation was an important aspect of being accepted in teams.

c) Entering: Coping with continual alterations to team membership

Some teams experienced continual changes to team membership, particularly those in intersecting arenas of collaborating. These continual changes often affected the ongoing team members, with some expressing frustration at the repetitive nature of adjusting to constant alterations:

I think that the anchors, or the people who don’t move, get a bit sort of frustrated by [constant team member alterations]. No sooner [do they] get to know who the physio is, or who the speechie is, or whatever, than they change. And that whole knowing how somebody will work or what you can expect from them or how reliable they are [is lost]. People just express the hope that there will be more consistency in the future. [P31]

Frustration with continual alterations to team memberships related to a number of factors. Recurring role negotiations were often required to clarify how best to work each new team member:
A new grad every 3 months, that was very difficult because you were adjusting every 3 months to a new person. (...) You get used to people’s ways of working I suppose, you feel like you’ve got to start all over again (...) [It’s a matter of] “What’s this [one] going to do? Is she going to tread on our toes?” [P62]

Frequent baton changes created by staff shortages also provided challenges of continuity to patient care.

If we’re having a bad time with sick leave, you do notice a big difference. The casual staff just don’t know. Some of our casual staff are used to working here, so they’re used to our ways and rehabilitation, but if it’s casual staff that don’t work here, then it’s really hard to get across what exactly they need to do. [P63]

Constant disruptions to established ways of working created a sense of unpredictability and insecurity, and challenged the continuity of teams’ established ways of working.

During ongoing alterations the importance for the ongoing team members of continuity in rehabilitation services was evident.

I think there is a core team, which is probably not a bad thing. I mean they’re people that have been there for a long time, and who probably know how the unit runs and who probably keep the unit ticking over I guess. The others come and go. [Some] only stay 2 months so it’s incredibly quick. So they really hardly even have time to get into the running of the place, you know and they’re gone again. [P62]

Within this constant alteration was the risk that incoming rotating team members were depersonalised and viewed primarily as generic representatives of their disciplines.

Frequent team beginnings, particularly those of the baton-change style, could become a disincentive for caring about incoming team members as people. At such times attention to team continuity took precedence over team friendliness, and the incoming team members tended to be valued in relation to what they brought to teams, rather than who they were beyond their discipline contributions:

[In relation to getting to know new team members] my rule is very simple actually, if they’re still there after 6 months I remember their name, or if they really hit some things and you say “Yeah they’re fantastic” you remember their names. I mean it’s terrible, it’s primitive. (...) [However, that is] what it is for me, they’re a physiotherapist, show us your physiotherapy. And then I get to know the person as a person, an individual, thereafter. [P48]

Although depersonalisation may have helped continuing team members cope with the constant stream of new team members, it is unlikely to help incoming team members overcome feelings of vulnerability.

This element highlights the importance of acknowledging team members as people. For teams, members were not just interchangeable members of their disciplines. Changes of people within disciplines impacted on teams.
d) *Entering: Free text poem*
A poem illuminating the dimension of *easing* is shown in Free text poem 5.2.

e) *Entering: Comparison of findings with key aspects of the literature*

The well-known stages of “forming, storming, norming and performing”, described by Tuckman (1965) and Tuckman and Jensen (1977), are commonly used in relation to team development. Like the dimension of *entering* into the form and feel of the team, these stages reflect a temporal component to team beginnings. However, a key difference between the two relates to the “what” that is beginning and developing. In Tuckman’s and Jensen’s stages, the “what” that is beginning is the team as a collective; whereas in *entering* the “what” is the individual team member. Whole teams in this research did not tend to have designated starting points from which to develop. Most teams in this research reflected what Lingard et al. (2004, p.404) described as “a complex and fluid entity composed of core and expanded groups”; thus the notion of the team as a collective having a definite beginning and entity to develop was not as relevant as individuals having beginnings in on-going teams.

The differences between team beginnings identified in this research can be viewed as reflecting different organisational metaphors. I propose that the rapid baton change beginning, which resulted in team members being seen as interchangeable components of a team, best fits the organisational metaphor where teams are viewed mechanistically as factories (in which managers organise work, and workers are selected, trained and monitored to ensure they work efficiently). In contrast, the slipstream beginning relates well to an organic organisational metaphor (in which humans variably shape and construct their organisational work environments).

Collective entities that have relevance for the organic fluid nature of rehabilitation teams are communities of practice (Lave & Wenger 1991; Wenger 1998) and knotworks (Engeström 2000). The widely recognised concept of communities of practice (CoP), introduced by Lave and Wenger, incorporated notions of “social participation as a process of learning and knowing” (Wenger 1998, pp.4-5). Learning within CoP involves engaging with and contributing to these communities’ practices (Wenger

80 These concepts are outlined in Section 4.3.4.

81 Morgan (2006) described organisational metaphors as a means for conceptualising different understandings and theories of organisation. These are outlined in Section 1.4.3.
ENTERING
Our team.
Then you arrive.
We welcome you.
But for how long?
Are we a merry-go-round or apple cart?
Will you contribute to our momentum?
Or unbalance us?
How quickly and how well?
Are you contributing ... are we connecting ... yet?

Your team.
Then I arrive.
A baton change or slipstream entry?
I bring with me
myself, my experiences, my expectations.
.... but what am I coming to?
Am I myself or my discipline?
What is concealed within your welcomes?
Judgements, uncertainties, a sense of repetition?
Where do I fit?
How will I connect?
Am I guided or do I find my own path?
Can I reach the peloton?
Can I maintain its momentum?
Are we one ... yet ... ?

Then we change: again.
Legitimate peripheral participation in CoP frames the transformation of newcomers to full practitioners who are agents of action and integral to the maturing of the field of practice (Lave & Wenger 1991). The interrelated concepts of CoP and legitimate peripheral participation support “learning in the context of our lived experience of participation in the world” (Wenger 1998, p.3). Although the emphasis in Lave and Wenger’s work is on practitioners learning through communities of practice, participants in my research reflected the move from peripheral to full participation in relation to developing collaborative practice in the context of their new team. That is, they learned about how the team worked, and gained the trust and respect of their team members. This research also emphasised the fluid nature of CoPs. The term community of practices is used to emphasise the social and relational feature of teams/groups. A collective identity can be fluidly maintained regardless of individual membership. To retain a sense of being aCoP such teams/groups do not need to be stable entities in terms of membership; members come and go, yet the CoP remains. They do, however, tend to be more stable or perhaps more fluidly evolutionary in terms of purpose and terms of reference.

Engeström’s (2000) knotworks are another example of a particular type of collaborative network that provides an alternative to teams as the primary entities for conceptualising collaborative situations. Engeström coined the knotwork to describe “partially improvised orchestration of collaborative performance between otherwise loosely connected actors and activity systems” (p.972). Because a key feature of knotworks is the constantly changing combinations of people coming together to perform specific tasks (Engeström 2004), knotworking has pertinence for complex health care contexts where situational responsiveness is required. Although people in rehabilitation teams commonly work together over relatively long periods of time, I propose that the strength of the concept of knotworks for rehabilitation is its capacity to reflect the potential for many simultaneous interrelated knotworks to exist in the rehabilitation unit. Warmington, Daniels, Edwards et al. (2004, p.8) recognised the value of knotworking’s focus on a specific task as a means of providing “a mechanism for meanings to be shared and constructed across professional boundaries”. However, the notion of knotworking is not common within health literature.

The findings of my research support the relevance of organic collective entities as a means of conceptualising teams in rehabilitation. I propose that the concept CoP is a relevant means of recognising the new team member’s acceptance into the team, and
knotworks are particularly appropriate in relation to teams responding to changing situations, including different groupings of professionals required for particular patients. Underpinning this proposition is the recognition that a mechanistic view of teams is inadequate to describe or support the complexities of collections of people working together to provide rehabilitation services.

5.14.3 Establishing ways of communicating and working together

To establish means to “bring about” (Delbridge & Bernard 1992, p.320) and “set up (...) to settle or install in position” (The Macquarie Dictionary Online 2009)

In general people that work in these jobs are communicative and they’re good interactors. They like to share information. They get the picture that we’re all working towards the one goal. [P68]

This dimension, building on the previous dimension entering into the form and feel of the team, explores how team members established the means through which they worked together and communicated with each other. The term establishing was chosen to highlight the effort required to develop these processes and actions. Importantly, working and communicating together did not happen mechanistically. Bringing people into contact with each other, and with the systems within which they worked, was insufficient to ensure collaboration. Rather, interpersonal awareness, flexibility and reciprocity were required by team members as they adjusted to the team’s ways of working, negotiated role overlaps and intertwined predetermined communication systems (such as patient records and meetings) with opportunistic means of communication (such as corridor chats). Underpinning this dimension is the notion of communicating and working together for the purpose of patients’ rehabilitation. Table 5.11c provides an overview of the elements in this dimension.

Table 5.11c Dimensions and elements of experience of collaborating

<table>
<thead>
<tr>
<th>Dimension of experience of collaborating</th>
<th>Elements within the dimension</th>
</tr>
</thead>
</table>
| c) Establishing ways of communicating and working together (highlighting complexities of interacting with others) | • adjusting to teams’ ways of working  
• negotiating and developing roles with others  
• intertwining structured and organic communication |

82 A mechanistic view of teams is consistent with the metaphor of organisations as machines (as outlined in Section 1.4.3).
a) Establishing: Adjusting to teams’ ways of working

Inherent in the need for adjusting to teams’ ways of working was the notion that while teams could learn from other teams’ ways of working, there was no single correct way of working together:

Different teams work in different ways and one thing might work in one place but unfortunately you try and transplant that into another team, and it doesn’t seem to work as well. There doesn’t seem to be an absolute model [of working together] that fits everywhere. [P65]

New ways of working together were introduced by some team members, based on judgements of their current team compared to their previous teams:

They were probably sick of me for the first 6 months [in the team] because I was sort of saying “In [my previous team] we did it like this”. I’d try and look at what we were doing in [the current team] and see if the way we did it in [my previous team] would be beneficial to [this] team and then introduce that idea to the team, most of which were picked up. (...) I felt that I needed to bring some more ideas in. [P45]

Other team members did not seek immediately to alter teams’ traditions and conventions. Some team members complied, at least initially, with their new teams’ rules and patterns:

I slotted in because that’s the way it was done, I think because being number three (of a particular discipline) I didn’t think it was my role to say “This is the wrong way to do it.” [P32]

Others sought to understand and accept the differences, particularly when these differences were not core to their contributions to rehabilitation:

I really think the big thing (...) is comparing it [the current team] to other teams and thinking “OK well (...) that [particular way of working] is not going to happen here”. [P35]

In some teams, change was perceived to be difficult due to the embedded nature of the institution’s traditions:

A larger institution like this also has an influence on the way the things work, and I think that has an impact on the teams as well. I think there’s a fairly entrenched pattern of behaviour of how the team meetings run and what people’s expectations are. And that was, I guess, a bit of a shock when I started. [P53]

Evident within these mismatches between expectations and actual practices were understandings that there were many ways of working and not necessarily one “best” way.

Team members often had to balance the decision to introduce new ideas about ways of working with the complying with teams’ traditions and conventions. The nature of the ideas and their relationship with entrenched organisational structures influenced how
team members adjusted to each other’s ways of working, and how they perpetuated the team’s traditions.

**b) Establishing: Negotiating and developing roles with others**

Negotiating roles with others was integral to establishing ways of working together synergistically. Expectations for discipline roles often varied between different teams and needed to be situationally negotiated. In particular, role overlaps and interconnected ways of working were not standardised and tended to be adjusted for each team situation:

> In those early stages you’re kind of gauging who does what and what the local culture is. (...) There is quite a lot of overlap there as well. So all of that is gauged through talking, communicating, negotiating. [P24]

Negotiations, however, could be challenging. At times there were clashes of role expectations:

> Sometimes there have been in the past been some slight conflict between members of the allied health in particular. (...) [With one particular discipline] saying you know, “I’m the one that decides [that]”, and somebody else feeling that [they should be able to decide it as well]. [P65]

Although role negotiation was often undertaken informally in many teams, formal documentation of role expectations was required in some situations when informal negotiations faltered:

> It’s mightily important really [for team members to understand each other’s roles], that was one of the reasons why we’ve been trying to draw up those documents, to get an overall awareness of people’s perceptions of different roles. I mean people’s perceptions of what they think their job is, how other people perceive their job can be quite different, can’t they? [P65]

Role negotiations appeared to relate primarily to discipline interests and territories, with the potential for conflict apparent in the need to tread softly.

The interconnected nature of team members’ contributions provided potential for their collective contributions to be greater than if they all worked in isolation of each other:

> So if someone is being seen by all the people who they need to be seen by, and all of those people are communicating, and are aware of all the other problems and issues that are going on, and everyone has a clear idea of what everyone else thinks and where we’re headed and what we need to do to get there, and you can help each other out, make suggestions to each other and pick up on problems that other people might have missed, that sort of thing, [then] I think it can only benefit the patient and their family if you’re working towards that together. [P1]

Working together in this interconnected way could be considered to be synergistic. I propose that this synergy arises from team members developing their roles in relation to others and in response to particular situational challenges.
Understanding how roles interconnected with each other was an important aspect of this role development. Such understandings were developed effectively through the experiences of working with others:

You get a bit of an idea [of people’s roles in the team from training] but certainly in the team meeting, people start talking about what they do and identifying what areas the clients have got problems in. So you go “Oh right, that’s what you do then.” [P27]

So just that experience of working with each of them I would say I’ve got a fairly good understanding of each of them now. [P20]

Capabilities related to team members’ own rehabilitation roles could also be developed through working with others from different roles:

It’s so nice to watch someone else at work and kind of go “Oh wow I like the way they did that” or “Oh is that right? I didn’t know that one”. [P11]

Working with others provided the potential to develop specific discipline capabilities, as well as personal capabilities for interacting with others. Collaborating with others brought new depths of understandings about roles, their interconnections and their contributions to patients’ rehabilitation.

While openness to others’ diverse ways of operating (similar to that which was required for the interpersonal endeavour of engaging) was necessary to develop professional roles in relation to others, reluctance to develop effective role interconnections risked alienating team members.

That person [who would trust other disciplines’ decisions] then left and we got someone that felt that she was the only one that could make a decision, and that everyone else was going to be wrong and incorrect. So that has been a very big thing for some of the nursing staff that have been here for like 30 years. [P26]

Synergistic working required team members to develop their professional roles in relation to others. By working with others to effect improvement in patients’ functional capabilities, team members developed their own professional roles and understandings of others’ roles. Such understandings were integral to synergistic working of teams. The dynamic nature of team membership and the diverse nature of teams (as discussed in entering into the form and feel of the team) provided many opportunities for ongoing negotiation and development of roles in relation to others.

c) Establishing: Intertwining structured and organic communication

Fundamental to working in teams was the intertwining of structured and organic communication. Structured communication guided how team members shared information with each other, and provided them with parameters for documentation of assessments, goals and treatments. By being explicit and predictable in nature, such
systems rendered communication easily visible. Some structured systems, such as patient records, were externally imposed, obligatory in nature and part of the organisational context. Other systems, such as communication boards for timetabling patients’ sessions and intra-team meetings, were developed internally by team members. Internally developed systems often evolved in response to particular problems, or were introduced proactively based on ideas taken from experiences in other situations. Despite this range of structured communication systems, such systems were often insufficient for the rich and rapid communication required by people in teams. The flexibility and nuances of spontaneous and opportunistic means of communication enabled interactions to be more interpersonal and immediately responsive than those occurring according to structured systems. With each team having a range of different predetermined (and organisationally influenced) communication systems, team members needed to fulfil requirements of multiple systems in order to work with others in the team.

As a structured form of communication, case conferences provided key opportunities for regular face-to-face discussions between team members with different patient care roles, these being 24-hour care, treatment and support roles. This was an important opportunity for establishing understandings of the whole patient:

> [When] people actually physically meet face-to-face each week and share the information, (...) I actually get a sense of the patient. [P6]

The regularity and routine nature of these meetings was often valued:

> There’s value for those meetings because we all need to know [information from others] for that patient’s sake, in terms of planning their next week of rehabilitation and the week after that and the week after that. [P22]

Not all team members were able to attend case conferences. In particular, those providing 24-hour care tended to have one representative at each meetings. In such situations, the team members not participating in case conferences could feel more connected to their discipline than to the rehabilitation team:

> If you asked us where our loyalty lay first, I would have to say the nurses would stick together. (...) Our first loyalty would be to the nurses. [P52]

Thus, while providing a valuable forum for discussions about patients, case conferences were only one part of a myriad of communication strategies necessary for teams to implement decisions at case conferences and feel connected to others in the team.

Regular meetings of smaller groupings of team members enabled team members to deal with issues that arose between meetings. For example, staff providing 24-hour care
regularly met at the junctions of shifts, and at other times as required, to plan the coordination and carryover of patients’ care within and between shifts:

We [the nursing team on the day shift] communicate in the morning of what our little plan’s going to be for the day. [P63]

Meetings such as these were integral to the construction of communication webs within teams. They provided opportunities for all team members providing care, therapy and medical treatments and assessments to be included in discussions about patients. Further, they also provided timely opportunities to deal with issues arising between meetings.

Despite the guidance and support they provided for communication, the use of structured systems was not necessarily straightforward. Some systems were not meaningful to team’s communication. At times such systems were gradually replaced by more informal arrangements:

We did have a [communication] board at the end of gym, where people booked their patients. But we don’t use that any more. (...) It is a matter of working it out yourself, I think. [P31]

Thus procedures did not necessarily have a “life of their own”. They were often dependent on the people who enacted them. For some complex procedures to be reliably used, their value needed to outweigh the challenges imposed by their implementation.

Although predetermined communication systems played important roles in guiding communication and fulfilling reporting obligations, they were insufficient to meet all communication needs within teams. Issues could not always wait until case conferences or other intra-team meetings to be resolved; sometimes they needed to be addressed between meetings:

If it’s something that we don’t talk about at the meeting we can talk about it the following day or we talk about it as it arises. [P73]

At times informal face-to-face explanations were better able to provide nuances of meaning than more formal written or verbal reporting formats:

I think you can articulate a little bit more verbally than you can write. [P30]

Team members therefore used a range of informal means of communication outside of team meetings, including office and corridor chats, phone calls and emails. Such communication relied on team members’ initiatives and was often opportunistic in nature:

I just grab them and have a chat with them or I’ll ring them upstairs, depending on how urgent it is. [P63]
I’ll hang around the nurses’ station and listen to what’s happening, talk to them informally about what’s going on if there is a problem, an issue, I’ll grab them and talk to them formally about it. [P18]

The speed and flexibility of such communication helped team members keep up-to-date with and respond to issues.

The geographical layout of the rehabilitation unit could facilitate or impede opportunistic communication. Being co-located with other team members was viewed positively, due to the opportunities available for informal interactions:

I think that [being in the same location] is pretty much what makes it work actually; the fact that we do all work within close proximity of one and other. There’s a lot of informal contact between people. Everyone has morning tea in the same room and lunch in the same room. And it’s not far to walk to one another’s offices. [P17]

When team members were located separately they could feel isolated and excluded:

I’m downstairs (…) and the rest of the team’s up here and they can see each other from their doorways. They can see the comings and goings. So I felt quite isolated. (…) I think when you’re in a close vicinity of each other it really helps with the team. [P11]

Thus, having other team members close by engendered feelings of community and provided chances for informal opportunistic interactions. The value of proximity for facilitating informal communication indicates the potential for institutional contexts to influence collaboration.

Informal means of communication were rarely used in isolation; rather they were often intertwined with structured communication systems. Using a range of means of communication facilitated thorough, predictable, timely and responsive communication.

For example, reading patients’ progress notes and chatting with people between meetings blended effectively with case conference participation:

I can go and read everybody’s report in the notes, [but it] doesn’t always give you a feel. I can talk to people and I do (…). But I think it is valuable for the patient that we all take the time once a week to sit down and go through the person’s progress and make goals and plans that are open and obvious to everybody on the team. [P22]

Humour could bring a sense of camaraderie to case conferences:

We always have a laugh. (…) The whole team is fairly easy-going and enjoy [being] not so serious sometimes. [P18]

Relief from the intensity of providing rehabilitation services could also be provided through humour:

More often than not [humour] is a stress relief thing. I think this is a place where you can burn out very quickly if you don’t allow yourself to laugh at some of what’s going on. You just get too bogged down in it otherwise. [P8]
However at times humour could have a divisive rather than a cohesive effect on the team, with some team members feeling uncomfortable and unsure of how to respond. A balance was required between stress release for team members and respecting those at the centre of the humour. This balance was not necessarily easy to maintain, leaving some team members concerned that the dignity of patients was not being maintained:

If your case conference is running for two and a half hours and you’re only talking about patients nonstop very seriously, if you were to do that week in week out over a year, I think it can be very draining. And I think you’d need a little bit of humour as long as it’s not taking away from the person you’re talking about. [P30]

Although team members generally agreed that an element of light-heartedness in teams was positive, they had different ideas of what constituted appropriate humour. This highlighted the individuality that accompanied informal elements of communication.

Preferences for informality within case conferences also reflected individual situations. Some people sought to have quick meetings, often reflecting their personal time constraints:

Condense it down. (...) Get it shorter. Get it more precise. Get a plan. Cut the waffle. [P48]

Other people were aware of opportunities within case conferences for team members to “touch base” with each other as people. The need to debrief about challenges is an example of personal needs brought to case conferences:

Sometimes it’s really important to let [team members] actually vent it. [P25]

Team members’ individual constraints and needs influenced their expectations for and participation in informal communication within teams.

Formal systems provide parameters for communication, but it was the interactions of people that brought these systems to life. Woven throughout the explicit structured communication systems were the less visible, and consequently more difficult to control and measure, spontaneous, opportunistic forms of communication. Informal communication provided a means to explore issues and subtleties related to individual patients’ changing situations and aspirations. By intertwining formal and informal styles of communication, team members were people (as individuals) interacting with each other about (and with) their patients as people. While organisational support for formal communication was evident in the provision of explicit spaces and times for attending team meetings and writing in patient records, there appeared to be realised opportunities for organisational support in relation to informal communication, such as co-locating team members to encourage and facilitate opportunistic encounters. A
predominant focus on supporting structured communication systems risks overlooking the interpersonal effort and reciprocity required for collaboration.

d) Establishing: Free text poem
A poem illuminating the dimension of establishing is shown in Free text poem 5.3.

e) Establishing: Comparison of findings with key aspects of the literature
The importance of relationships, role negotiation and communication (key elements in the dimension of establishing) is widely recognised in the literature relating to collaboration, to the extent that these processes are almost synonymous with collaborative capabilities. In a manner similar to tendencies noted in the literature, this study has discussed these concepts separately in order to explore them in more detail. However, unlike many explorations of collaboration, their interdependency and intricacies are embraced, preserved and highlighted in this study. Key to preserving and highlighting such interdependency and intricacies is their location within the interrelated dimensions of interpersonal endeavour identified in this study.

Thus although discussed separately, relationships, role negotiation and communication are part of the larger overarching framework of endeavouring to work effectively in teams and achieve positive collaboration. In this framework, role negotiation (establishing) is reliant on and facilitates communication and relationships (and vice versa); and relationships (engaging) inform and are established through communication (establishing) (and vice versa). Rather than seeking to simplify the concepts of relationships, role negotiation and communication, this study embraces and frames the complexities inherent in these behaviours within a broader conceptualisation of interrelated dimensions of interpersonal endeavour.

Considering role negotiation more specifically, the notions of multidisciplinary, interdisciplinary, or transdisciplinary ways of working (that are so prominent in the literature) were not at the forefront of team members’ descriptions of their experiences. In some teams, particular ways of working were overtly encouraged (particularly for team members in integrated arenas of collaborating) but were not necessarily explicitly

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83 Literature relating to relationships, communication and role negotiations was discussed in Section 4.3.

84 These terms, and the related notions of multiprofessional, interprofessional and transprofessional are described in Section 4.3.2.
ESTABLISHING
People in motion.
Gauging:
who does what here, and how?

Individuals and disciplines
Seeking meaningful interactions
and connections with consequence.
Treading carefully around role overlaps.
Sidestepping barriers.
Creating webs of understanding.
Foundations and groundwork.
Returning and manoeuvring.
About patients.

But at times,
beneath the surface of professional momentum,
Drift people afloat in a sea of traditions -
“This is the way it has always been done.”
Adhering to patterns and rules: written and unseen.

And within this locale reside
obligations of patient records and expectations at meetings,
eased and encouraged
by food, stories, and
careful humour.
Also in corridors and wards
more opportunities – created and taken –
to glean insights, understandings, confirmations and links.
These in-between instances
reinforcing the continuum of communication
and mesh of connections.
labelled. In other teams, individual team members worked out their role boundaries, often in relation to particular people and situations. Furthermore, different styles of boundary blurring between team members were evident in the same team.

Considering role negotiation more specifically, the notions of multidisciplinary, interdisciplinary, or transdisciplinary ways of working (that are so prominent in the literature) were not at the forefront of team members’ descriptions of their experiences. In some teams, particular ways of working were overtly encouraged (particularly for team members in integrated arenas of collaborating) but were not necessarily explicitly labelled. In other teams, individual team members worked out their role boundaries, often in relation to particular people and situations. Furthermore, different styles of boundary blurring between team members were evident in the same team. Thus it appeared that the notions of multi-, inter-, and transdisciplinary were not necessarily “owned” by team members, nor were the styles of role boundaries homogeneous throughout teams (i.e. a team member might work in parallel with some team members but blur discipline roles with others). Although the terms multidisciplinary, interdisciplinary, or transdisciplinary might be useful for conceptualising ways in which different disciplines work together in teams, they are insufficient to fully represent the interpersonal and dynamic nature of collaborating for participants in this study.

In relation to communication, the findings of this study are consistent with literature proposing the value of using a range of communication strategies in rehabilitation teams (e.g. Suddick & de Souza 2006; Sinclair et al. 2009) and the importance of organisational support for such strategies (Wertheimer et al. 2008). Following their exploration of collaboration between neuropsychologists and speech pathologists, Wertheimer and colleagues (p.282) recommended that organisational support for collaboration include “facilitating physical proximity and accessibility among team members ... [and] establishing formal team meetings to discuss assessment results, patient goals, patient progress, and discharge planning”. Such support involves ensuring the provision of sufficient time and space for collaboration.

Besides highlighting the importance of using a range of communication strategies, the nuanced use of communication is also emphasised by the findings of this research. An example of such nuanced use was making decisions about the appropriate use of humour. The importance of humour in developing relationships and releasing stress was

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85 These terms, and the related notions of multiprofessional, interprofessional and transprofessional are described in Section 4.3.2.
recognised by Martin (2001, p.82), who claimed that in relation to organisational culture, “humour bridges uncomfortable moments, offers a way of releasing tension, and permits people to express that which they otherwise might be forbidden to say”. While supporting these concepts, the findings in this study also highlight the importance of, and the challenge for, making humour respectful of patients. Team members (and patients) can have different perceptions of what “being respectful of patients” means; what is suitable in one situation might not be suitable for another. Leiber’s (1986, p.167) caution for critical care situations may have relevance for rehabilitation: “Care must be taken to consider not only the appropriateness of the humor used, but also under what conditions it is being used, and whether others not involved are being affected”.

The identification of role negotiation and complex communication as integral to collaboration supports many literature claims and research findings. However, framing of role negotiations and communication within the framework of interrelated dimensions of interpersonal endeavours provides a means to access and explore these concepts, without ignoring their complexity, nuances and interdependency.

5.14.4 Envisioning together frameworks for patients’ rehabilitation

To envision means “to picture mentally, especially some future event or events”

(The Macquarie Dictionary Online 2009)

What we do try and do is look at what we would expect of a patient, and also find out from them where they were at before, what they hope to achieve, and how prepared they are to work with us. [P54]

This dimension focuses on teams’ collective envisioning of frameworks for patients’ rehabilitation that occurred at case conferences when team members discussed patients’ rehabilitation progress, goals and discharge dates. Team members envisioned together. This envisioning together was based on combining team members’ individual knowledge, experience and professional judgements of their patients’ situations, goals, fears and aspirations. As well as being grounded in participant quotes, the identification and interpretation of this dimension relied substantially on my notes from case conference observations. The overlapping conversation-style interactions interspersed between the formal sequences of contributions observed in case conferences provided
fertile ground for enabling patients’ voices to be heard even when they were not physically present.

The term *envisioning* was chosen to highlight the notions of future possibilities and “mental images” that were integral to teams collectively discussing individual patients’ aspirations and potential for improvement:

> In our first team meeting after the patient’s admitted, I try and make sure I’ve got a good feel of what we’re aiming for and what we’re going to do for the patient. [P63]

By drawing on their own clinical experience, assessments and impressions, team members brought to the team meeting images of how they expected patients to progress in rehabilitation, then combined their individual images with information from others (team members, patients and carers). These images, developed through individual discussions with and observations of patients and carers, were brought to case conferences and collectively shared.

*Envisioning together frameworks for patients’ rehabilitation* was not an exact science. Rather it involved uncertainties, drew on judgements, relied on the understandings and connections developed between team members (as described in the dimensions of *engaging, easing* and *establishing*). Judgements and understandings were grounded in health professionals’ individual relationships with patients and their carers.

Images and storying of patients’ progress were shared at meetings through descriptions and recounting of patients’ situations, opinions about relevant directions and suggestions for goals. Experienced team members often provided substantial guidance to those with less experience during this process. Team members contributed their own views and from these views a collective vision evolved. Clinical information was blended with stories of patients’ situations and aspirations during this process. The collectively derived vision for each patient’s rehabilitation pathway became collective visions for team members’ collaborative and individual actions.

I have labelled this collective vision a *framework* for patients’ rehabilitation to differentiate it from the individual images and views team members brought to meetings, and to highlight the guidance it provided for rehabilitation. I note that the term framework does not imply a common framework for groups of patients; individual patients had unique frameworks that were organic and evolving in nature. Details of how the framework would be used and implemented often appeared to be tacit. Individual team members did not commonly need to have the fine points and
implications of each framework articulated. Introducing the notion of frameworks for patients’ rehabilitation provides a means through which the implicit complexity of collective goal setting can be appreciated and from which collaborative care can be developed.

The complexity of envisioning together frameworks for patients’ rehabilitation tended to be disguised by the concreteness of recorded goals, often in the form of discharge dates. Table 5.11d provides an overview of the elements in this dimension.

Table 5.11d Dimensions and elements of experience of collaborating

<table>
<thead>
<tr>
<th>Dimension of experience of collaborating</th>
<th>Elements within the dimension</th>
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| d) Envisioning together frameworks for patients’ rehabilitation (in relation to patient-centred collective clinical decision making) | • sharing expectations and information
• negotiating mutual understandings
• portraying patients as people |

Patients’ experiences with teams’ envisioning illustrated the inappropriateness of considering them as team members. For example (as explained below), although they were the focus of teams’ decisions, patients’ views of the team rarely extended beyond what was immediately visible to them in their day-to-day interactions with team members:

[The team was] not so [visible] much physically though I was aware that a team meeting would happen every week. (...) I wasn’t invited. You know patients don’t go to that meeting. They have the meeting and then they do the ward rounds. [P51]

Moreover, to consider patients and carers as team members overlooks the complexity of becoming part of a rehabilitation team (as explained in the dimensions of engaging, easing and establishing).

a) Envisioning: Sharing expectations and information

This element within the dimension envisioning together frameworks for patients’ rehabilitation is underpinned by the complexity of working together to share expectations and information at case conferences. A number of factors contributed to this complexity, including case conferences having multiple purposes; the myriad of interpersonal interactions involved in sharing information; team members’ individual experiences with rehabilitation; differing images for patients’ progress; and the subtle negotiations required to develop shared understandings and visions of patients’ future possibilities.
There was general agreement among team members that the primary purpose of case conferences was to provide a forum for planning their patients’ goals for rehabilitation:

The idea of case conference is to bring your information together and then plan towards appropriate goals for that client. [P62]

This focus on collective goals informing the frameworks for patients’ rehabilitation provided a sense of cohesion and forward movement.

Encouragement from team leaders was at times required to facilitate team members’ sharing of forward-looking information, articulation of expectations for patients, and participation in collective decision-making about patients’ rehabilitation. Some team members needed their team leader’s support to develop the capacity to envisage patients’ future rehabilitation directions and articulate goals:

[The team leader] is very focussed on goals, so he really guided me in the sense that I would say “x” about a patient and then he’d say “All right but what’s your goal?”. So he sort of teased out [of me] a lot of the things that I do now in terms of goal setting and working out time frames for when I think patients can achieve x, y, z and what the most important things to achieve are. [P71]

However, encouragement and facilitation of sharing were not always provided:

In the past we’ve had some prickly characters who kind of dictated what would happen, [they] didn’t take a lot of the input on board from what other people said, made decisions without discussing [them] with others. [Our current team leader] really tries not to operate like that so I think that it all works really well. [P68]

Thus, developing shared expectations and goals for patients required suitable opportunities for team members to contribute and participate, as well as the capacity to identify appropriate rehabilitation goals and time-frames.

Team members developed a personal repertoire of images by being encouraged and supported to share expectations and information. These images were drawn on at team meetings to collectively form a framework for rehabilitation for the patient being discussed. This framework then informed team members’ decision making and actions (such as ongoing assessments, therapy, care, treatments and discharge arrangements).

b) Envisioning: Negotiating mutual understandings and visions

 Discussions at case conferences appeared straightforward when team members’ understandings and images of a patient’s future direction aligned seamlessly into a collective framework for rehabilitation. In these situations decision points were not necessarily obvious to me as the observer, and the collaborative care envisioned might or might not have been explicitly articulated. Team members appeared to have implicit understandings about how they would work together. In contrast, when team members’
images for patients’ rehabilitation were not aligned, discussion often ensued and plans were often more explicitly articulated:

One person in that team will make an assessment in relation to that patient (...) and then another professional in that team will actually have a differing view, and so [a discussion begins] “I don’t think that’s the reason the patient’s doing that, I actually think it’s because of this”. And so I think [differences] generate discussion and it increases that opportunity for better patient care. [P4]

Resolving differences between perspectives generated robust understandings of patients’ situations and potentials. Team members gleaned insights and developed new understandings from having their points of view challenged by others’ different perspectives. From these challenges the framework for rehabilitation was negotiated and realigned. Plans for implementing collaborative care tended to be more visible when team members explicitly discussed and planned such care, for example as activities in their diaries or in the patient records.

Being based on images rather than certainties, and because patients’ conditions and situations changed, a framework for rehabilitation could be (or become) not optimal. Some decisions about patients’ rehabilitation frameworks were revisited, often with reluctance, when the initial framework was based on overly optimistic expectations or the patient’s condition unexpectedly deteriorated:

We all are disappointed when we have to finally sort of pull the pin on somebody and we say “This is not working.” It is always a sad sort of decision and we try and do it cooperatively. [P12]

Frameworks for rehabilitation could also begin to fragment during the course of rehabilitation. The beginnings of fragmentation were evidenced by the emergence of differing opinions about patients’ ongoing improvement. Negotiation between team members was often required for new shared understandings to develop:

I find some [team members] want to cut off fairly quickly with rehab. [They’ll] say “Well I’m not going to get any further with this patient”, so it’s negotiating, [I’ll say] “Well hang on let’s look at this on a team basis”. A case conference is about negotiating within the team. [P28]

Being open about the need for flexibility in frameworks enabled information and opinions to be revisited and re-evaluated, and patients’ rehabilitation re-envisioned.

Despite team members valuing consensus for developing frameworks for rehabilitation, this did not always occur. At times a balance was required between seeking consensus and needing to progress the case conference:

There’s got to be a balance between consensus and consultancy, versus someone making decisions ultimately and moving it [situation under discussion] forward. [P37]

At such times team leaders could gently guide team members’ negotiations:
The team leader will make suggestions. It’s never “You should do this or you must do that”. [P36]

At other times people in the team, often team leaders or those with extensive clinical experience, needed to take control of decisions:

Ultimately [if there is “to and fro-ing”, the senior clinician] makes the decision but it’s based on what everybody thinks. [P46]

So that frameworks for rehabilitation evolved from team members’ visions rather than being imposed onto them, those who took control of decisions needed to be sensitive to and incorporate the input of others.

Team members varied in their experience in and optimism for anticipating patients’ progress. However, through discussing differences and evaluating progress they learned from each other and created new understandings. These new understandings were in turn challenged and developed further to expand the repertoire of frameworks for rehabilitation. As these frameworks for rehabilitation were enacted they needed to be revisited to ensure their ongoing appropriateness to patients’ changing situations conditions.

c) Envisioning: portraying patients as people

Developing frameworks for rehabilitation at case conferences often involved team members weaving concrete and evocative information in a manner that enabled patients to be portrayed as people. This process required team members to facilitate, provide and use different types of information. Concrete information (such as the tangible and measurable details in discipline reports, goals and discharge dates) was often interwoven with more evocative forms of information contained within stories and anecdotes. Stories and anecdotes tended to portray a sense of patients as people (including their aspirations, successes and challenges). Team members’ confidence and uncertainty with rehabilitation progress also became apparent through stories. At case conferences team members’ contributions seemed to move easily between concrete and evocative information:

I think that’s true of quite a lot of rehab teams, that no matter how structured you try to make things, people will always come back to telling a story about a patient. (...) I think sometimes it’s hard to do that [talk about goals and plans] without reflecting upon the person and their story. [P17]

Seamless interweaving of different forms of interaction appeared integral to many of the case conferences I observed. Team members contributed perceptions and gained
insights from others about patients through anecdotes and stories. Such sharing often evoked a strong sense of the patient as a person:

I suppose I try and personalise it [with stories about the patient we are discussing]. Sometimes I think the person can get a bit depersonalised and [we can be] a bit issue-focused, so sometimes I try and put in an anecdote or make it more about the person as a person. [P64]

We do give a lot of anecdotes and examples. I guess it makes it more real. [P36]

Stories conveyed a feel for individual patients and their particular situations that was not always evident from concrete information:

I mean there’s the bare bones of the facts that that might be written down in [a] report. And then there’s [people] trying to colour that out, flesh that out, give it more detail. [This gives] a more accurate picture (...) [The stories] are important because we’re dealing with people in different situations and different environments. It’s important for everyone to be aware of that. I guess that I probably pay a bit more attention to the stories than the bare bones. [P58]

Discipline jargon was often explained through anecdotes:

If I’m going to use [a technical jargon term] in case conference I’ll then give an example, so for example an object agnosia is when you don’t know the use of an object, so then I’ll say “For example they tried to comb their hair with their razor”. [P62]

Thus, stories highlighted patients as individuals with diverse situations, potential and responses to rehabilitation, and provided nuances to understandings imparted through concrete information.

Patients’ wishes and aspirations were brought into the meeting through recounted snippets of their conversations with team members. These were particularly obvious when team members repeated verbatim patients’ words in “she said” or “he said” types of contribution. This added a patient-centred authenticity to the collective envisioning. Like stories and anecdotes, these contributions often triggered responses from others, including recall of other relevant incidents. These spontaneous, often seemingly disordered interactions contributed valuable information for envisioning future patient-centred directions and aligned rehabilitation frameworks. The following quotes are examples of recounted conversations about different patients that I heard during case conferences and recorded in my field notes:

“He is very motivated. He said to me yesterday ‘I want to get home, I have been doing this so I can get as good as I can get.’”

“His walking looks odd, he brought that up himself.”

“He is quite adamant that it is not going to happen when he gets home.”

86 Quotation marks in my field notes indicate that I recorded comments that people made.
Each of these comments triggered further discussion about the patient’s future rehabilitation directions that were often integrated into decisions about goals and discharge dates.

Some patients knowingly directed team members to incorporate their views in the information presented at team meetings. For example one patient, who was a health professional with a sound understanding of rehabilitation team processes, ensured that her voice was heard at case conference:

“I took the initiative, knowing that they were getting together, having a meeting. I told a variety of people [the direction I wanted to be heading] so they would all say “Oh yeah, yeah she said that to me too”. I was using their process to try and facilitate my point of view.” [P51]

While audible during meetings, patients’ and carers’ voices then merged into decisions and rehabilitation pathways, and often disappeared into measurable goals. Once they become part of teams’ decisions there could be no evidence that they were ever there.

The seamless moving between concrete and evocative information required free-flowing exchanges between team members within the more formal structures of case conferences. Times pressures, such as tight meeting structures during busy times, could constrain this free flow of information:

“We’ve had a lot of patients, and I think over the last number of weeks we’ve sort of constrained ourselves a bit [with sharing stories about patients] because we’re conscious we’ve got [a number of] patients to get through. [P64]

Free flowing exchanges could also be interrupted by changes to the ways team meetings were run.

We have had some loopy people [running the meeting in our team leader’s absence]. [Some are] very disinterested in the client, “oh well whatever”, or so intellectual that they don’t seem to be connecting to the reality of the situation. (...) [However, with our usual team leader] we’ve got these regular opportunities to have input and people are listened to. (...) I feel it works well. [P68]

Responsiveness to others’ information and situations was important for establishing shared understandings and goals. The concrete information that team members contributed in their discipline turn-taking during case conferences was augmented with evocative patient-centred information. However, such evocative patient-centred information and stories were not necessarily recorded in patients’ notes; rather, explicit plans and measurable goals tended to the focus of these notes. Simplification of these complex team interactions into measurable goals recorded in patients’ notes can (a) disguise the complexity of people and patient centredness, as well as the variety of
input, the wisdom of judgements and the uncertainty of progress; and (b) overlook the importance of ensuring adequate time for meetings for informal exchanges about patients (through the storytelling process being invisible to organisational management).

e) Envisioning: Free text poem

A poem illuminating the dimension of envisioning is shown in Free text poem 5.4.

f) Envisioning: Comparison of findings with key aspects of literature

In this research, envisioning was a collective process that provided a basis for patient-centred collaborative care. The importance of shared goals for teams and the collaborative nature of goal setting is well recognised in the literature (e.g. Wade 2009). This research contributes to understandings of goals and goal setting by: (a) framing goals in terms of the broader frameworks they provide for patients’ rehabilitation directions (thus emphasising the process of reaching the goal as well as achieving the goal itself); (b) highlighting the need for frameworks to be flexible and respond to the team’s developing understandings of the patient’s condition, aspirations, situation and potential for progression; and (c) emphasising the presence of patients’ voices in the informal communication exchanges in team meetings.

The uncertain nature of envisioned frameworks for patients’ rehabilitation echoes the description of the messiness and complexity of professional practice by Higgs, Titchen and Neville (2001) in Section 1.4.5. To deal adequately with the complexity involved in envisioning together and providing collective care, rehabilitation team members need resources (such as co-location, allocated time for meetings and meeting rooms) and support (including professional development).

The notion of envisioning supports Fleming and Mattingly’s (2008) description of narrative reasoning, Boshuizen and Schmidt’s (2008) identification of illness scripts and Opie’s (1997) use of the term “team narratives”. Fleming and Mattingly (2008, p.59) stated that “in occupational therapy at least ... narrative reasoning is a guide to a therapist’s future actions because it provides images of a possible future for the client”. Employing narrative reasoning, clinicians can project their understandings of patients’ potential, with the aim of creating images that “point towards a future life story [that] will carry the patients through the long, tedious, often painful routines of treatment” (p.60).
ENVISIONING
“Next patient ...”
I listen, contribute, question and clarify.
Seamless decisions, unspoken agreements.
Written, recorded, regulated.

Then ... an unexpected addition ...
“But he told me he wants to go home for the weekend”.

Our meeting’s conveyer belt falters.
Anecdotes, stories and snippets surface besieging the order, the plan, the jargon.
Overlapping and unfolding conversations,
triggering recalls from others.
“She said ... he said ... they think ... .”
Other voices, though not present, are clearly heard.
Our patients’ voices. Their families’ voices.
Proxies informing our decisions.
Perspectives alter, plans evolve.
Shared visions for future action emerge.

Yet measured commitments of our decisions belie the depth of narratives just shared.

But ... when,
( perhaps through time pressures or team changes)
our conveyor belt maintains its momentum,
are our patients’ voices drowned by the mechanistic rhythm of discipline jargon?

“Next patient ...”
I listen, contribute, question and clarify ...
Stories and banter,
and patters ...
“Illness scripts”, as described by Boshuizen and Schmidt (2008, p.115), provide a conceptualisation of clinical reasoning that “generates expectations for other signs and symptoms the patient might have”. Illness scripts are a type of knowledge organisation that includes (a) the enabling conditions of a disease, (b) the pathological process, and (c) the consequences of these processes. Through their focus on the consequences (that is, future aspects of the patient’s condition) and through development from experience, illness scripts resemble the frameworks for patients’ rehabilitation described in this study. However, frameworks include bio-psycho-social perspectives (as described in Section 2.4.1), rather than the purely biomedical perspective implied by the words “signs and symptoms”. Further, as in narrative reasoning, the emphasis in illness scripts is on individual rather than collective reasoning.

Opie (1997, p.19) used the term “team narrative” to describe shared discursive activity that is not “authored” by any one member of the team and yet is “the sum of all team members’ attempts to provide an adequate and purposeful account of the situation of the service user”. The notion of team narrative provides a useful means of conceptualising and labelling the process of team members using their own and other team members’ images to develop a collective understanding of how each patient might progress and the means through which this progress might be achieved.

Bandura’s (1997) notion of collective efficacy\(^{87}\) provides an appropriate theoretical framework for conceptualising the collective group action evident in teams’ envisioning of frameworks for rehabilitation. According to Bandura, collective efficacy refers to “a group’s shared belief in its conjoint capabilities to organize and execute the courses of action required to produce given levels of attainments” (Bandura 1997, p.477). Although the frameworks for patients’ rehabilitation are the outcomes of the team’s collective actions, the shared beliefs in the team’s ability to achieve these outcomes are implicitly assumed and evidenced through team members’ participation in envisioning. Accordingly, the development of frameworks for patients’ rehabilitation in teams could be viewed as an “emergent group-level attribute rather than simply the sum of the members’ perceived efficacies” (based on Bandura 1997, p.478).

\(^{87}\) Bandura’s notion of collective efficacy is outlined in Section 3.4.3.
In this research collective reasoning was enriched by the inclusion of snippets of patients’ stories. This research supports Toomb’s (1993, p.103) argument that “the story of the illness as told by the patient” highlights the different worlds that patients and health professionals occupy. She claimed that patients’ narratives related to the patient’s lived experience of illness and disclosed what was personally significant about the illness and how it impacted on the patient’s life, whereas the “medical history is the biomedical view of reality”. Toomb (p.104) proposed that “attending to the patient’s story is vital if one is to understand the patient’s illness”. In the rehabilitation teams I observed, the patients’ narratives were aligned with identifying frameworks for patients’ rehabilitation rather than seeking only to understand their experiences in rehabilitation. That is, the snippets were shared with a forward-focused intention, not just understanding the patient’s current position. That forward-focused attention was integral to the implementation of collaborative care and the ongoing monitoring of the framework’s appropriateness.

Nussbaum’s (1990) emphasis on the role and value of experience in dealing with unknown situations provides an additional basis for understanding team members’ abilities to plan for situations they have not necessarily encountered before (particularly in relation to the images for patients’ rehabilitation directions they bring to team meetings and in their realisation of the frameworks for patients’ rehabilitation):

The good navigator does not go by the rule book; and she is prepared to deal with what she has not seen before. But she knows, too, how to use what she has seen; she does not pretend that she has never been on a boat before. Experience is concrete and not exhaustively summarizable in a system of rules. Unlike mathematical wisdom it cannot be adequately encompassed in a treatise. But it does offer guidance, and it does urge on us the recognition of repeated as well as unique features. (Nussbaum 1990, p.75)

This recognition of experience in clinical reasoning is supported by others who have explored the complexities of professional practice (e.g. Higgs & Titchen 2002; Kemmis 2006). However, despite the contributions of authors such as Opie (1997), who proposed that knowledge creation in health teams involves interactive and recursive processes between different disciplines as their team narratives were developed, the use of experience in collective reasoning remains largely unexplored in the literature.

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88Toomb used the term “clinical narrative” to describe the patient’s story. Due to the potential confusion with a clinician’s narrative I have chosen to use the term “patients’ narrative”.

264
The literature is largely silent on how patients’ voices are brought to teams’ clinical reasoning and decision making. The large body of literature relating to shared decision making tends to be concerned with one-on-one clinical situations where the patient’s presence is integral to their inclusion in decision making. However, in presenting snippets of patients’ stories this research challenges the notion that patients must be included in team meetings for their perspectives and values to be heard and considered. Also challenging the importance of patients’ presence at team meetings is research by Abreu et al. (2002). These authors reported that patients’ attendance at interdisciplinary meetings did not necessarily promote patient-centredness as patients were minimally engaged and “appeared subservient and disempowered” (p.700). While not disputing the importance of creating environments for patients that enable them to be equal partners and tell their stories themselves, or of encouraging patients to have agency to participate in team meetings, it could be argued that (a) patient-centredness is more complex than having patients present at meetings, and (b) patient-centredness can be facilitated by patients’ situations, fears and aspirations being brought to meetings by team members. In this way, the clinical narratives and snippets provide a proxy for patients’ presence at team meetings. Underpinning team patient-centredness is the patient-centredness of individual team members.

5.14.5 Effecting changes in people and teams

To effect means “to bring about; accomplish; to make happen”
by oneself and with others
(based on Delbridge & Bernard 1992, p.299)

She [a patient] was able to take away something; all the achievements that she had accomplished while she was in hospital.
In that way I think we did work really well as a team. [P13]
I think sometimes it (the team) is probably influenced by things outside of our control. [P71]

The term effecting was chosen for its connotations of moving forward and achieving improvement. This dimension relates to working with others in organisational contexts to effect change in patients’ capabilities, to deal with systems requirements and to develop and sustain teams. These three elements are interrelated. To improve patients’ capabilities and help them progress through rehabilitation, team members need to ensure that issues arising from the larger health organisation context do not negatively impact on teamness. In highlighting the multifaceted nature of collaborative outcomes,
this dimension acknowledges team members in relation to their patient’s progression through rehabilitation, and acknowledges teams in relation to their wider organisational influences. Table 5.11e presents an overview of the elements in this dimension.

Table 5.11e Dimensions and elements of experience of collaborating

<table>
<thead>
<tr>
<th>Dimension of experience of collaborating</th>
<th>Elements within the dimension</th>
</tr>
</thead>
</table>
| **a) Effecting** changes in people and teams (highlighting working with others in organisational contexts) | • helping patients progress through rehabilitation  
• dealing with system changes and requirements  
• sustaining teams within organisational contexts |

**a) Effecting: Helping patients progress through rehabilitation**

Helping patients progress through rehabilitation was the primary motivation for team members to collaborate with each other. Satisfaction derived from patients’ progress tended to have a beneficial effect on team morale. There was a sense of collective achievement:

> He’s now at a stage where he can walk independently. (...) [Working with everyone to get those results] that was really good, and the end result is very rewarding. [P17]

Team members commonly sought to ensure that such progress through rehabilitation was a positive experience for patients:

> We [want to see if we] can make the “patient flow” [for each patient] peaceful and pain-free, without distresses [P74]

The challenge for team members was to facilitate this progression in a manner that was sensitive to individual patients’ situations and personally rewarding for team members, yet was undertaken in accordance with managements’ requirements for measurable efficiency and for adherence with allocated lengths of stay.\(^89\) Demands for beds and budgetary constraints created pressure from management to increase the speed at which patients were moved through rehabilitation:

> There is a lot of pressure on beds, and I am asked [by hospital management] every day who’s going home and, and we do try and get people through as quickly as possible. [P74]

Management’s focus on length of stay involved a numerical perspective of rehabilitation teams’ outcomes, whereas team members incorporated an experiential element into their views of the outcomes. A balance of both appeared to provide important cohesion for the team members to work together for patients’ appropriate progress while at the same time ensuring ongoing viability of rehabilitation services.

\(^{89}\) Each patient condition is allocated (by management) a particular length of stay (in days).
b) **Effecting: Dealing with system requirements and changes**

Teams did not exist in a contextual vacuum. Obligatory requirements from their wider structural and organisational environments did not necessarily assist the teams’ provision of rehabilitation services or contribute to their *teammess*. The requirement for FIM\(^90\) scores is an example of such an imposed obligation. FIM provided challenges for many teams:

> [It’s a] major challenge [to make] sure that everybody is […] accredited [for using FIM]. … [We] are not supported adequately for that to occur [P12]

Despite managements’ requirement for FIM scores for each patient, these scores had minimal clinical relevance to some team members:

> I don’t think [the staff] really take a whole lot of interest in what the final [FIM] outcome was or the result. They can see it physically. They can see [patients] coming in totally dependent and see them walk out and find that rewarding, more than looking at the score of what they got when they were discharged. [P10]

Team members complied with FIM reporting for the sake of the rehabilitation unit’s ongoing funding:

> Our survival depends upon it. [P17]

Concern was expressed, however, about simplistic interpretations of the efficiency associated with scores that did not account for the complexity of rehabilitation patients’ conditions and situations:

> The bean-counters would probably (...) say “Well you know unit A got this person 20 points better on their FIM score in 5 days, and these people did it in 10 days, they’re inefficient.” [P17]

Other contextual requirements also inadvertently disturbed teams’ ways of working. It appeared that team members often worked together despite, rather than because of, their organisational context. For example, financial constraints limited resources for team development in some teams:

> The Area Health Service hasn’t actually seen itself as being able to provide the resources required for the team to develop to the full extent that it needs to. (...) It [is] very difficult to be able to sit down and find time for effective strategic planning. [37]

Fulfilling clinical roles and management obligations tended to be prioritised over team development.

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\(^90\) As outlined in Section 2.3.1, FIM is a commercial product that is part of NSW Health’s reporting requirements for rehabilitation.
Communication between team members was affected in unexpected ways by changes to teams’ environments. In one team a simple change of desk impeded the flow of team members’ communication as they sat together to write their reports:

We just had the refurbishment here and there was an offer of rather a flashy desk. (…). I was very keen that we had it. We tried it and it was awful. [Now] all we’ve got in there at the moment is an old desk, but we can sit round it, and we do. And we talk and it’s set up well so that we just communicate all the time. [PX]

Following another team’s move to a different premises, the new team location was reported to be like a hollow shell of the previous location:

I’ve been thinking that the relocation process, it’s really like a group bereavement. It’s not going to be home for a long time. (…) The ward environment is so different (…) that people have just put energy and effort into adjusting to a whole different way of working, whole different systems, and no one’s actually had time to think about [our team] environment. [PX]

The team’s new location did not facilitate the familiar sense of teamness, and team members initially did not have the energy to amend this. Their energy needed to be directed towards adjusting to new organisational systems.

Teams in intersecting arenas of collaborating were particularly vulnerable to staff shortages in other areas of their organisation. In these situations, team processes could suffer:

When other units, other sections of the hospital, become much busier (…) we lose additional staff in those areas. (…) That’s when we can’t participate [in team activities] as much, and when we don’t participate as much, then the whole team process tends to suffer. [P41]

During such times of staff shortage, relationships between team members could become problematic. Care was required that team members’ support for each other did not suffer:

I think we’re largely supportive of the individual in the post [who is having to do the work of 2 people]. We don’t tend to sort of blame the person [for not being able to provide timely services for the team]. We blame the system I think, and try and see what we can do to alleviate that. [P65]

Team members were commonly required to navigate solutions to organisational constraints as they sought to improve patients’ functions, develop their professional roles and ensure the viability of the team and its provision of rehabilitation services.

c) Effecting: Developing and sustaining teams

Opportunities to discuss team issues were seen as important for developing teams’ ways of working. At the business meetings of some teams, members discussed improvements to how they worked together and the rehabilitation services they provided:
Once a month we have a management meeting just to look at the structure of how the team’s working and if there are things that we could be doing better. [P4]

Education sessions (although not held in all teams) provided some team members with a means of introducing new ideas to the team:

I’ve presented [at our monthly education session]. It was great. I just put it to the team: “This is something that I want to try and bring in. This is the research behind it”. And everyone was quite supportive of that, asking questions and we had a good discussion. [P71]

Besides team development (with its emphasis on improvement) there was the practice of sustaining teams during difficult times. Teams often needed to sustain themselves as they faced challenges from their organisational contexts. At times team members needed to be assertive with management to ensure adequate space for rehabilitation:

Part of this [rehabilitation space] was going to be taken. It was already decided. (...) We felt that we were fighting for our existence and recognition of what we needed in rehab. (...) We made sure that we argued strongly our case, and it’s turned out quite well. (...) We have a good relationship [in our team] which was enhanced by that adversity or that need to come together [to keep our space]. [PX].

Such collective action could assist with the team’s sense of teamness.

At other times team members needed to accept imposed organisational changes and position themselves in relation to these changes to ensure the viability of the team and ongoing provision of rehabilitation services:

We’ve managed to just say “while deck chairs are being moved we’re continuing in the engine room”. [P5]

The goodwill evident in engaging with others’ diversity also appeared in relation to overcoming the challenges of organisational contexts:

What’s kept the team together [during the relocation]? I think personnel. (...) I think it’s commitment to this particular team and these kinds of patients. [P64]

An annual social event with patients provided one team with a confirmation of their teamness:

We have the rehab Christmas barbie where we work as a team to put on breakfast. A Christmas breakfast once a year for patients and staff. And I mean that’s a really nice, there’s [the rehabilitation specialist] flipping the eggs and there’s lots of “ho-ho-ho” and good vibes and I think “oh what a nice little bunch they all are”. [PX]

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91 An Australian term for barbeque
Teams were not static entities. Many teams recognised the importance of, and had opportunities for, improving their teamwork and rehabilitation services. As part of their broader organisational contexts they were also required to ensure that their teamness and services they delivered were not negatively influenced by externally imposed changes.

d) Effecting: Free text poem
A poem illuminating the dimension of effecting is shown in Free text poem 5.5.

e) Effecting: Comparison of findings with key aspects of literature
In this dimension of interpersonal endeavour (effecting changes in people and teams) team members were fulfilling professional commitments and managerial expectations for efficiency, while developing their collaborating capabilities and professional practice, and simultaneously seeking personal and professional work satisfaction. Thus the multifaceted and interrelated effects of collaborating identified in this study support the body of literature that acknowledges the complexity of collaborative purposes in rehabilitation. Such interrelated purposes highlight a limitation of relying on numerical evidence to portray changes achieved through collaborative practice in rehabilitation. Gibson’s (2000, p.1) claim that “all medical practitioners should have one primary goal – to ensure measurable and positive patient outcomes” refers to a goal that does not encompass team members’ experiences of working together in health care. Measures such as FIM describe changes in patients, but they do not capture or reflect the human understandings, and the satisfaction gained by improvements in people.

Findings from this study also support claims in the literature that collaboration is influenced by contextual factors and requires organisational support (e.g. Baxter & Brumfitt 2008; Sinclair et al. 2009). However, this study identified difficulty in achieving the reverse influence of people seeking to change their context. For instance, teams had little agency to influence to managerial requirements, policies and restructuring that hindered their collaborative practice. Thus management could change teams’ contexts, but teams appeared to have little influence over management. The agency for effecting contextual change appeared to remain external to where collaboration occurred. This disparity can be explained by Baxter and Brumfitt’s (2008, p.245) contention that “the current climate seems to focus on addressing practice within

92 Literature discussing interrelated purposes of collaboration is explored in Section 4.3.3
Free text poem 5.5

EFFECTING

Together in parts,
Roles developed and fulfilled in relation to others.
Goals of the whole – aligned and enmeshed.
Patients and professionals
Moving forward,
Improving, progressing.

But our teams’ contexts can encircle and divide.
Financial constraints, restructuring, staff shortages.
We continue among these challenges and constraints.
Within this dissonant milieu, where is our team, our teamness?

Through doing and learning together...
through achieving with patients,
through developing ourselves.
we support ...
we understand ...
we sustain ourselves and our team.
Nourished and supported within
and by
our organisation.

Teams creating spaces for positive experiences
(ours’ and our patients’).

Our synergy
from being part
of an emerging whole.
Together within differences.
teams, such as meetings and record keeping, while appearing to put less emphasis on addressing organizational conditions”. Their contention is supported by (a) the numerous examples in the literature of management seeking to facilitate collaborative practice (e.g. Dowswell et al. 1999; Blankenship 2006; Stevens et al. 2007), and (b) the paucity of examples of management seeking to adjust organisational conditions to facilitate teams’ needs for collaboration.

Team members in this study needed each other to help patients progress through rehabilitation. Although working together appeared to make sense to team members, teamwork in the literature is not necessarily portrayed as “normal” or “just happening”; rather there is a sense that teams rely on management to instigate collaboration, or to improve its efficiency. This notion of teamwork as an intervention is interesting, considering the long history of rehabilitation teams, as evidenced by Sensenich’s comment from a 1949 conference presentation:

This whole process of rehabilitation seems to me to be the responsibility of a professional team that includes: doctor, nurse, medical social worker, nutritionist, rehabilitation counselor, physical therapist, occupational therapist, and vocational trainer. (1950, p.971)

Despite the apparent longevity of team practice in rehabilitation, a question seldom asked of team members by policy-makers and managers is “what do you think we, as people who influence your organisational context, can do better in order to help you with your team’s efficiency”? When the question is asked the focus tended to be on team development rather than developing the broad organisational context to suit collaborative practice (e.g. McLellan, Bateman & Bailey 2005).

As well as presenting insights related to the complexity of collaborative outcomes and influence of organisational factors, this study also highlighted that changes to team environments (both small and extensive) could have unforeseen impacts on the ways people worked together. Team members were required to deal with unexpected effects of change. Effecting change in people and situations did not necessarily proceed in a predictable manner. Although researchers have tended to seek teamwork and collaboration that can be replicated and controlled (e.g. Stevens et al. 2007), recognition of the non-linear implications of change provides a suitable basis for understanding change. For example, Plsek and Greenhalgh (2001) proposed that many aspects of health care, including clinical practice, organisation and professional development, are interdependent and built around multiple interacting systems. They noted that the machine metaphor was insufficient to explain change in health care organisations,
proposing that “new conceptual frameworks that incorporate a dynamic, emergent, creative and intuitive view of the world must replace traditional ‘reduce and resolve’ approaches to clinical care and service organisation” (Plsek & Greenhalgh 2001, p.625). They also proposed that health care systems can be viewed as complex adaptive systems, that is, as “a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that the action of one part changes the context for other agents” (p.625). Thus, through the interconnection of individual actions within rehabilitation teams where health professionals, patients and carers interact and learn from each other, and the sometimes unpredictable consequences of change, the concept of health care as a complex adaptive system is supported by the findings of this study.

5.15 Explaining the reviewing dimensions

*Reflexivity*, in relation to *self, the subject, as object* means

*looking at self and changing in response to the reflections*

(based on The Macquarie Dictionary Online 2009)

*Reciprocity* means basically “*mutual exchange*”

(The Macquarie Dictionary Online 2009)

*Responsiveness* means “*responding readily to influences, appeals, efforts*” (Delbridge & Bernard 1992, p.845)

Throughout the *endeavour* dimensions of collaborating (of *engaging, entering, establishing, envisioning and effecting*) were threaded three dimensions involved in reviewing the experience of collaborating: *reflexivity, reciprocity* and *responsiveness.* *Reflexivity*, which involves critical reflection and development of self in relation to others, was evident in people’s abilities to reflect on and monitor their own actions. *Reciprocity*, which facilitates mutuality of rehabilitation roles, underpinned the sharing of information within the teams and was inherent in people’s goodwill to others. *Responsiveness*, which facilitates situationally appropriate and contextually relevant adjustments, was implicit in the constant modifications team members made to their interactions as they dealt with changes, unpredictabilities and uncertainties. In this section the sense of these dimensions is evoked by scenarios depicting different perspectives of collaborating between people demonstrating high and low levels of these (meta-)reviewing dimensions.
5.15.1 Reviewing dimensions in relation to collaborating

The requirements for collaborating, as explored within the endeavour dimensions (engaging, easing, establishing, envisioning and effecting) seem daunting. How can people in rehabilitation teams be expected to be capable of (often simultaneously) a range of accomplishments that include:

- being aware of self in relation to others;
- being optimistic, yet realistic, about others’ capabilities and potentials;
- becoming part of a team in which boundaries and parameters might be nebulous and ever-changing;
- working within changing system requirements;
- coming to a shared approach to patient-centred care;
- coping with personal vulnerabilities while focusing on patients’ needs;
- being reliable and predictable in communication, yet having flexibility to discuss issues quickly and meaningfully;
- balancing personal expectations for authentic discipline practice against others’ expectations for roles;
- seeking agreement in spaces that are potentially fraught with discipline conflicts;
- hearing patients’ voices in the milieu of discipline perspectives and reports;
- developing professional and personal capabilities while actively contributing to patient care;
- being sensitive to patients’ parallel universes to foster collaborative experiences;
- being both person-centred and management aware?

The requirements for collaborating contain ambiguities, subtleties and fragilities that are multifaceted, challenging and constantly changing.

Yet collaborating as positive human engagement in rehabilitation teams (in multiple forms and degrees) does happen, despite and perhaps because of these ambiguities, complexities and challenges. In essence, the strength of the “human” element overcomes the challenges of the “human-created systems” element. A key to understanding how collaborating occurs lies within the notions of *reflexivity, reciprocity and responsiveness* that are threaded throughout the endeavour dimensions of collaborating. These notions represent the meta-behavioural *reviewing* dimensions of collaborating and can be viewed as the means through which the interpersonal, interdisciplinary and situational ambiguities, subtleties and fragilities of collaboration are embraced, reconciled, modified and challenged to enable collaboration to be
optimally or realistically realised for a given situation. The dimensions of *reflexivity, reciprocity* and *responsiveness* tend to be embedded in, and inherent to, interpersonal endeavours, not as clearly visible or appreciated as the more active endeavours. Deep engagement with the wide range of participants in this research was necessary to illuminate these dimensions.

Underpinning the dimension of *reflexivity* are the attributes of critical reflection on personal understandings, interactions with others, and situational differences, as well as the desire and capacity to improve. This was particularly evident in team members’ descriptions of how they learned from their experiences and monitored their actions in relation to the needs, capabilities and situations of others. Those with high levels of this dimension showed a strong awareness of *self* in relation to *others* and were acutely aware of the influence of their actions on others and the need to modify their behaviours and approach in relation to others and different situations.

*Reciprocity* relates to a sense of *role contribution* in the team, and facilitates mutuality whereby team members exchange knowledge and actions for benefit of patients and the organisation. Such reciprocity often involved the notion of “passing on” benefits, rather than simply mutual exchange between two people. It was more than “what we can do for each other”; it included “what we can all do for the patient”. This dimension was implicit in the ways team members negotiated roles and shared information with others. Those with high levels of *reciprocity* were highly aware of how their roles fitted with the roles of others.

The dynamic contexts of collaborating, as well as people’s different interactive needs, styles and preferences, create the need for *responsiveness*. Responding was evident in this study in the ways people intertwined and adjusted their communication and actions to suit different situations. People demonstrating high levels of this dimension were well equipped to deal with the changes, unpredictability and uncertainties inherent in working with others.
5.15.2 Illuminating reflexivity, reciprocity and responsiveness

Because of their embeddedness, I illuminate these reviewing dimensions through two scenarios I compiled (shown in Figures 5.5 and 5.6). Rather than relying entirely on direct quotes, these scenarios explicate insights I obtained from interpreting people’s experiences with collaborating from different perspectives (that is, what they said about themselves and what they said about others). The scenarios are grounded in, based on, and linked to research data, but do not represent any one particular person or team. Further, some of the data used in the scenarios relates to participants’ experiences with previous team members or their previous teams.

The scenarios illustrate experiences with different levels of reflexivity, reciprocity and responsiveness. The first scenario (Figure 5.5) demonstrates low levels of these reviewing dimensions. A key feature of the style of this scenario is the use of other people's perspectives to highlight these low levels. This was a necessary feature as I discerned through my interpretation of data that low levels of reviewing behaviours were more obvious to others than to the person involved. As the dimensions require reflexivity and insights about self, it follows that people might not be aware that they demonstrate low levels of reviewing. The scenario is compiled from the experiences and perspectives of a range of different participants and is not based on one particular person. Similarly the second scenario (Figure 5.6) is based on participants’ quotes (although again not necessarily used verbatim), and does not represent one particular person or team. In this scenario the insights of others are used to highlight the often implicit nature of reviewing behaviours.
I know my role in the team.
I worked it out long ago. It’s now documented as team policy and I explain it to each new team member. I am quite clear about it.

They seem to understand how I work. I don’t need a lengthy discussion about who does what for each patient, or about every little change that we encounter.

I have been doing this job for long enough to know what the others do. And I can provide them with guidance.

“Her patients seem to like her and she gets good results.”

“But she seems to inhabit her own space.”

“Yes. And a space that is pretty fixed!”

“She decides things by herself and then says to us ‘OK this is what we are doing. Can you please do this?’”

“She is a bit oblivious about what we can offer the patients. She seems only to be aware of her own relationship with them and what she is doing.”

“She doesn’t take our opinions on board.”

“We need to tread carefully with her, plan what we are going to say, and how to say it.”

“And have all the reasons worked out beforehand.”

“I know she is busy, but she can get a bit impatient!”

I really want the best for my patients.
And I will go out on a limb to get it. I am not scared of getting people offside if it’s in the patients’ best interests.

Her participation seems to be at a superficial level.”

I do feel part of the team.
I participate in every case conference. I make sure my assessments are clear and accurate. And I let the others know the goals for my patients.

But meetings can be trying. Sometimes they stretch out for far too long. I don’t think all that chat is necessary when there are patients to be seen.

Figure 5.5 Low levels of reflexivity, reciprocity and responsiveness
I think that we have to have team cohesiveness to cope with complex patients. But team cohesiveness isn’t something that can be enforced; it’s better to model it and be open to discussion, not be autocratic.

Some people are team-focused. Others are just there to do their own individual job: I think it works better when they learn to step outside their discipline territories to understand other people’s disciplines, and what they offer patients.

It is important for patients’ goals that we all talk the same language and are going in the same direction. We need to understand the same thing about being patient-centred.

There’s been some evolution of team changes, but traditions are a hefty mass to shift. It is good if people can talk about to do things better.

I have made conscious decisions about how I think I should work with this team.

The people who make the team are important, but you can’t expect everyone to be the same.

We all need broad horizons if we are to approach the patient as a whole.

We need to be aware of how we can do things better.

I do think about how our team works, and what we are about!

Team members’ responses to high levels of reflexivity, reciprocity and responsiveness

“It’s hard to put your finger on why our team works. I don’t think there’s anything formal in place. We just seem to work as a team. People communicate, and it’s easy to get input into decisions.”

“People listen and respond to each other, rather than just giving directions. We work together.”

“There’s flexibility to support each other when someone is snowed under. We really do go the extra distance for our patients and for each other.”

Figure 5.6 High levels of reflexivity, reciprocity and responsiveness
With her low levels of *reflexivity, reciprocity* and *responsiveness*, the team member in Figure 5.5 was unable to embrace the uncertainties and ambiguities of collaborating. This team member appeared to be rigid, uninterested, and self-centred. She also demonstrated an apparent lack of awareness of how others might see her. Hence a paradox is presented in this scenario. People need to be reflexive in order to understand that they do not demonstrate high levels of *reflexivity, reciprocity* and *responsiveness*. The implications of this paradox are frustration for team members when dealing with others with low levels of reviewing, and reliance those with higher levels of these dimensions to enable viable collaboration to be present.

In contrast to the team member with low levels of (meta-)reviewing dimensions in Figure 5.5, the team member with high levels in Figure 5.6 appeared to be concerned, thoughtful, flexible, approachable and caring. For this team member, dealing with uncertainties and ambiguities seemed integral to working with others. Teams where people with high levels of reviewing behaviours predominate have leeway to absorb and provide guidance to those with lower levels of these behaviours. It is beyond the scope of this research to comment on the degree to which individuals may change from low to high meta-behaviours (or perhaps even vice versa).

In Figure 5.6, critical reflection on and of self in relation to others (evident in explicit modelling of sought-after meta-behaviours) and critically seeking development and improvement (in relation to team, professional capabilities and patients) are indicative of *reflexivity*. In these situations the *self* and *self’s actions* are the objects being reflected upon. In relation to *reciprocity*, awareness of others’ roles and their contribution to patient care denotes a collective mutuality. *Responsiveness* in this scenario is revealed in the ongoing adjustments made in relation to different people’s needs and situations, and in being receptive to the dynamic nature of the team, its context and its people. Despite being independently visible, these dimensions are essentially interdependent.

A poem illuminating the experiences with differing levels of *reflexivity, reciprocity* and *responsiveness* is shown in Free text poem 5.6.

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93 The pronoun “her” could be exchanged with “his”. No gender implication is intended. The female pronoun reflects the larger number of female than male participants.
COLLABORATING

We are
afloat on waves of possibilities
for self, for others, for situations.

Collaborating, once truly experienced, is not forgotten.
Seeing further from the crests of

reflexivity, reciprocity and responsiveness,
we surf the breakers as a team.

Though ...
for some these crests are unattained and their surfing is unpractised.

No insightful developments in relationships.
No gentle alternations.
No waves of give and take.

Their occasional ripples of awareness are welcomed and nurtured.
Sometimes merging with our momentum; but often dampened.

Their decrescendo of collaborating potential is our crescendo of disappointment.
Felt and lamented by us.

Can they not see what is missing?
Can they not see themselves as we see them?
Do they not “get it”; that it is not all about them?
Is it through their choices or their limited capabilities?

We tread carefully with them.
Why don’t they move with us
as we buffer challenges,
synergise opportunities and
embrace the moments of “us”
as we are ...?

engaging, entering, establishing, envisioning and effecting.
Transforming our patients, ourselves and our situations.
Through our choices and through our capabilities with

reflexivity, reciprocity and responsiveness.
5.15.3 Interdependence of reflexivity, reciprocity and responsiveness

I propose that the (meta-behavioural) reviewing dimensions of the experiences of collaborating are interdependent. *Reflexivity* in particular plays a key role in this interdependence. In the face of diminished ability to critically reflect on *self* in relation to *others*, low levels of *reflexivity* are likely to affect levels of both *reciprocity* and *responsiveness*. Conversely, being aware of *self* and *others* in relation to roles and situations provides a good foundation for the mutuality and situationally appropriate endeavours that are inherent to the complexity of collaborating. Thus high levels of *reflexivity* can enable team members to be responsive (that is, to sense, interpret, influence and respond to changing situations and needs of people and contexts) and to contribute reciprocally to shared goals.

Reviewing dimensions need to be directed at collaborative endeavours with people in order that they are realised. Thus the reviewing behaviours are dependent not only on each other but also on *engaging* with other people’s diversity, *entering* into the form and feel of a team, *establishing* ways of communicating, *envisioning* together patients’ rehabilitation pathways, and *effecting* changes in people and situations. Team members’ levels of *reviewing* behaviours influenced the experiences of these collaborating endeavours, and the extent to which collaboration was present in rehabilitation teams.

5.15.4 Comparison of findings with literature

The notions of multiple intelligences (as described by Gardner 1996) and collective emotional intelligences (as described by Goleman 1996) have relevance for the *reviewing* dimensions. Although *reflectivity*, *reciprocity* and *responsiveness* are not the specific focus of these notions, multiple intelligences and collective emotional intelligences provide a basis for understanding team members’ differing levels of the meta-behaviours in the *reviewing* dimensions. In his well-known theory of multiple intelligences Gardner (2003, p.4) explained that “a fuller appreciation of human beings occurs if we take into account spatial, bodily-kinesthetic, musical, interpersonal and intrapersonal intelligences”. Interpersonal intelligence “builds on a core capacity to notice distinctions among others – in particular, contrasts in their moods, temperaments, motivations, and intentions” (p.15) and “allows one to understand and work with others” (p.18). Intrapersonal intelligence is concerned with self-knowledge and “allows one to understand and work with oneself” (p.18). It could be postulated that these forms
of intelligence are more richly present in people demonstrating high levels of the meta-behavioural reviewing dimensions.

Building on Gardner’s ideas of multiple intelligences, Goleman (1996) proposed the notion of emotional intelligence as incorporating the notions of self-awareness, empathy, communication and insight. Collective emotional intelligence is evident “in teamwork, in cooperation, in helping people learn together how to work more effectively” (p.163). Teams where team members have high levels of the meta-behavioural reviewing dimensions are likely to be teams with high levels of individual and collective emotional intelligence.

The reviewing dimensions of reflexivity, reciprocity and responsiveness are presented here as integral to many conceptualisations of complex professional practice. This research supports a number of authors’ conceptualisations of complex practice, including those of Paterson and Higgs (2001; 2008), Titchen (2001), and Eraut (2007). Eraut (2007, p.406) recognised “meta-” notions in his view of professional practice as requiring “metacognitive monitoring of oneself”. The notion of reflexivity is inherent in his claim that situational awareness and conscious monitoring of thought and activity are integral to meta-cognition for professional learning.

The importance of reflexivity as a meta-behaviour is also evident in the notion of judgement artistry in professional practice as “the capacity of professional artist practitioners to make highly skilled micro-, macro- and meta-judgements that are optimal for the circumstances of the client and the context (Paterson & Higgs 2001, p.3). For Paterson and Higgs (2008, p.186), being reflexive is integral to judgement artistry:

Within the making of judgements, practitioners are constantly reflecting on their judgements, their capacity for judgement and their practice actions and learning from these actions. This is a process of self-critique and self-development.

Although not focusing specifically on collaborating, Paterson and Higgs placed importance on the role of meta-judgements in judgement artistry for ensuring that health professionals respond to their patients’ circumstances and contexts. The findings of Study B support the ideas of these authors and suggest a broader relevance for meta-judgements to include circumstances and contexts where health professionals work with each other to provide patient-centred care.
Titchen (2001) considered reciprocity to be a component of the relationship domain in critical companionship (a strategy or framework she proposed for working with others to develop expertise in patient-centred health care). In this framework she considered reciprocity as “embodied in a mutual, collaborative, educative and empowering exchange of feelings, thoughts, knowledge, interpretations and actions between the companion and practitioner” (p. 82). In conjunction with reciprocity, Titchen also highlighted a number of other attributes that related to ambiguities and subtleties of professional practice and were grounded in reflexivity: mutuality (being attuned to learning opportunities, building on the learner’s starting point, and offering one’s own knowledge and experience as a resource); particularity (understanding the particular details, needs and context of the learner to determine an appropriate starting point); problematisation (bringing to the surface unseen and habitual practices to enable the learner to see them afresh); and self-reflection (providing opportunities for critical reflection on experiences, rationalisations and feelings in relation to practice and learning opportunities). Inherent in this list are the attributes of responsiveness and reflexivity. The findings of this research (a) support Titchen’s recognition of the importance of reciprocity and reflexivity, and (b) move these notions beyond the health professional-patient relationship to relationships between health professionals in the provision of patient-centred collaborative care in rehabilitation.

The form of reciprocity identified in this research is broader than mutuality between two people in relation to direct benefits for both. In my research, collaborating in rehabilitation teams required team members to move beyond the notion of “what can I do for you, and what can you do for me” to incorporate a patient-centredness notion of “what can we do for each other as we work together with our current and future patients”. I describe this form of reciprocity as flow-on reciprocity, where the benefits people receive from each other are carried over to others and into future situations. Flow-on reciprocity recognises a network of benefits and the durational nature of these benefits beyond the immediacy of the particular interactions for the current situation.

The dimension of responsiveness incorporates the notion of agency. In relation to human agency (in social cognitive theory) Bandura stated (1989b, p. 1175):

Persons are neither autonomous agents nor simply mechanical conveyers of animating environmental influences. Rather, they make causal contribution to their own motivation and action within a system of triadic reciprocal causation. In this model of reciprocal causation, action, cognitive, affective, and other personal factors, and environmental events all operate as interacting
determinants. Any account of the determinant of human action must, therefore, include self-generated influences as a contributing factor.

I propose that agency is needed to respond to situational challenges and changes (including management-imposed changes, such as reporting requirements, and changes to team membership) while simultaneously ensuring that the focus remains primarily on patients, and that team members demonstrate “causal contributions”.

Schön’s (1983) influential notions of reflection-on-action and reflection-in-action are also relevant for the reflexivity identified in this thesis. The relevance and value of reflection for situations of uncertainty and ambiguity are well recognised in professional practice. For example Christensen et al. (2008, p.104) described reflective thinking as relating to the

clinical reasoning of a practitioner, both when engaged with a patient over a period of time, considering and evaluating performance in past experience and also in an immediate sense, reflecting on the moment while working with a patient.

There is a tendency, however, for discussions of reflection to be limited to considerations of the individual’s professional practice rather than also including reflection with others about collaboration, and the individual’s role in collaborating. For example, in the phenomenological exploration of reflection in teams by Sutton and Dalley (2008), team members’ reflection on how they worked together was incidental to their reflection on clinical care for their patients. The authors noted that individual reflection was more common than team members reflecting with each other, and claimed that team reflection could be beneficial, with organisational support required to support it. Besides continued support for individual reflection, there is scope for exploring collective reflection on collaborating and the influence of designated times and organisational support for facilitating team reflection.

Although the subtleties and uncertainties of professional practice and teamwork are well recognised, individual people’s different capabilities for reflectivity, reciprocity and responsiveness, and opportunities for developing these capabilities with others, were not a major focus in the literature relating to collaboration in health care teams. It is beyond the scope of my findings to examine the extent to which these reviewing dimensions were (a) implicitly used by individuals, (b) explicitly developed through education and professional development, and (c) influenced by the organisational context. Illuminating

94 Schön’s concepts are outlined in Section 2.2.3.
meta-behavioural *reviewing* dimensions (as part of the *experience* dimensions of collaborating) provides another lens for future explorations of collaboration in rehabilitation (and other health care teams).

### 5.16 Critical appraisal of Study B

Hermeneutic phenomenology was an appropriate strategy for interpreting the lived experience of the participants in this study of collaborating in rehabilitation teams. Using this strategy I addressed the research questions:

- What is the nature of the lived experience of collaborating in rehabilitation teams?
- What dimensions of collaborating are evident in team members’ experiences?
- How can collaborating contribute to patient-centred health care?
- What organisational support is required for collaboration to flourish and effectively contribute to patient-centred health care?

The *endeavour* and *reviewing dimensions* of collaborating identified in this research were interpreted from the diversity of lived experiences explored in this study. The nature of the lived experience of collaborating illuminated through these *endeavour* and *reviewing* dimensions highlighted the centrality of *people* (and their uniqueness) in rehabilitation teams. The focus by team members (as individuals with different perspectives and capabilities) on each of their patients as a *person* (with will, needs, agency and preferences), provided an impetus for collaborating. In turn, as team members learned from and with each other about their patients’ perspectives, potential and aspirations and planned collective rehabilitation, collaborating contributed to patient-centred rehabilitation. Important for patient-centred collaboration was organisational support that enabled team members to value, interact and develop understandings of others with and about each other. Organisational support included allowance of appropriate time and provision for suitable spaces for situationally appropriate interactions, education about other disciplines, adequate staff, and some degree of protection from the unsettling effects of institutional change.

I began this study with the view that the phenomenon of collaboration had a *presence*. Because I sought to understand more deeply the experience of *collaborating* rather than of *not collaborating*, the dimensions I identified in this research relate to the presence of collaboration (in differing degrees), rather than its absence or what collaborating is like.
when it is dysfunctional or destructive. Further research is required to understand more deeply the experiences of unconstructive, destructive or dysfunctional collaborating.

As I was aware that a positive orientation to collaboration could mean that my findings reflected my positive (and perhaps optimistic) perspective, I needed to critically appraise this orientation to ensure that participants in Study B were not over-representing the presence of collaboration or deliberately or unintentionally hiding behaviours and intentions that were unconstructive, destructive or dysfunctional. Comments by participants about not being aware of my presence in team meetings supported my belief that I was able to observe “normal” team interactions. Although I did not observe team members’ interactions between meetings I could access their experiences with collaborating through interviews. Indications that I was “open” to hear about what not collaborating was like were apparent through participants’ insights into “prickly” team members, and their descriptions of barriers and challenges to collaborating. In particular, comments about diminished collaborating provided insights into the presence of collaborating, and were important for identifying the reviewing dimensions of reflexivity, reciprocity and responsiveness. Although I did not seek to explore participants’ experiences of not collaborating, their descriptions of this at times provided insights into what collaborating was like. These insights were like an inadvertent silhouette, where the “presence of” was evident through the “absence of”. Additionally, although I contend that my participants did not over-represent the presence of collaboration, (a) I chose rehabilitation teams, a context which was likely to have strong teamwork and collaborative structures and cultures (although I did not deliberately choose teams with a history and reputation for collaboration); and (b) it could be argued that teams might have chosen to participate because they were collaborative. Nevertheless, these collaborative teams’ experiences were most valuable in illuminating the nature of collaborating.

A limitation of this study is that I contained the observations of team members’ interactions to case conference sessions for reasons of manageable and ethical issues with invading personal patient-spaces; this restricted the richness and scope of data collected in this research. For example, because not all team members attended the observed case conferences, I was unable to observe all team members interacting. Further, I did not observe many of the team members’ interactions (often informal) that occurred between case conferences. However, these restrictions to the potential richness of data were necessary to ensure that data collection and analysis remained within the
feasible scope of this PhD project. In fact, care needed to be taken to ensure that the amount of data itself did not become a limitation for analysis. Important aspects of interpreting the large volume of data collected were (a) careful and systematic data management, (b) making sufficient time for iterative return to data and deep thinking about data and emerging insights, and (c) presentations of emerging findings for critique at workshops and conferences.

Teams were chosen to participate in Phase 2 on the basis of their location (rural, regional and metropolitan) and their arena of collaborating (intersecting, integrated or hybrid). Team membership changes may have limited the depth of exploration with participants who had already engaged with the phenomenon (in their first interview) of particular characteristics related to location and arenas of collaborating. My original intention in this study was to re-interview team members of specific teams to explore these characteristics. Despite this intention, only 10 of the 26 participants in Phase 2 had been previously interviewed in Phase 1. However, the team membership changes offered a new opportunity. I was able to explore these characteristics within different “life-cycles” of teams. This inadvertent access to team changes provided an important source of data for this study. Further research is required to investigate more deeply the implications of collaborating in different locations and in different arenas of collaborating.

Another area deserving of further investigation relates to patients’ voices (but not the patients) being brought to team meetings (and to the collective decision making occurring there) through reports of conversations with them and through their articulated aspirations. Although there has been little research into the involvement of patients and carers in team decision making in case conferences, my findings challenge the notion that patients need to be present “in person” for their interests and voices to contribute to collective decision making. Further research exploring the nature of patients’ involvement in patient-centred collective decision making is warranted, particularly in relation to decisions made within team meetings.

The relevance of the findings of this study to other types of team situations is based on the transferability of this research. Transferability in qualitative research is determined by its readers (Lincoln & Guba 1985). Three key dimensions provide a basis for readers to critically evaluate this research and determine its transferability to other situations: (a) quality of research, including rigour of the method and trustworthiness of my actions.
(see Kitto, Chesters, & Gribch 2008), (b) description of the conceptual framework of the research, which includes my philosophical stance and theoretical context (see Higgs 2001a), and (c) readers’ understanding of their own situations (Lincoln & Guba 1985). Readers might ask themselves the following questions in relation to transferring the research findings to their own situation:

- Does my setting have a range of disciplines (or different ways of thinking and acting) working together that is similar to Anne’s study?
- How does my team compare to those in the study in relation to such factors as:
  - being already in operation, with people entering and leaving it at different times
  - team members being co-located
  - having regular team meetings
  - having a focus on patients’ care and improvement?
- Do these findings have resonance and verisimilitude for my team(s) and situation?

These questions represent key aspects of the nature of the teams studied. I argue that the range of rehabilitation teams included in this project means that the findings are not necessarily confined to rehabilitation teams or settings. Rather, the findings may relate to a range of teams composed of different disciplines, occupying shared spaces and holding regular meetings.

This research raises a number of different areas for further investigation (in addition to issues of dysfunctional collaboration and patients’ involvement in interprofessional decision making identified above). Areas for future investigation:

- How effective are the _endeavour_ and _reviewing_ dimensions in preparing students and novice health professionals for collaborating?
- What are the implications of team members bringing differing levels of capabilities for reviewing collaboration?

### 5.17 Conclusion

Study B has enabled me to present rehabilitation team members’ experiences of collaborating in a manner that van Manen (1997, p.10) would say “awakens and shows us the lived quality and significance of the experience in a fuller or deeper manner”. By embracing the complexities, ambiguities and uncertainties of my teams’ experiences, I
interpreted collaborating as being composed of eight interdependent dimensions of the experience of collaborating. The five *endeavour* dimensions relate to *engaging* positively with each other’s diversity, *entering* into the form and feel of the team, *establishing* ways of communicating and working together, *envisioning* together frameworks for patients’ rehabilitation with others and *effecting* change in people and teams. The three (meta-behavioural) *reviewing* dimensions of the experience of collaborating are *reflexivity, reciprocity* and *responsiveness*. Different levels of these (meta-behavioural) reviewing dimensions were related to different levels of collaborating success. Team members with high levels of the meta-behaviours demonstrated high levels of collaborating, and conversely for those with low levels of meta-behaviours collaborating was diminished.
CHAPTER 6
A RESPECT MODEL OF COLLABORATION, AND REFLECTIONS ON THE PROJECT

Within the blurred boundaries between noun and verb
lies a blend of knowing and knowledge
that stands aside from the abstract and general
and enters the world of the tacit, aesthetic, and richly personal
(Higgs & Horsfall 2007, p.239)

6.1 Introduction

In this final chapter of my thesis I reflect on my research phenomenon (collaboration and collaborating) in relation to the questions and answers that this research has generated. I introduce The RESPECT Model of Collaboration (developed from the merged findings of Studies A and B), then conclude with my reflections on the quality and implications of this project.

6.2 Collaboration and collaborating

In pursuing a deep understanding of collaboration I found early in my exploration that collaboration was only half of the story; it needed to be accompanied by collaborating. Indeed, I was exploring a dual phenomenon as both an abstract concept (noun) and a human experience (verb). Higgs and Horsfall (2007, p.239) highlighted the value of the “knowing and knowledge” that can develop through exploring the boundaries between nouns and verbs. Their ideas, expressed in the following excerpt, eloquently capture and reflect my experience with understanding the abstract notion of collaboration and the action of collaborating:
nouns are abstractions, symbols promoting vision, representing things that are widely accepted, they are more general, passive and distant, more finished

verbs are active immediate, particularised and person-based they represent experiencing and understanding of being in the midst of the lived experience

(Higgs and Horsfall 2007, p.239).

In Study A, collaboration (as a noun) was clearly represented in the literature by ordered and organic modes of collaboration that operated across the dimensions of people, place, processes and purposes. In my exploration of the experiences of collaborating (the verb) in Study B, I interpreted the interrelated active, doing dimensions of engaging, entering, establishing, envisioning and effecting (i.e. the endeavour dimensions) and the overarching reviewing dimensions of reflexivity, reciprocity and responsiveness that served to engage reflexively with the endeavours of collaborating. The sense of a systematic and rather “finished” structure provided by the PPPP dimensions and collaboration modes contrasts with the sense of an “unfinished” dynamic, situated and subjective reality expressed in the experiential dimensions of collaborating.

By merging the findings of the two studies, I combined the abstracted notion of collaboration as interpreted from the literature with the lived experiences of collaborating. In this merging I reconciled the notion of collaboration as a positive, sought-after contributor to patient-centred health care, with the messiness and challenges (arising from other people, their discipline characteristics and the organisational contexts) that embody collaborating, with all of its difficulties as well as its unexpected possibilities. This merging provides both an overarching framework for understanding the multifaceted and interrelated nature of knowing and doing collaboration and a vision or frame for pursuing patient-centred care that is real, personal and optimal for individual patients in their settings.
6.3 Answering my research questions

My key research questions were:

- What is the nature of collaboration?
- How do people experience collaborating in rehabilitation teams?
- How does effective collaboration in teams promote patient-centred health care?
- What organisational support is required for collaboration to flourish and effectively contribute to patient-centred health care?

In summary, the answers to these questions that arose from this research are:

- The abstracted composite view of the complex nature of the phenomenon of collaboration encompasses ordered and organic modes of collaboration (i.e. the way people interact together) across the four core dimensions of collaboration, people, place, process and purpose. This view of collaboration highlights different motivations and intentions behind the different undertakings of, and support for, collaboration (such as the need for predictability alongside the need for flexibility when people work together, particularly in situations where service delivery is involved and people’s individuality is both the goal of and influence on collaborating).

- Collaborating is experienced as a blending of the endeavours (engaging, entering, establishing, envisioning and effecting) and the reviewing (reflexivity, reciprocity and responsiveness) activities or dimensions. The experience of collaborating is influenced by the “self” and “others” who are collaborating, the context in which collaborating occurs, and the situations, problems or concerns being addressed.

- Effective collaboration promotes patient-centred care when those who are collaborating are person-centred; that is, when they are acknowledging, allowing for, engaging with, and learning from (a) each other’s different perspectives, experience, needs, situations and capabilities, and (b) their patients’ varying situations, fears, needs and aspirations. “Person-centred” applies to both staff and patients. Patient-centred care is provided for people, by people and with people. A focus on patients as diverse individuals provides an impetus for collaborating, and in turn a collective focus on patients as people encourages each health professional to develop and enact an individual patient-centred focus.

- Policy-makers, discipline leaders, educators and team managers need to embrace and support both ordered and organic modes for collaboration to flourish and
effectively contribute to patient-centred health care. To be effective, organisational support cannot be indifferent to the various modes of collaboration, particularly those they cannot readily “see” or control. Although ordered modes (being more explicit, manageable, measurable and predictable) may be easier to support than organic modes (which are flexible, less easily controlled by organisation, unpredictable and evolving), organic modes enable health professionals to develop understandings of, interact with, and value others. Organisational support for collaboration is underpinned by the recognition that responsibility for developing effective collaboration is shared between policy-makers, discipline leaders, educators and team managers, and those who are collaborating in the immediate rehabilitation workplace.

6.4 Merging the studies

The products of this research are: (a) the answers to the research questions (above) and (b) The RESPECT Model (see below). These products arose from combining the theoretical and abstract interpretations of collaboration (from Study A) with the interpretations of actual, lived experiences of collaborating (from Study B).

In Study A I began my philosophical hermeneutic interpretation of the literature by acknowledging my difficulty grasping the phenomenon of collaboration in its entirety. No one view of collaboration presented in the research and theoretical literature adequately encompassed the diversity of meaning I encountered in the literature or through my own practice and life experience. This raised for me questions about how the many varied meanings, approaches to, and details of collaboration related to each other and to the whole of the phenomenon.

My iterative interpretation of the texts enabled me to abstract these different meanings, approaches to and details of collaboration and to represent them as PPPP dimensions (people, place, process and purpose) and modes of collaboration (ordered and organic). These dimensions and modes comprised a more complete view of the phenomenon of collaboration. This systematic view of the dimensions of collaboration reflects its theoretical and reported shape; that is, the view indicates the theoretical core structure of the phenomenon based on textual accounts and descriptions of collaboration. They are summarised and depicted in Figure 6.1.
<table>
<thead>
<tr>
<th>Dimensions of collaboration</th>
<th>Ordered modes of collaboration</th>
<th>Organic modes of collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place</td>
<td>Collaboration occurs in teams with stable membership and discernible boundaries, that are isolated from complexities of context.</td>
<td>Collaboration occurs in evolving networks, informal groups, teams of varied nature that are part of a wider societal context.</td>
</tr>
<tr>
<td>People</td>
<td>Team members represent discipline clinical roles and team functioning roles.</td>
<td>Team members are seen as unique individuals with socialised discipline characteristics and personal and professional experiences.</td>
</tr>
<tr>
<td>Purpose</td>
<td>The drive for collaboration is external. Coordination and integration are sought.</td>
<td>The drive for collaboration is internal. Synergy, innovation and learning are sought.</td>
</tr>
<tr>
<td>Processes</td>
<td>Interactions are directed predetermined, trainable, reproducible, measurable.</td>
<td>Communication is opportunistic, evolving, situationally specific and based on developing relationships.</td>
</tr>
</tbody>
</table>

Figure 6.1 Overview of findings of Study A: Typical features of ordered and organic modes of collaboration
This abstracted composite view of the phenomenon of collaboration can be used to understand the differences in meanings of collaboration in the literature. The varied emphasis on particular dimensions and modes of collaboration explains many different views; that is, some texts focused particularly on ordered modes of collaboration to identify trainable processes and measurable outcomes, while others were concerned with learning that occurred when team members collaborated and learned together in an organic manner. Reasons for the differences could also be clarified by the various breadths of collaboration explored; in some texts the scope was broad, encompassing both ordered and organic modes, whereas other texts were focused more on one mode. The composite view of collaboration provided by the PPPP dimensions of Study A also provides a means of ensuring that the less visible organic and human (compared to theoretical and organisational) dimensions of collaboration remain evident during ongoing interpretations and theorising (by me and others).

In Study B I sought to explore a range of highly personal and subjective experiences of collaborating. In this exploration I embraced the messiness and uncertainty of collaborating. The meaning structure I interpreted in this study was comprised of eight interdependent dimensions of the experience of collaborating:

- the **endeavour** dimensions of engaging positively with each other’s diversity, entering into the form and feel of the team, establishing ways of communicating and working together, envisioning together frameworks for patients’ rehabilitation with others and effecting change in people and teams; and

- the **reviewing** dimensions of reflexivity, reciprocity and responsiveness. High levels of these meta-behaviours facilitated collaborating success.

The dimensions are summarised and depicted in Figure 6.2.

The dynamic, layered and responsive nature of collaborating represented in these dimensions provides a sense of the temporal and situational elements. Collaborating is not static or predictable; it changes in response to people (team members and patients) and to situational and organisational influences. Views and experiences of collaborating are never “whole” or complete; rather, they are like snapshots that capture a particular perspective in a moment and situation. There is scope in the experience dimensions for embracing the changes that team members bring about and experience in themselves, others (particularly their patients) and their team.
### Dimensions of Interpersonal endeavour

- **Engaging** positively with each other’s diversity (which is accompanied by a respect for others and a willingness to learn from or manage differences);
- **Entering** into the form and feel of the team (which is influenced by the nature of people’s entry to teams, together with their personal experiences and role expectations);
- **Establishing** ways of communicating and working together (where interrelated use of a range of structured and opportunistic communication is required);
- **Envisioning** together patients’ rehabilitation frameworks with others (where clinical information is often interwoven with stories about the patient’s situations and aspirations);
- **Effecting** changes in people and teams (which relates to working with others in organisational contexts to effect change in patients’ capabilities, to deal with system requirements and to develop and sustain teams)

### Meta-behavioural reviewing dimensions

- **Reflexivity** involving critical reflection and development of self in relation to others
- **Reciprocity** enabling collective mutuality to develop health care roles
- **Responsiveness** facilitating situationally appropriate and contextually relevant adjustments

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![Diagram](image.png)

Figure 6.2 Overview of findings of Study B: *Endeavour* and *reviewing* dimensions of collaborating
Although Study A and Study B are presented sequentially in this thesis they were largely undertaken concurrently. As I was beginning to appreciate the abstracted theoretical dimensions and modes of collaboration (and their relationships) more deeply, I was also beginning to see clearly the meaning structures emerging from participants’ experiences with collaborating. There was a synergy of understanding as the findings from one study provided insights informing my analysis of the other. I identified a number of parallel ideas across the dimensions of the two studies. Four primary messages were interpreted from these parallel ideas. Those messages related to the notions of diversity, balance, engagement and respect.

**Diversity** is a key impetus for collaboration and collaborating. The notion of diversity extends further than the differences that team members bring to collaborating, and work with, as they collaborate. It includes the varied motivations and intentions that underpin personal involvement in collaboration and organisational support for collaboration across multiple areas, including discipline and education. To support collaboration, people in all positions need to care for and engage with diversity. Collaborating becomes merely a shell of its potential when people overlook the value of diversity in other people and situations or are indifferent or unresponsive to it. Engaging with diversity provides the life-force of collaboration.

Dealing constructively with the need to **balance** different aspects of collaboration is integral to the success of collaboration (in terms of achieving the best from both ordered and organic modes of collaboration) and in collaborating (for example, being able to juggle being a person and a member of a discipline, being a member of multiple teams, and meeting sometimes competing expectations such as being patient-centred and measurably efficient). Balancing competing roles, expectations and influences can be impeded by insufficient time, material and/or human resources and agency. Such agency can vary between those supporting collaboration and those collaborating. Policy-makers, organisation managers, discipline leaders and discipline educators (rather than team members, generally) can have significant scope to vary support for ordered collaboration, but less scope to drive or externally influence organic modes of collaboration; the latter arise from participants’ intentions, capabilities and roles. Team members shape their organic endeavours in collaborating through their choices and experiences in engaging, entering, establishing, envisioning and effecting, and reflexivity, reciprocity and responsiveness.
By providing an important source of momentum, engagement is an important influence on the durability of collaboration. Engaging positively with other people’s diversity is a gentle propellant of the endeavour dimensions. Engagement is also a reflection of the importance of people intentionally working together towards patient-centred care in rehabilitation. Throughout Study B the participants spoke of taking initiative, action, and responsibility. Engagement as an active, lived choice and pursuit, not just a passive or expected participation in teamwork, was a key feature of genuine and intentional collaboration.

Respect is a core ingredient and key facilitator of genuine collaboration, particularly in relation to respect for people (and their diversity) and respect or appreciation of the inevitability and value of variability and uncertainty (in relation to health care situations). Respect encompasses intentions, attitudes and behaviours towards people (including the self, others involved in health care, patients and carers) and their diversity (such as discipline knowledge and socialisation, capabilities, experience, needs, fears and aspirations), as well as the uncertainty, complexity and specificity of the situations they face. Respect is accorded to people and disciplines; it is also earned by team members as individuals. This respect can be lost if certain behaviours and attitudes are displayed. Ideally, respect creates opportunities (through intertwining ordered and organic modes of collaboration) (a) to penetrate deeply into collaborating and become interwoven into communication and relationships between team members and with patients and carers, and (b) to permeate broadly the organisation support for collaboration in terms of dealing with the uncertainty and ambiguities of providing collaborative patient-centred care. Respect is important for embracing diversity, dealing with the need for balancing multiple aspects of collaborating with others, and actively engaging with teamwork.

The parallel messages of diversity, balance, engagement and respect were important for combining the studies and developing The RESPECT Model of Collaboration. The messages bring alive the theoretical abstracted shape of collaboration, and provide a foundation for the dynamic endeavour and reviewing dimensions to operate.
6.5 The RESPECT Model of Collaboration

Drawing together all of the above findings and threads of argument I created a model, The RESPECT Model of Collaboration as shown in Figure 6.3. This model presents collaboration as

\[
\begin{align*}
R & \quad \text{Reflexive} \\
E & \quad \text{Endeavours (in)} \\
S & \quad \text{Supportive} \\
P & \quad \text{Practice (for)} \\
E & \quad \text{Engaged} \\
C & \quad \text{Centred-on-People} \\
T & \quad \text{Teamwork.}
\end{align*}
\]

6.5.1 Presenting The RESPECT Model of Collaboration

The RESPECT Model builds on the PPPP composite, systematic view of collaboration (from Chapter 4) and the action and reflexive dimensions of collaborating (from Chapter 5). The experience dimensions of collaboration are overlaid on the PPPP framing of collaboration.

Descriptive interpretation of the model:

The RESPECT Model positions the temporal and iterative nature of collaborating (as represented by the circular motion of the meta-behavioural reviewing arrows and the fluidity and “echoes” of the endeavour dimension shapes) within a clearly shaped PPPP composite, systematic view of collaboration. Ordered modes of collaboration (with outer visibly brighter triangles), and the less visible organic modes of collaboration (in muted colours) provide the framework upon which (through endeavours and reviewing) the collaborators “dance and weave” their unique collaborating pattern to suit the context, situation and people. The overlaying of the swirling dimensions of collaboration accentuates the difficulty of “seeing” organic collaboration.
Figure 6.3 The RESPECT Model of Collaboration
a) Embracing diversity

The RESPECT Model of Collaboration is a means of encompassing and embracing the diversity that provides the life force of collaboration. The model is grounded in the diverse motivations, contexts, situations and people that were explored in this research. In Study A, I selected for interpretation diverse texts from the literature that would challenge my beginning horizon of understanding of the research phenomenon (collaboration). In Study B, I explored experiences of collaborating from a range of team members who worked in various rehabilitation teams.

As well as being grounded in and fuelled by diversity, the model is composed of diverse ingredients and encourages varied, responsive ways of practising collaboration; there is no one “right” way for collaboration or collaborating to be undertaken. The structure provided by The RESPECT Model for conceptualising and appreciating collaboration encompasses collaboration’s different meanings, perspectives, approaches and opportunities.

b) Balancing different aspects of collaboration

The RESPECT Model represents a balancing of different aspects of collaboration by blending noun and verb, ordered and organic, overt and experiential, and by translating the broad concept of person-centredness into patient-centred practices, for team and patient.

i) Blending of noun and verb

The blending of noun and verb is an important element of The RESPECT Model of Collaboration. The separate exploration of the theoretical and organisational concepts of collaboration (the noun) and the dynamic experiences of collaborating (the verb), followed by my interpretive blending of the findings, provides a new interpretation of collaboration. This interpretation incorporates a systematic overview of collaboration (arising from the PPPP dimensions) with the sense of ongoing change (reflected in the E and R dimensions of collaboration). The temporal and situated nature of collaborating means that although some aspects of collaboration can be structured to a certain extent, there will always be a degree of unpredictability and uncertainty. Thus while the P’s can be used for planning, education and support, the E’s and R’s facilitate the dynamic flexibility that is necessary for pursuit of person- and patient-centredness in rehabilitation.
ii) **Blending of ordered and organic modes of collaboration**

The blending of *ordered* and *organic* modes of collaboration acknowledges the different interests, motivations and drivers that are balanced and interwoven at an interpersonal level by collaborating people in the immediate rehabilitation workplace. It is these collaborating *people* who have the final responsibility for working within and balancing the different interests, motivations and drives. Organisational support (with all its different intentions) can provide order in terms of structures and resources (such as processes, spaces, staff and time) to guide and facilitate (or at times challenge and impede) collaboration, while collaborating (as *endeavouring* and *reviewing*) uses these structures and resources for *organically doing* collaboration. As team members work within the explicit structures of collaboration they use nuances available to them through the actions of collaborating to respond to the needs (organisational, personal, team-based and patient-centred) of the different situations they encounter within the dynamic context of health care. The scope for and capability of team members to engage with and respond to different interests, motivations and drivers through their *endeavours* and *reviewing* actions are key to the balancing *ordered* and *organic* modes of collaboration.

iii) **Blending of overt and experiential element of collaboration**

The model incorporates the overt and explicitly teachable elements of collaboration with the evolving and experiential elements of collaborating. People bring to teams their capabilities for the *endeavour* and *reviewing* dimensions of collaborating. Some of these capabilities are relatively predictable and teachable, such as understandings of other health professionals’ roles and perspectives, and expected ways of acting within prescribed interactions (such as providing information about patients’ assessments, and setting measurable goals). In contrast, the subtle reciprocity involved in negotiating shared treatment sessions and the wisdom required to deal with difficult team members (perhaps those with significant time pressures or low capacity for reviewing) may be more suited to learning through experience within practice.

iv) **Translating the broad concept of person-centredness into patient-centred practices: for team and patient**

In this thesis, person-centred is both a concept and a philosophy. In this section the broader notion of person-centredness is examined in relation to two ideas and strategies. The first is patient-centred care. My argument is that patient-centred care needs to
engage with the patient as a person not as the object of care. It could be argued, for instance, that highly technical health care that provides services to the patient is care that is centred on the patient. However, this thesis expects more of patient-centred care, in that such care should also be centred on the person as an agent and decision-maker in health care, and should be embedded in their life contexts. The second of these ideas and strategies is that person-centredness needs to apply to the team members as well as to the patient. If a team espouses patient-centred care but its members do not value each other, then they have to learn about taking their philosophy not just to their clinical tasks but also to their interpersonal tasks within the team.

This thesis explicates that a person-centred focus facilitates patient-centred care. At the forefront of collaboration are people’s capabilities for *endeavouring* and *reviewing*. Team members as *people* bring their individual personal and professional perspectives and experience to their work and interactions in teams, allowing them to be responsive to their patients’ situations, aspirations, fears and capabilities. A focus on patients as *people* underpins and facilitates the *endeavour* and *reviewing* dimensions of collaborating.

c) Illuminating and valuing engagement

At the centre of The RESPECT Model of Collaboration is the quality of *engagement*. From its central position, engagement provides a certain (though gentle and often understated) momentum for team members’ ongoing pursuits with endeavouring and reviewing. Yet, partially obscured by the movement and progression of the actions surrounding it, *engagement* can be hard to see, particularly through a lens of *ordered* collaboration. The central position of *engaging* in the model serves to illuminate the value of *engagement*’s pivotal role in collaboration.

d) Highlighting the notion of *respect* in collaboration

As implied by its title, The RESPECT Model of Collaboration highlights the notion and practice of *respect* for others, and for the potential and complexity inherent in collaboration. *Respect* is deeply reflective of the research findings and provides the coherence for this model, bringing all the ideas together. In the context of the model, the notion of respect (a) underpins the *endeavour* and *reviewing* dimensions of collaborating, and (b) frames the attitudes towards these complex interpersonal endeavours by all those who influence collaboration from policy, educational and management levels. *Respect* for the contributions of both *ordered* and *organic* modes of
collaboration is also integral to the model of collaboration, as evidenced by the emphasis in the model on intertwining these modes. Respect is related to people’s differences as well as their inherent value as humans. Without the coherence provided by respect, people may be indifferent to the value of each other’s differences and the need to engage with others. Through such indifference people forego a key facilitator of collaborating and an important source of momentum. Thus in The RESPECT Model of Collaboration the absence of respect is not disrespect but rather indifference to people’s differences and the need to engage with these differences.

6.5.2 The RESPECT Model of Collaboration and my thesis

The RESPECT Model presents the core thesis or argument of this research:

Collaborating involves actively engaging-entering-establishing-envisioning-effecting together to achieve person-centred teamwork and collaboration for the provision of rehabilitation services which occurs within the context and framework of people-places-processes-purposes and operates in a way that requires metacognitive and meta-behavioural pursuits of reflexivity-reciprocity-responsiveness.

In essence:

THE R’s ENABLE THE E’s

IN THE CONTEXT OF THE P’s IN THE PURSUIT OF ENGAGED, PERSON-CENTRED CARE

a) The enabling R’s

The meta-behavioural reviewing dimensions of reflexivity, reciprocity and responsiveness are presented as key for facilitating the interpersonal actions that intertwine the different modes of collaboration (arising from and in response to complex intentions for collaboration and situations of health care). In The RESPECT Model individuals can, knowingly or otherwise, produce a situation where the measurable expected outcomes and processes are seamlessly augmented with evolving relationships and learning (and vice versa) through flexibility, willingness and care for others.
b) The endeavour of E’s
The endeavour dimensions of collaboration (engaging, entering, establishing, envisioning and effecting) are dynamic and iterative. They are experienced differently by different people in different contexts and situations. It is through the endeavours of the people who are collaborating (in conjunction with their capabilities with reviewing) that collaboration is an ongoing durable entity and that the modes of collaboration are intertwined.

c) The contextual/structural P’s
The P’s portray the core structural dimensions of collaboration. They provide the conceptual structure upon which ordered and organic modes of collaboration are intertwined. In relation to the P’s, these modes (a) represent the contextual and personal interests, drivers and motivations of collaboration, and (b) provide a basis for guiding and informing organisational support for collaboration. The diagrammatic representation of the P’s as background and scaffolding in the model affords a framework that enables the different interests, motivations and drivers of collaboration to be articulated and their influences on collaboration to be appreciated.

d) Pursuing person-centred collaboration
This model represents the synergistic potential of person-centred collaboration. Person-centred collaboration is the pursuit of actions and intentions of collaborating that embraces people’s endeavours with engaging-entering-establishing-envisioning-effecting within the ordered and organic modes of collaboration across the dimensions of people-places-processes-purposes, using reviewing strategies of reflexivity-reciprocity-responsiveness. Organisational support for such collaboration not only facilitates the achievement of positive outcomes of collaborating but also demonstrates how organisations as well as the individual players within them are key agents in realising collaboration that is truly person-centred. Person-centred collaboration informs patient-centred health care.

6.5.3 The RESPECT Model and support for collaboration
The notion of respect (through its position as the key element of coherence in the model) incorporates the need for people to respond to each other’s diversity, their agency to do so and the behaviours involved. The complexity with which respect is bestowed in The RESPECT Model is supported by Dillon’s (2010) portrayal of the
concept. Based on Dillon, respect in this thesis is accorded the following elements of attitude and behaviour:

- a responsive relation, where conscious rational people respond to each other from a patient-centred perspective to provide constructive and appropriate health care;\(^{95}\)
- an expression of agency, in which respect “is deliberate, a matter of ... attention, of reflective consideration and judgement” (p.7); and
- a behavioural component involving appropriate conduct to each other.

The RESPECT Model provides scope and guidance for individuals with different roles related to the provision of (and education for) health care to critically reflect on their respect for, input to, and influence on, collaboration for patient-centred services. Support for collaboration can be provided by people working in various roles at different levels of health care, including:

- policy-makers (who determine health care structures, allocation of health care funding, and avenues and incentives for collaboration);
- discipline leaders (who determine discipline territories and specialisation within disciplines);
- health professional educators (who educate and socialise individuals into their health professional discipline ways of working); and
- team managers (who employ team members, implement team health care policy, strategies and processes, and facilitate team building).

By providing a framework for respecting, understanding, conceptualising and appreciating collaboration, The RESPECT Model can guide organisational support for person- (and patient)-centred collaboration.

Critical reflection on support for collaboration requires individuals to (a) recognise the importance of capabilities with and opportunities to practise and develop collaborative endeavours and meta-reviewing actions, (b) question their own (often taken-for-granted) intentions and modes of collaboration, and (c) understand the implications of these intentions and collaboration modes for patient-centred health care. The aim of this reflection is not necessarily to achieve consensus and harmonious agreement among

\(^{95}\) This is based on Dillon’s (2010) explanation of responsive relation in which “the subject responds to an object from a certain perspective in some appropriate way” (p.5) and in which, although the object can vary (such as being related to people, non-living things and the natural environment), the subject of respect “is always a person, that is, a conscious, rational being capable of recognizing and responding” (p.6) to the object of respect.
individuals with different roles in health care provision and education, but rather to begin discourse that can inform appreciation of, critical support for and development of collaborative patient-centred care.

Figure 6.4 illustrates The RESPECT Model framed by broad organisational influences. This framing is informed by findings from Study A and Study B that:

- individuals working in policy, management and educational roles can influence the collaborating experiences of clinicians, particularly in relation to their opportunities to facilitate (a) a range of ways for team members to communicate (by ensuring that team members are co-located where possible and have time and space for opportunistic and structured communication), (b) a sense of belonging in the team (through ensuring a degree of stability in team membership or sufficient time for supported entry to team, and shared values and purpose), and (c) a basis for understanding the value of other disciplines’ contributions to health care (through appropriate education and socialisation); and

- individual team members have little scope to influence the modes of collaboration preferred by policy-makers, managers and educators.

In light of team members’ limited ability to alter context and settings, I propose that policy-makers, discipline leaders, educators and managers need to be proactive in ensuring that they share responsibility with team members for facilitating and developing the complex interpersonal *endeavours* and *reviewing* meta-behaviours required for collaborating. Individuals at policy level may be able to address many of the contextual challenges that limit collaboration, such as the frequency of change in health care structures, the over-emphasis on measurable outcomes of collaboration, and the use of funding incentives for protocol-driven practices. Issues to be explored and addressed by discipline leaders and educators include implications for collaboration across specialisations, discipline socialisation, interprofessional education, and focus on the measurable aspects of education. Team managers and educators can address team members’ capabilities for (and opportunities to develop) interpersonal endeavour and reviewing. Both individual and collective agency need to be present at all levels to create the momentum to maintain a focus on collaborative patient-centred health care.
Figure 6.4 The RESPECT Model framed by broad organisational influences
Endorsement for the notion of health professionals effecting change in health care systems is evident in the claim by Higgs, Neubauer and Higgs (1999, p.30) that “Health professionals are immune from neither the effects of nor responsibilities for the changing health care context and need to participate in shaping the future of the health care system”. Building on this claim, I note that health professionals do not work only as clinicians at the “coal face”\(^\text{96}\) of health care, they may also work as policy-setters, managers, discipline leaders and educators. However, in highlighting a need for clinicians to take leadership in shaping their collaborative endeavours, I also acknowledge that a realistic view needs to be taken of the scope and energy for clinicians to institute or influence change rather than have change imposed on them.

6.5.4 The RESPECT Model and collaborative tasks

The demands on health professionals from different tasks they encounter in health care are quite variable. Tasks such as providing objective information from assessments or following simple protocols, for example, do not require high levels of capability for interpersonal endeavours and reviewing of collaborating. Further, team members may differ in their capacity (or willingness, preference and interest) for developing these capabilities. Some individuals might be better suited to tasks with limited emphasis on interpersonal actions. In recognition of the importance of matching tasks and capabilities I have proposed in Figure 6.5 a spectrum of matches and mismatches of individuals’ capabilities in relation to collaborative tasks. This spectrum relates The RESPECT Model to situations of different task complexity and levels of team members’ capabilities.

Two matches are shown in this spectrum: (i) complex tasks and high levels of capability for interpersonal endeavours, and (ii) simple tasks and low levels of capability for interpersonal endeavours. In the mismatch shown in “(b)”, team members’ capabilities are inadequate for the complexity of the task, whereas in “(c)” the capabilities of team members are under-utilised. I suggest that in developing and supporting collaboration it is necessary to seek the appropriate matches (and avoid mismatches) between task complexity and team members’ capabilities.

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\(^\text{96}\) The idiom “coal face” refers to “doing the work involved in a job, in real working conditions, rather than planning or talking about it” http://dictionary.cambridge.org/dictionary/british/at-the-coalface accessed 20/10/10
Collaborative task
suitable for ordered
modes of
collaboration

Collaborative task
requiring intertwined
modes of collaboration

Low capabilities of interpersonal endeavours
and reviewing of meta-behaviours

High capabilities for interpersonal endeavours and reviewing of meta-behaviours

Figure 6.5 Matches and mismatches of individuals’ capabilities and collaborative tasks
I recognise that not all health care tasks require rich interpersonal endeavours inherent in The RESPECT Model of Collaboration. However, in recognising this I also highlight the risk of incorrect designation of complex tasks as simple tasks. For example, Ilott, Rick, Patterson et al. (2006, p.550) qualified their definition of protocol-based care with the caution that “staff retain responsibility for using them [protocols] appropriately and for obtaining informed patient consent”. If the rich interpersonal and interprofessional endeavours potentially inherent in the “appropriate use” of such protocols are ignored, complex collaborative tasks could be misconstrued as simple tasks.

6.5.5 Critical appraisal of The RESPECT Model of Collaboration

In this section I provide a critical appraisal of the nature and value of The RESPECT Model of Collaboration and compare the model to existing literature. I then discuss its relevance for future practice and explore implications for future research.

a) Nature and value of model

The RESPECT Model is grounded in interpretation of conceptualisations of collaboration from a broad range of literature and from team members’ experiences of collaborating in rehabilitation teams. This grounded interpretation enables a sense of order (in relation to the key dimensions of structure of collaboration) to be reconciled with the sense of unpredictability and the need for flexibility (that accompany the lived experience of collaborating).

The model provides a theorisation of collaboration arising from the iterative interpretation undertaken in its development (that is, interpretations as part of Study A, Study B and their merged findings). Through this theorisation the importance of meta-behavioural capabilities is acknowledged and a means of conceptualising individuals’ and teams’ different levels of collaboration is provided.

Relationships between apparently disparate elements or notions of collaboration can be embraced through this model. For example, some apparently (or potentially) disparate nature elements within organic and ordered modes (such as “team” as a delineated stable structure or an evolving, dynamic network) are intertwined through people’s endeavours with engaging, entering, establishing, envisioning and effecting (through their actions and situations people can be concurrent members of multiple teams and communities of practice).
Many ambiguities associated with collaboration can be embraced through the model. For example, ambiguous team structures (which initially led me to questions “what is a team?” and “is this a team?”) and team processes (leading to the question “is it a team process if it is not seen and used by all team members?”) are integral to the model. The model frames these ambiguous elements in relation to different modes of collaborating.

In critically appraising this model in terms of usefulness and application in the real world some questions and challenges arise.

(i) Effective implementation of this model requires professionals to have a heightened understanding of their own practice model as collaborating team members, not just as individual professionals. In Study B some professionals demonstrated this awareness and others did not. When such awareness is not an embodied part of team members’ practice models it is hoped that The RESPECT Model of Collaboration will promote recognition of the value of heightened awareness of collaborative activities. In the years of self-development following graduation, practitioners should reflect on and challenge their models of practice, and seriously question what being patient-centred means to them and how this approach to health care can work well, so that they are patient-centred as well as person-centred.

(ii) In looking at this model as a positive, empowering philosophy and strategy it is important to not minimise the problems that may be encountered in embedding it in an institutional culture. Firstly, institutions such as hospitals have historical ways of acting (e.g. via hierarchies and bureaucracies). Secondly, staff face both internal and external managerial drivers related to accountability, efficiency and economic constraints, which can compete against notions of person-centredness. It would require deliberate engagement of health systems’ hierarchies with notions of patient-centredness for The RESPECT Model to move beyond lip service to genuine person-centred collaboration.

b) Comparison of The RESPECT Model to existing literature

As it is partially based on my interpretations of literature, there is naturally a degree of resonance between aspects of The RESPECT Model and existing literature (e.g. EIPC 2005; Baxter & Brumfitt 2008; Nijhuis et al. 2007; Sinclair et al. 2009). However, my model encompasses a broader and more complete view of collaboration than was captured by any one text I found in the literature. Furthermore, the model clearly articulates and brings to the forefront relationships between elements (e.g. intertwined prescribed interactions and chosen communication) and interests (e.g. the need for
predictability that coexists with a need for flexibility) not necessarily articulated, explored in depth or clearly framed in the literature, as well as highlighting meta-behaviours of collaborating (not previously explicitly identified in relation to difficulties with collaborating). I propose that The RESPECT Model supports, contributes to and exceeds previous understandings of collaboration presented in the literature, particularly in terms of providing (a) an overarching structure to conceptualise collaboration in terms of the need for predictability alongside the need for flexibility, (b) a framework to conceptualise and realise relationships between (often apparently disparate) aspects of collaboration, and (c) insights into the challenges of working with team members with limited appreciation of what collaboration can be or how to pursue its potential.

The RESPECT Model also extends previous work. Nijhuis et al. (2007, p.195) identified a large range of “salient elements of team collaboration in paediatric rehabilitation”, including the team processes of commitment, evaluation, and team-member participation, plus organisational issues of fragmentation of services, support/resources and time. They concluded that “additional exploratory research focusing on the way these elements interact with each other” is needed. I propose that The RESPECT Model of Collaboration contributes insights into such interactions; in particular in relation to ordered (evaluation, support/resources and time) or organic (commitment and team-member participation) modes of collaboration and the motivations, interests and drivers underpinning these modes.

From ethnographic research in a rehabilitation unit, Sinclair and colleagues (2009, p.1196) identified themes of “team culture (divided into leadership, care philosophy, relationships, and the context of practice) and communication structures (both formal and informal)” (p.1996). They noted that these themes indicated a range of organisational, team and interpersonal influences on collaboration, and concluded that this understanding of interprofessional collaboration (IPC) “may guide initiatives to promote IPC in other clinical team settings”. In relation to guiding such initiatives, The RESPECT Model provides a means of identifying the location of agency to influence these themes or aspects of collaboration. For example, the context of practice and the care philosophy adopted across an organisation can be influenced by policy-makers’ directives, the leadership of managers, and (when sufficient time and resources allow) team members’ relationships and informal communication.
Within the extensive informative resources for collaboration provided by the Canadian Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative, a sense of flexibility coexisted with the portrayal of order and certainty, as evidenced by the following extracts (EICP 2005, pp.3-4):

- “each (team), over time, will develop its own character, working relationships and culture”; and
- responsibilities of the team include the development of “an organizational structure that defines the roles, responsibilities and reporting relationships within the Family Health Team”.

Extending these ideas, The RESPECT Model provided a greater conceptual depth to the EICP view of collaboration by explicitly acknowledging (through intertwining ordered and organic modes of collaboration) the importance of (a) the coexistence of structure and predictability with situational flexibility, and (b) the (potentially) different motivations, interests and drivers of those directly involved in collaborating and those with scope to influence collaboration.

Although different dimensions and modes of collaboration were inherent (yet discernable) in many literature portrayals of collaboration, they tended to be implicit and coexist rather than being explicitly articulated or explored. By making explicit what is often implicit in the literature The RESPECT Model provides a voice for the support and development of less dominant elements of collaboration (as portrayed in the literature).

Grounded in lived experiences, The RESPECT Model of Collaboration also contributes a deeper understanding of the difficulties encountered by team members in relation to various collaboration factors, such as (a) working in non-supportive or challenging environments and (b) collaborating with team members with low levels of team collaboration experience or of reflexivity, reciprocity and responsiveness in relation to collaboration. Despite the widespread recognition in previous research and by team members of challenges to pursuing collaboration (particularly in relation to discipline characteristics and/or hierarchies, and communication limitations) no previous models of collaboration has covered these challenges and strategies to address them with the scope of The RESPECT Model.
Of particular interest in my model was the identified importance of meta-behaviours and meta-cognition in relation to complex professional practice. The RESPECT Model identifies and labels reviewing meta-behaviours of collaborating and provides insights into the implications of limited capability with these meta-behaviours. I found no other research specifically exploring the impact on collaboration of team members having low capability in meta-cognitive behaviours.

In summary, The RESPECT Model of Collaboration resonates with and is supported by the literature. Moreover, it extends previous knowledge and understandings of collaboration by contributing a new interpretation that (a) embraces and resolves potentially divergent and/or ambiguous elements (b) incorporates different interests, motivations and drivers for supporting and participating in collaboration, (c) highlights the importance of meta-behaviours, d) explores matches and mismatches between individual capabilities and collaboration tasks and (e) emphasises the importance of organisational and managerial support for collaboration.

In life and in work, respect cannot be taken for granted: it needs to be earned and built. Similarly, embedding The RESPECT Model of Collaboration in a health care institution or system should not be thought of as an easy task just because respect and collaboration, on face value, have little to challenge them. Although many health care institutions have embraced patient-centredness in overt mechanisms (such as patient charters), taking the next step of embodying respectful collaboration into health care requires the recognition of the value and benefits of effective collaboration as well as of the potential organisational constraints to collaboration, not only by team members but also by managers and discipline-oriented staff.

c) Implications for practice and future research

The RESPECT Model has relevance for informing practice. As an ongoing lived experience, practice has explicit and tacit elements (Van Manen 1999a; Higgs & Titchen 2001). By bringing tacit and less visible elements of collaboration and collaborating into focus (and identifying relationships between them) the model provides a useful basis for the development of sound understandings and appreciation of collaboration. This understanding can enhance team members’, educators’, policy-makers’ and managers’ preparation for, education of, development of and support for the practice of collaboration.
i) Informing understandings of practice

The ability to collaborate with other health professionals is an essential for health professional practice. The RESPECT Model can inform team members’ preparation for collaboration by clearly articulating the types of endeavour involved in collaborating (engaging, entering, establishing, envisioning and effecting), and by providing an explanation (on the basis of the identified reviewing dimensions, reflexivity, responsiveness and reciprocity) of people’s different capabilities. On this basis team members can prepare to enter a team (or help others enter the team), for their ongoing development within the team, for understanding others’ limitations and for helping them improve.

Educators can use The RESPECT Model to guide preparation for complex professional practice as well as to inform in-service training for collaboration. Educators need to pay particular attention to the endeavour and reviewing dimensions of collaborating. Capability in these dimensions facilitates ongoing development of collaboration and provides a basis for intertwining ordered and organic modes of collaboration. The model also highlights a potential limitation of a predominant focus on ordered modes of collaboration. Although ordered modes may be more easily taught and assessed than organic modes, they are not sufficient to ensure that health professionals are adequately prepared for the unpredictability and complexity of collaborating in practice.

The reviewing dimensions articulated in the model may be particularly useful for team managers dealing with difficult team members, particularly those demonstrating low levels of capability for collaboration. Team managers can also “raise the team’s expectations” by articulating the need for capabilities with (and facilitating development of) collaborative endeavour and reviewing actions.

The model gives policy-setters, discipline leaders and team managers a broad and encompassing view of collaboration and its human and implementation complexities. By bringing into clear view organic (and responsive, unpredictable) modes of collaboration, The RESPECT Model provides a framework for policy-setters, discipline leaders and health care managers (a) to critique the influence of a predominantly measurement and operational focus on health care and collaboration, and (b) to consider the impact of their policies and actions on both modes of collaboration. An implication of The RESPECT Model is that it is insufficient for people to predominantly support (or
use) only those aspects of operational and organisational collaboration that are readily apparent.

**ii) Reflective questions**

The RESPECT Model of Collaboration is generative of topics that can inform individual and collective reflection, as well as encourage dialogue between team members, educators, policy-makers, managers and discipline leaders. I propose three sets of reflective questions, informed by The RESPECT Model, to develop and support collaboration.

Reflection is receiving increasing emphasis in health professional education and development (e.g. Robertson 2005; Smith, Ajjawi & Jones 2009). In line with this increasing emphasis, I propose that these reflective questions provide a framework for (a) ensuring that the complexity of collaborating is recognised, (b) responding to other people's collaborative situations and needs, and (c) helping individuals to seek personal awareness of different modes of collaboration. These questions could be used for individual or collective reflection.

Questions for team members are shown Question Box 6.1. A challenge is to ensure that sufficient consideration is given to all elements of collaboration and collaborating, including those of an implicit nature. Critical reflection by team members on their own capabilities with the *endeavour* and *reviewing* dimensions might improve teams’ overall levels of collaboration.

Although a discussion about the practicalities and challenges of team members’ individual or collective reflection on collaborative practice is beyond the scope of this thesis, it is proposed that *reflexivity, reciprocity and responsiveness* are as integral to reflection on practice as is collaboration itself. For example, team members need to be aware of and responsive to others’ situations, capabilities and perspectives so that they can negotiate suitable times and locations for collective reflection. They also need to ensure that reflection is personally and collectively constructive. Whereas team members with high capability for reviewing are well placed to negotiate challenges, those without such capability might need facilitation to reflect deeply and collectively. Such facilitation itself requires *reflexivity, reciprocity and responsiveness*. 
The rationale for posing reflective questions for educators, policy-makers, discipline leaders and team managers is that (a) individuals have responsibility and agency for shaping the future of society, (b) they can do this through challenging and changing societal structures and perceptions, and (c) education, policy directions and directives, and management strategies influence and are influenced by health care perceptions and structures. Social ecology, the theory of structuration and social cognitive theory (as outlined in Section 4.2.3) are the theoretical underpinnings of this rationale. On the basis of this rationale, in Question Boxes 6.2 and 6.3 I propose a series of questions for critical reflection by individuals (individually and collectively) at different levels of education, policy-setting and health care management. The questions for educators in Question Box 6.2 guide their reflection on opportunities to teach patient-centred health care and (in particular) the organic modes of collaboration (requiring high levels of meta-behaviours).
Question Box 6.2 For educators

**Scope and opportunities for educating for person-centred collaboration:**
- What opportunities do I have in my role to educate for patient-centred collaboration?
- What do I do with these opportunities?
- How can I facilitate student learning and embrace person-centred collaboration across the various disciplines and roles of team members?

**Modes of collaboration (ordered and organic):**
- What mode of collaboration do I personally prefer (ordered, organic or intertwined)?
- What is it about my experiences with collaboration that has influenced this preference?
- What mode of collaboration do I educate for? Why? What are the merits of other approaches?

**Intentions for collaboration (measurable efficiency and effectiveness, discipline security, staff with capabilities for complex practice and patient satisfaction):**
- What reference points do I use for collaboration?
- What are the relationships among these reference points?
- How might this be changed?

The questions for policy-setters, discipline leaders and team managers in Question Box 6.3 particularly relate to the dominance of *ordered* modes of collaboration, in order that such dominance can be acknowledged and addressed. These questions incorporate notions of *reflexivity, reciprocity* and *responsiveness*.

Question Box 6.3: For policy-setters, discipline leaders and team managers

**Scope and opportunities for supporting person-centred collaboration:**
- What scope does my role in health care have to support person- and patient-centred collaboration?
- What opportunities do I have in my role to support patient-centred collaboration?
- What do I do with these opportunities?
- What changes would I like to make in my approaches and policies?

**Approaches to collaboration (technical rational and human organic):**
- What mode of collaboration do I personally prefer (intertwined, ordered or organic)?
- What is it about my experiences with collaboration that has influenced this preference?
- What mode of collaboration does my role require? Why?
- Are changes required to my approaches?

**Intentions for collaboration (measurable efficiency and effectiveness, discipline security, staff with capabilities for complex practice and patient satisfaction):**
- What reference points do I use for collaboration?
- What are the relationships among these reference points?
- How might this be changed?
ii) Implications for future research

Although The RESPECT Model provides a broad, comprehensive and inclusive view of collaboration, there is scope for its development through further research. Apart from the questions for future research from Studies A and B (see Table 6.1), The RESPECT Model of Collaboration suggests areas for future investigation. These are concerned particularly with the nature of optimal education for, organisational support for and management of intertwining modes of collaboration. Based on these issues, questions for further research include:

- How do health professionals learn to intertwine \textit{ordered} and \textit{organic} modes of collaborating?
- How can team leaders provide adequate support for the effective intertwining of \textit{ordered} and \textit{organic} modes of collaboration?
- How do the setting and broad contexts of rehabilitation and/or health care influence the use and intertwining of the collaboration modes?

<table>
<thead>
<tr>
<th>Study A</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How do people working at different levels of health care understand their influence on collaboration?</td>
<td></td>
</tr>
<tr>
<td>What do people working at different levels of health care understand by ordered and organic modes of collaboration, and what do they see as the contributions and limitation of both modes?</td>
<td></td>
</tr>
<tr>
<td>How do team members view the influence of policy-makers, discipline leaders and managers on their collaboration?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study B</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How effective are the endeavour and reviewing dimensions in preparing students and novice health professionals for collaborating?</td>
<td></td>
</tr>
<tr>
<td>What are the implications of team members bringing different levels of capability for reviewing collaboration?</td>
<td></td>
</tr>
</tbody>
</table>

Beyond the scope of this model are recommendations related to the facilitators and enablers of (i) individual and collective reflection on collaborative practice, and (ii) dialogue between those at different levels of influence over collaboration. These issues are also suitable for future research.
6.6 Reflecting on the quality of this project

This reflection builds on the critical appraisal of Study A (in Chapter 4) and Study B (in Chapter 5), and is additional to ensuring ethical conduct (as described in Section 5.5). Areas of quality on which I reflect are rigour (in relation to research methods), authenticity (in relation to myself as a researcher) and credibility (in relation to my findings).

6.6.1 Rigour

Rigour relates to the notion of “doing the method well”. Mays and Pope (1995, p. 109) stated that “the basic strategy to ensure rigour in qualitative research is systematic and self conscious research design, data collection, interpretation, and communication”. Making careful choices in research design and being explicit about these choices was important for the rigour in my research. For example, Table 3.1 provided details of the research framework I used (a) to develop the research questions and strategy, and (b) to reflect on the congruence between my chosen research paradigm, strategy, question and purpose, and findings.

A key feature of my research design was the use of two studies to explore the phenomenon from different angles; that is, different conceptualisations of collaboration in the literature (the noun), and team members’ experiences of collaborating (the verb). Integral to the choice of this research design were multiple methods of data collection (the construction of text sets in Study A and the interviews and observations in Study B). I articulated the different philosophical underpinnings for each of these studies.

Besides careful choice and articulation of research design I also sought rigour by being transparent, reflective and systematic in my data collection, interpretation/analysis and presentation of findings. For example, I used textual description, summary tables, figures, free text poems and models to present my findings.

6.6.2 Authenticity

Authenticity of my actions as a researcher was pursued by ensuring congruence and coherence between research paradigm, research approaches and analysis of data. A sound understanding of principles of philosophical hermeneutics and hermeneutic phenomenology informed my research actions and enabled me coherently to fuse the complementary research approaches to develop a deep understanding of the phenomenon. My procedural and analytical journals (described in Section 5.7.4) guided
my ongoing reflection on the congruence between research paradigm, question and approaches, and ensured that I could articulate the reasoning behind my decisions, insights and findings in a transparent, rigorous and trustworthy manner.

My adherence to ethical principles throughout all research stages was consistent with the humanistic stance of this research and contributed to its authenticity. Presenting my research approaches and emerging findings at workshops, seminars and conferences provided opportunities to gain critical appraisal and feedback and to reflect iteratively on (a) the rigour of my research and (b) the credibility and plausibility of my findings and their implications.

6.6.3 Credibility

Credibility relates to plausibility of the findings in relation to the methods used and the “fit between respondents’ view of their life ways and the inquirer’s reconstruction and representation of same” (Schwandt 2007, p.299). The credibility of my research was underpinned by the achievement of congruence between the research paradigm, research approaches, research methods and my own perspectives. This congruence was facilitated by the use of Higgs and Llewellyn’s (1998) research question framework to guide decisions related to method (as discussed in Chapter 3).

The strategy of using multiple research approaches, different methods of data gathering, and a number of sources of data enabled me to investigate the phenomenon from different methodological perspectives, and in doing so increased the richness of my findings. As described in Chapters 4 and 5, my iterative analysis of the texts and participants’ experiential data facilitated deep engagement with the phenomenon. The identification of parallel ideas and key messages from two studies strengthened the findings. Distinctions were dialectically resolved through further interpretation and abstraction. This final interpretation drew the findings of the two studies together in a coherent manner.
6.7 Conclusion

In this thesis I explored collaboration in the context of delivering, providing and enacting patient-centred health care. My thesis is that collaborating involves actively engaging, entering, establishing, envisioning and effecting together to achieve person-centred teamwork and collaboration for the provision of rehabilitation services that occurs within the context and framework of people, places, processes and purposes and operates in a way that requires meta-cognitive and meta-behavioural pursuits of reflexivity, reciprocity and responsiveness.

This view of collaboration and collaborating fits with patient-centred health care because patient-centred health is about people, and thus demands that the human characteristics are embraced. RESPECT is an important human element that needs to be embraced in patient-centred collaboration. Essentially, this model argues for and provides a strategy to support this argument, that if people wish to achieve genuine patient-centred care (in rehabilitation) then it is essential to embed and embody respectful collaboration at system and interpersonal levels.

I conclude this thesis with my aspiration for respectful collaboration that, in relation to people (at all levels of health care) and their modes of collaboration, they are:

- **together within differences**
- rather than
- **together with indifference.**
REFERENCES


Baron, R. (1985). An introduction to medical phenomenology: I can’t hear you while I’m listening. *Annals of Internal Medicine, 103*, 606-611.


Carlisle, C., Cooper, H., & Watkins, C. (2004). “Do none of you talk to each other?”: The challenges facing the implementation of interprofessional education. *Medical Teacher, 26*(6), 545-552.


Appendix 1: Health teams as open systems

(based on Harris et al. 2006)
Appendix 2: Information sheets and consent forms

Information sheets and consent forms from Phases 1, 2 and 3 are included in this appendix. As I was enrolled at the University of Sydney during data collection for Phases 1 and 2 (involving rehabilitation staff), and part of Phase 3 (involving patients and carers), the University of Sydney’s letterhead was used in all three phases of the research. During Phase 3 of data collection my supervisor transferred to Charles Sturt University (CSU) and I enrolled with CSU. Therefore the information sheets and consent forms for Phase 3 were required to be on CSU’s letterhead as well as on the University of Sydney letterhead. Because data collection for Phases 1 and 2 was complete by the time of my changed enrolment, CSU’s letterhead was required for Phase 3 only.

Note that Phase 4 (referred to in the information sheets) was not included in this research study. Phase 4 was an option in the initial research plan and allowed for rehabilitation team members to be offered the chance to participate in focus groups in order to explore ways in which they perceived their collaboration approaches might be developed. However, this phase did not proceed for a range of reasons, including:

- feasibility factors (i.e. the large volume of data provided by the greater than anticipated acceptances to participate in this research introduced time constraints for completing Phase 4 as part of this thesis)
- research design factors (as the research progressed I decided that exploring the ongoing development of collaboration in Phase 4 was beyond the scope of the hermeneutic phenomenology study)
- future research plans (Phase 4 is well suited to be a postdoctoral research project).
RESEARCH PROJECT: COLLABORATION IN REHABILITATION TEAMS
PARTICIPANT INFORMATION STATEMENT

Phase 1 - Rehabilitation Team Meeting Observation and Interview

As a member of a rehabilitation team in the Hunter New England Area Health Service, you are invited to take part in the research project ‘Collaboration in Rehabilitation Teams’ conducted by the School of Physiotherapy at the University of Sydney.

I am a PhD candidate with the School of Physiotherapy, University of Sydney, under the supervision of Professor Joy Higgs. I am researching collaboration in rehabilitation teams. The goal of this research is to identify and explore different models of team practice within rehabilitation teams. The major research question is “How do rehabilitation team members collaborate with other members of their team?” The research aims to increase understanding of collaboration in rehabilitation teams and will be valuable in educating and preparing health professionals for effective teamwork. Effective teamwork assists in optimising health care for patients in rehabilitation.

Different rehabilitation teams have different collaborative requirements and demonstrate different collaborative approaches. Despite these differences in rehabilitation teams there is a paucity of information on the following aspects of team collaboration in rehabilitation:

- characteristics of different team collaboration approaches
- challenges facing different team collaboration approaches
- ways team members learn to collaborate
- perspectives of health professionals, patients and carers regarding team collaboration.

This qualitative research project will contribute to knowledge in these areas.

The research project is composed of 4 phases. Some teams will participate in Phase 1, others in all phases.

Phase 1 will explore approaches to collaboration in rehabilitation teams through observation of team meetings and interviews with some individual professional team members.

Phase 2 will involve closer investigation of identified approaches of collaboration with some teams and individual team members.

Phase 3 will incorporate the client perspective of the different team collaboration mode, and will involve interviews with individual patients, and or individual patients with their carers, to explore how they perceive the way the team interacts and collaborates.
Phase 4 will use focus group interviews to investigate the ways in which rehabilitation teams, after becoming aware of their current collaboration practices, might seek to change these practices.

Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. If you decide to participate, you may with withdraw from the project at any reason time without giving a reason.

If you agree to participate in this phase of the study, Phase 1, researchers may observe you, if you agree, together with the other team members during 1 or 2 regular rehabilitation team meeting/s. The focus of this observation is on patterns of interaction, not on clinical matters or client management. The study will also involve 1 or 2 conversational style interviews on an individual basis, if you agree. The duration of each interview will be between $\frac{3}{4}$ and $1\frac{1}{2}$ hours. You will be asked for your permission to have the team meetings observed and audio-taped by the researcher. You may also be asked for your permission to be interviewed and to have the interviews audio-taped. You may ask for the tape to be stopped, erased or edited at any time during the interview. If you wish, you will be given a copy of the transcript to review or edit. There are no foreseeable risks for participants in this research.

All information you provide will be confidential. This project will be written up as a PhD study. Excerpts of interviews may appear in journal articles or other academic documents. No identifying details will be used in the writing up of this study. Pseudonyms will be used to protect participants’ anonymity and where personal information is used, details will be changed, so those individuals will not be recognizable. Information collected will be stored for at least 7 years in a locked filing cabinet or password protected computer accessible only to the researchers. Thank you for considering this invitation. Please ensure that sure you understand this information statement before you consent to participate. If you wish to have more information about this study, please contact:

Mrs Anne Croker, Email acro8333@usyd.edu.au Phone/Fax 02 67 667120, 74 Upper St Tamworth 2340
or Professor Joy Higgs, Email J.Higgs@fhs.usyd.edu.au Phone 02 9351 9070 or FAX 02 93519323

If you wish to participate please send completed consent form by post or fax to Anne Croker.

Any persons with concerns or complaints about the conduct of a research study can contact the Manager, Ethics and Biosafety Administration, University of Sydney on Phone 02 93514811.

This project has been approved by the Hunter Area Research Ethics Committee of Hunter New England Health (reference number 05/04/13/3.14 ). Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or if an independent person is preferred, to Dr Nicole Gerrand, Professional Officer, Hunter Area Health Research Ethics Committee, Hunter Health, Locked Bag 1, New Lambton NSW 2305, telephone (02) 49214950 email nicole.gerrand@hnehealth.nsw.gov.au
CONSENT FORM
Phase 1a - Rehabilitation Team Meeting Observation

I, ……………………………………………, voluntarily agree to participate in the study of Collaboration in Rehabilitation Teams, directed by Professor Joy Higgs and Mrs Anne Croker. I have been given an explanation of the project, and I have had an opportunity to ask questions and my questions have been answered to my satisfaction.

In signing this consent form, I understand that:
- I am under no obligation to accept the invitation.
- I am free to decline participation, or if I do agree to participate that I may withdraw from the project at any time without penalty or prejudice.
- I will be participating in 1 or 2 of my regular rehabilitation team meetings that will be observed and audio-taped by the researchers. I give my permission for audio-taping of the rehabilitation team meetings, and for these tapes to be transcribed for use in this study.
- I may be asked to participate in 1-2 interviews lasting between \( \frac{3}{4} \) and \( 1 \frac{1}{2} \) hours. My permission for audio-taping of these interviews, and for these tapes to be transcribed for use in this study will obtained using another consent form.
- I can discuss any questions or problems with the project directors, as detailed above.

I also understand that:
- The team’s collaborative approaches and processes are the focus of the team observation, and that neither the clinical content of the meeting, nor the outcome of clinical decision making will be studied.
- The information from the rehabilitation team meetings, and any corresponding documents will be used only for research purposes.
- The researcher will treat all material obtained from rehabilitation team meetings as confidential and that my identity, or the identity of anyone I mention during team meeting, will not be revealed at any time.
- The information collected will be stored in a locked filing cabinet or password protected computer accessible only to the researchers.

I have read and understand the Subject Information Statement and Consent Form for Rehabilitation Team Meeting Observation, and understand the purpose and level of risk of the study.

____________________________________  ______________________________________
Name (Printed)  Witness (Printed)

____________________________________  ______________________________________
Signature  Signature
Date

Any persons with concerns or complaints about the conduct of a research study can contact the Manager, Ethics and Biosafety Administration, University of Sydney on Phone 02 93514811.
I, .............................................., voluntarily agree to participate in the study of Collaboration in Rehabilitation Teams, directed by Professor Joy Higgs and Mrs Anne Croker. I have been given an explanation of the project, and I have had an opportunity to ask questions and my questions have been answered to my satisfaction.

In signing this consent form, I understand that:

- I am under no obligation to accept the invitation.
- I am free to decline participation, or if I do agree to participate that I may withdraw from the project at any time without penalty or prejudice.
- I will be participating in 1-2 interviews lasting between 3/4 and 1 1/2 hours. I give my permission for audio-taping of these interviews, and for these tapes to be transcribed for use in this study.
- I can discuss any questions or problems with the project directors, as detailed above.

I also understand that:

- The information from the interviews will be used only for research purposes.
- The researcher will treat all material obtained from interviews as confidential and that my identity or the identity of anyone I mention during team meeting will not be revealed at any time.
- The information collected will be stored in a locked filing cabinet or password protected computer accessible only to the researchers.

I have read and understand the Subject Information Statement and Consent Form for Rehabilitation Team Meeting Interview, and understand the purpose and level of risk of the study.

Name (Printed)       Witness (Printed)

____________________       ______________________
Signature       Signature

Date

Any persons with concerns or complaints about the conduct of a research study can contact the Manager, Ethics and Biosafety Administration, University of Sydney on Phone 02 9351 4811.
Phase 2 - Rehabilitation Team Meeting Observation and Interview

Thank you for your participation in Phase 1 of the above study. Phase 2 of the research project continues the study of Collaboration in Rehabilitation Teams. This phase focuses on the different collaborative requirements and approaches of particular team practice models. Your team has been selected for closer observation and interviews following initial analysis of data from the first phase of the research, in order to study team interaction further. Selection of teams for this phase is based primarily on the team’s collaborative characteristics. You are invited to participate in this second phase of research.

The specific purpose of this phase of the study is to develop a deeper understanding:

- characteristics of particular team collaboration approaches
- challenges facing particular team collaboration approaches
- ways team members learn to collaborate
- perspectives of health professionals regarding team collaboration.

Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. If you decide to participate, you may withdraw from the project at any reason without giving a reason.

If you agree to participate in this phase of the study, researchers will observe you, together with the other team members, during 1 or 2 regular rehabilitation team meeting/s. The study may also involve 1 or 2 interviews on an individual basis, if you agree. The duration of each interview will be between 3/4 and 1 1/2 hours. You will be asked for your permission to have the team meetings observed and audio-taped by the researchers. You may also be asked for your permission to be interviewed and to have the interviews audio-taped. You may ask for the tape to be stopped, erased or edited at any time during the interview. All information you provide will be confidential. If you wish, you will be given a copy of the transcript to review or edit. There are no foreseeable risks for participants in this research.

This project will be written up as a PhD study. Excerpts of interviews may appear in journal articles or other academic documents. No identifying details will be used in the writing up of this study. Pseudonyms will be used to protect participants’ anonymity and where personal information is used, details will be changed, so those individuals will not be recognizable. Information collected will be stored for at least 7 years in a locked filing cabinet or password protected computer accessible only to the researchers.

Thank you for considering this invitation. Please ensure that sure you understand this information statement before you consent to participate. If you wish to have more information about this study, please contact:
Mrs Anne Croker, Emailacro8333@mail.usyd.edu.au Phone/fax 02 67 667120, 74 Upper St Tamworth, 2340
Professor Joy Higgs, Email J.Higgs@fhs.usyd.edu.au Phone 02 9351 9070 or Fax 02 93519323

If you wish to participate please send completed consent form by post or fax to Anne Croker.

Any persons with concerns or complaints about the conduct of a research study can contact the Manager, Ethics and Biosafety Administration, University of Sydney on Phone 02 93514811.

This project has been approved by the Hunter Area Research Ethics Committee (whose functions will now be performed by the Hunter New England Human Research Ethics Committee from 1 January 2006) Reference No: 05/04/13/3.14. Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or if an independent person is preferred, to Dr Nicole Gerrand, Professional Officer, Hunter New England Human Research Ethics Committee, Phone (02) 49214950 Fax (02) 49214818 Email nicole.gerrand@hnehealth.nsw.gov.au
CONSENT FORM

Phase 2- Rehabilitation Team Meeting Observation and Interview

I, .................................................., voluntarily agree to participate in the study of Collaboration in Rehabilitation Teams, directed by Professor Joy Higgs and Mrs Anne Croker. I have been given an explanation of the project, and I have had an opportunity to ask questions and my questions have been answered to my satisfaction.

In signing this consent form, I understand that:
• I am under no obligation to accept the invitation.
• I am free to decline participation, or if I do agree to participate that I may withdraw from the project at any time without penalty or prejudice.
• I will be participating in 1 or 2 of my regular rehabilitation team meetings that will be observed and audio-taped by the researchers. I give my permission for audio-taping of the rehabilitation team meetings, and for these tapes to be transcribed for use in this study.
• I will be asked to participate in 1-2 interviews lasting between 3/4 and 1 1/2 hours. I give my permission for audio-taping of these interviews, and for these tapes to be transcribed for use in this study.
• I can discuss any questions or problems with the project directors, as detailed above.

I also understand that:
• The team’s collaborative approaches and processes are the focus of the team observation, and that neither the clinical content of the meeting, nor the outcome of clinical decision making will be studied.
• The information from the rehabilitation team meetings, and any corresponding documents will be used only for research purposes.
• The researcher will treat all material obtained from rehabilitation team meetings as confidential and that my identity or the identity of anyone I mention during team meeting will not be revealed at any time.
• The information collected will be stored in a locked filing cabinet or password protected computer accessible only to the researchers.

I have read and understand the Subject Information Statement and Consent Form for Rehabilitation Team Meeting Observation and Interview, and understand the purpose and level of risk of the study.

Name (Printed)  Witness (Printed)

Signature  Signature

Date  

The University of Sydney
Faculty of Health Sciences

Joy Higgs AM School of Physiotherapy PO Box 170 Lidcombe NSW 1825
Professor Telephone: 02 9351 9070 Email: J.Higgs@fhs.usyd.edu.au

Anne Croker 74 Upper St Tamworth 2340
PhD Candidate Telephone/Fax: 02 67667120 Email: acro8333@usyd.edu.au
As a patient, or patient’s family member, of a rehabilitation team in the Hunter New England Area Health Service, you are invited to take part in the research project ‘Collaboration in Rehabilitation Teams’ conducted by the School of Physiotherapy at the University of Sydney.

I am a PhD candidate with the School of Physiotherapy, University of Sydney, under the supervision of Professor Joy Higgs. I am researching rehabilitation teams. Rehabilitation is commonly provided by teams of health professionals. Rehabilitation team members work with each other in different ways. The purpose of this research is to understand more about the different ways people work together in rehabilitation teams. Understanding more about these different ways of working together will be valuable in preparing health professionals for effective teamwork. This could assist in providing better health care for patients in rehabilitation.

This part of the study looks at how the rehabilitation team works with patients and families.

Participation in this research is entirely your choice. Only those people who freely agree to participate will be included in the project. If you decide to participate, you may withdraw from the project at any time without giving a reason. Your decision not to participate or to withdraw from the research will not affect your care as a patient (or the patient’s care, if you are a family member or carer).

If you agree to participate, you will be asked for your permission to be interviewed and to have the interview/s audio-taped. You may ask for the tape to be stopped, erased or edited at any time during the interview. If you wish, you will be given a copy of the transcript to read and make changes. The interview will be like a conversation between you and the researcher. The researcher will direct the conversation by asking you questions about your views and ideas of how the rehabilitation team works together, how you are involved with the team; and what this means to you. The interview will last between 1/2 an hour and 1 hour, and will be arranged at time that is suitable for you. You will not be asked about any specific treatment or care given. Nor will you be asked about results of rehabilitation. All information you provide will be confidential.

There are no obvious risks for participants in this research.

This project will be written up as a PhD study. Parts of your interview may appear in journal articles or other academic documents: however your names and personal details will be changed so that you cannot be identified. Information collected will be stored for at least 7 years in a locked filing cabinet or password protected computer accessible only to the researchers.

Thank you for considering this invitation. Please ensure that you understand this information statement before you consent to participate.

If you wish to have more information about this study, please contact:
Mrs Anne Croker, Email acro8333@usyd.edu.au Phone 02 67 667120, 74 Upper St Tamworth 2340
or Professor Joy Higgs, Email J.Higgs@fhs.usyd.edu.au Phone 02 9351 9070 or Fax 02 93519323

If you wish to participate please send the completed consent form by post or fax to Anne Croker.

Any persons with concerns or complaints about the conduct of a research study can contact the Manager, Ethics and Biosafety Administration, University of Sydney on Phone 02 93514811.

\*This project has been approved by the Hunter Area Research Ethics Committee (whose functions will now be performed by the Hunter New England Human Research Ethics Committee from 1 January 2006) Reference No: 05/04/13/3.14. Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or if an independent person is preferred, to Dr Nicole Gerrand, Professional Officer, Hunter New England Human Research Ethics Committee, Phone (02) 49214950 Fax (02) 49214818 Email nicole.gerrand@hnehealth.nsw.gov.au
CONSENT FORM

Phase 3 - Patient and Family

I, ................................................., voluntarily agree to participate in the study of Collaboration in Rehabilitation Teams, directed by Professor Joy Higgs and Mrs Anne Croker. I have been given an explanation of the project, and I have had an opportunity to ask questions and my questions have been answered to my satisfaction.

In signing this consent form, I understand that:

- I am under no obligation to accept the invitation.
- I am free to decline participation, or if I do agree to participate that I may withdraw from the project at any time without penalty or prejudice.
- I will be asked to participate in an interview lasting between 1/2 an hour and 1 hour, to talk about my experiences and perceptions of collaboration in the rehabilitation team.
- I give my permission for taping of the interview and for these tapes to be transcribed for use in this study.
- I can discuss any questions or problems with the project directors, as detailed above.

I also understand that:

- The information from the interview will be used only for research purposes.
- The interview is confidential and my identity or the identity of anyone I mention during the interview will not be revealed at any time.
- Information collected will be stored in a locked filing cabinet or password protected computer accessible only to the researchers.

I have read and understand the Subject Information Statement and Consent Form, and understand the purpose and level of risk of the study.

Name (Printed) ........................................ Witness (Printed) ........................................

Signature ........................................... Signature ...........................................

Date ................................................

Any persons with concerns or complaints about the conduct of a research study can contact the Manager, Ethics and Biosafety Administration, University of Sydney on Phone 02 93514811.
RESEARCH PROJECT: COLLABORATION IN REHABILITATION TEAMS
PARTICIPANT INFORMATION STATEMENT
Phase 3 – Patient’s and Family Interviews

As a patient, or patient’s family member, of a rehabilitation team in the Hunter New England Area Health Service, you are invited to take part in the research project ‘Collaboration in Rehabilitation Teams’ conducted by the School of Community Health at Charles Sturt University.

I am a PhD candidate with the School of Community Health at Charles Sturt University, under the supervision of Professor Joy Higgs. I am researching rehabilitation teams. Rehabilitation is commonly provided by teams of health professionals. Rehabilitation team members work with each other in different ways. The purpose of this research is to understand more about the different ways people work together in rehabilitation teams. Understanding more about these different ways of working together will be valuable in preparing health professionals for effective teamwork. This could assist in providing better health care for patients in rehabilitation.

This part of the study looks at how the rehabilitation team works with patients and families.

Participation in this research is entirely your choice. Only those people who freely agree to participate will be included in the project. If you decide to participate, you may with withdraw from the project at any time without giving a reason. Your decision not to participate or to withdraw from the research this will not affect your care as a patient (or the patient’s care, if you are a family member or carer).

If you agree to participate, you will be asked for your permission to be interviewed and to have the interview/s audio-taped. You may ask for the tape to be stopped, erased or edited at any time during the interview. If you wish, you will be given a copy of the transcript to read and make changes. The interview will be like a conversation between you and the researcher. The researcher will direct the conversation by asking you questions about your views and ideas of how the rehabilitation team works together, how you are involved with the team; and what this means to you. The interview will last between 1/2 an hour and 1 hour, and will be arranged at time that is suitable for you. You will not be asked about any specific treatment or care given. Nor will you be asked about results of rehabilitation. All information you provide will be confidential.

This project will be written up as a PhD study. Parts of your interview may appear in journal articles or other academic documents: however your names and personal details will be changed so that you cannot be identified. Information collected will be stored for at least 7 years in a locked filing cabinet or password protected computer accessible only to the researchers.

Thank you for considering this invitation. Please ensure that sure you understand this information statement before you consent to participate.

If you wish to have more information about this study, please contact:
Mrs Anne Croker, Email acroke09@postoffice.csu.edu.au Phone/Fax 02 67 667120 74 Upper St Tamworth 2340 or Professor Joy Higgs, Email jhiggs@csu.edu.au Phone 02 8388911

Charles Sturt University’s Ethics in Human Research Committee has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer. Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

The Commonwealth Register of Institutions and Courses for Overseas Students (CRICOS) Provider Number is 00005F for Charles Sturt University and the Charles Sturt University Language Centre

The Executive Officer, Ethics in Human Research Committee, Academic Secretariat, Charles Sturt University, Private Mail Bag 29, Bathurst NSW 2795 Tel: (02) 6338 4628, Fax: (02) 6338 4194

www.csu.edu.au
CONSENT FORM
Phase 3 - Patient and Family

I, ________________________________, voluntarily agree to participate in the study of Collaboration in Rehabilitation Teams, directed by Professor Joy Higgs and Mrs Anne Croker. I have been given an explanation of the project, and I have had an opportunity to ask questions and my questions have been answered to my satisfaction.

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- The interview is confidential and my identity or the identity of anyone I mention during the interview will not be revealed at any time.
- Information collected will be stored in a locked filing cabinet or password protected computer accessible only to the researchers.

I have read and understand the Subject Information Statement and Consent Form, and understand the purpose and level of risk of the study.

Charles Sturt University’s Ethics in Human Research Committee has approved this study. I understand that if I have any complaints or concerns about this research I can contact: Executive Officer, Ethics in Human Research Committee, Academic Secretariat, Charles Sturt University, Private Mail Bag 29, Bathurst NSW 2795, Phone: (02) 6338 4628, Fax: (02) 6338 4194

______________________________  ______________________________
Name (Printed)                  Witness (Printed)

______________________________  ______________________________
Signature                      Signature

______________________________
Date