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Chapter 7 – What is an Interprofessional Health Care Team Anyway?

ABSTRACT

Developing a better understanding of health care teams (HCTs) and the behaviours that frame HCT practice is aided in this chapter by interrogation of theories relevant to groups, teams and human interaction. This understanding is also informed by research that provides insight into the realities of HCT practice. This chapter discusses teams in health from three aspects: perspectives on why people would chose to work with others rather than in isolation; an examination of social groups and the individual; and findings from research that explored physiotherapists' perspectives and experiences of practising in HCTs. In combination these theories and research findings help illuminate the complexity and fluid nature of HCTs, and the impact that individuals have, in making each team unique.

INTRODUCTION

Teams have become a fundamental component of modern health service delivery. Inspection of health care employment advertisements reveal that current employers require health professionals to be able to work in multidisciplinary teams. Likewise, promotions panels seek out people for senior positions who have proven ability in *multi-* or *interdisciplinary* practice. It is evident that professionals working in the health care context are expected to be able to practise effectively in *health care teams* (HCTs). In this chapter we aim to develop an understanding of health care teams by examining differing perspectives on why people would chose to work with others as opposed to working in isolation. This understanding will be enhanced by exploring findings from research into current practice in HCTs.

Membership of (HCTs) requires professionals to integrate their client management in an interprofessional context (Leathard, 1994; Wolf, 1999). This integrated approach is thought to be associated with many benefits. Research in the business literature reports several benefits of effective teamwork, including reduced cost to the organisation, improved morale of employees, improved use of people's time and talents, improved decision making and reduced duplication of work (Housel, 2002). Likewise, in the health literature, it is thought that when teams work effectively they result in more efficient work practices through reduction in duplication, improved patient care by preventing gaps in service delivery (Irvine Doran et al., 2002; Leathard, 1994; Ovretveit, 1990) and improved patient safety (Smith & Christie, 2004). Perhaps because of this, Australian governments advocate the use of teams; for example, the NSW Department of Health (2009) stated in their document *Caring together: the health action plan for NSW*:

“New doctors, nurses, midwives and allied health staff will be trained to work in teams in the interest of patient safety. Clinical skills will be taught, practised and assessed. They will also learn how the team can work better together, particularly when a patient's condition starts to deteriorate.”

Wherever health professionals work they are likely to encounter HCTs, as they are found across the spectrum of health care. HCTs range in scope from acute pain management teams (McDonnell, Nicholl & Read, 2003) to gerontology teams (Williams, Remington & Foulk, 2002), and in location from teams within the hospital system (Lake, Keeling, Weber & Olade, 1999) to those in the community (Johnson, Wistow, Schulz & Hardy, 2003).

The terms 'team' and 'teamwork' indicate quite different phenomena. Manion, Lorimer and Leander (1996) were careful to differentiate between these expressions by defining a team as a "specific structural unit in the organisation" (p. 5), whilst teamwork was "the way people work together cooperatively and effectively" (p. 5). Unfortunately the common practice of using the terms team and teamwork interchangeably, as occurs in the health literature, causes confusion in this field (Manion et al., 1996) perhaps leaving the impression that all teams cooperate.

The chapter is divided into three sections. The first section explores two differing perspectives on why people would choose to work with others rather than in isolation. Section two examines social groups and the individual. The final section, presents research that explored physiotherapists' perspectives and experiences of practising in HCTs to reveal two factors that influenced their behaviour as a member of a HCT.

Why would people choose to work with others?

Individuals tend to form groups including small social groups, such as families, volunteer groups and sports teams, or larger, organisational groups such as political parties, education systems and health care systems. In society, like-minded individuals form groups that reflect common identities that are expressed through common cultural forms (dress, values, habits) (Jureidini et al., 2003). Even when individuals strive to be different they may coalesce to form groups of like-minded "different" individuals, such as when individuals adopt non-conformist practices in a collectivist way (same clothes, likes, dislikes, behaviour,) in reaction to their perception of a society (McNair et al., 2001). Frequently in health care, groups of professionals are brought together to form HCTs. By exploring factors that influence the formation of groups in society and individuals' decisions to work with others, we may reach a deeper understanding of HCTs and our work within them.

Debate about why individuals form groups or work with others in society can be traced back to the Greek philosophers (Haralambos, van Krieken, Smith & Holborn, 1999). This debate has evolved over the years involving two seemingly diametrically opposed theoretical perspectives, the structuralist perspective and the social action perspective. Structuralist perspectives have been criticised for their deterministic focus on the overall structure of society and how distinct components

interact to impact on individuals (Haralambos, van Krieken, Smith & Holborn, 1999). A variety of structuralist viewpoints have evolved as different theorists such as Hobbes, Durkheim and Parsons have developed models relating to how components of society meet a set of basic needs that are common to all societies. From a structuralist perspective, the behaviour of HCT members would be determined by the society in which the HCT is set.

Conversely, social action perspectives, driven by theorists such as Mead and Blumer, see society as a product of human behaviour (Haralambos et al., 1999). Social action perspectives are concerned with individuals and their groups and the impact they may have on society. Although social action perspectives herald a significant shift away from the structuralist theories where society enforces its will on the individual, they have been criticised for their reductionist focus. Both perspectives are important to an understanding of health professionals' experience of working in HCTs as they help researchers add new dimensions to understanding individuals, groups and society.

Structuralist perspectives focus on the forces that construct and constrain individuals rather than on the individuals themselves (Jureidini et al., 2003). Parsons (1951) felt that control in society originates from integration between personalities and separate cultures within society (Parsons, 1951). He held that social systems strive for equilibrium, with deviance resulting in dysfunction. In Parson's interpretation, accepted norms of behaviour would sustain equilibrium, with deviance or non-conformity resulting in instability. He contended that the commitment of individuals to the same values provided a common identity which in turn provided a foundation for cooperation and common goals (Parsons, 1951). In HCTs, members may share a common purpose, that is, the provision of health care to a specific group of clients. However, sharing a purpose does not mean that they would also share a commitment to the same values. For example, members of different disciplines can work in different practice models. In addition, the values, rights and obligations that are assigned to individual roles may be influenced by the predomination of genders in specific roles and the unequal distribution of power (e.g. through hierarchical role power). The influence of gender and power in HCTs is important, as it highlights a key criticism of Parsons' Structuralist Systems Theory that by focussing on normative values, in that ascriptive differences such as power, gender and race are ignored (Zajdow, 2003).

Proponents of social action perspectives have differed significantly in their views on the structure of society in that they do not believe that a structured society dictates the way in which people behave (Haralambos et al., 1999). For instance, Mead (1967), (the founder of the theory of symbolic interactionism), argued that society and human consciousness emerged through the social act. That is, the individual, or self, is constructed in interaction with society, and society was in turn is constructed in interaction with the individual. Proponents of social action perspectives also acknowledge the

importance of the relationship between the individual and the group (Schuler, Aldag, & Brief, 1974). Mead (1967) argued that individual acts were components of larger, social acts. Therefore, understanding the behaviour of an individual is dependent upon understanding the behaviour of the whole social group to which they belong. He disagreed with structuralist views that all people are equal, arguing that society was made up of complex organisations of individuals and groups that hold varying degrees of power and status. In addition, he maintained that the freedom of one group often infringed upon the freedom of another as people strongly identified with their own group through hostility to another (Mead, 1967), essentially an 'us' and 'them' mentality. This concept has important implications for HCTs with membership drawn from a multiple professional groups where individuals have a strong identity with their profession.

Consideration of structuralist and social action perspectives is useful in understanding the impact of societal structures such as professional groups and HCTs on societal rules and values. Structuralists tend towards a belief that distinct rules and generalised values form the framework for individuals' behaviour, whilst proponents of a social action perspective argue that although individuals are not controlled by the system they are influenced by processes of norming and standardisation in society. Blumer (1969) shifted strongly away from the structuralist perspective that the system determines human behaviour, maintaining that the meaning each individual derives must be unique to the individual. In addition, he held that as people interact with others in the social world, they constantly re-evaluate their understandings of the meaning of things, modifying their previous constructions. Importantly, Blumer (1969) held that human behaviour could not be explained through set roles, culture, status or drives in the absence of interaction, rather, rules are developed and upheld through the interaction of individuals in a group. A classic example of this complex phenomenon in health care teams is demonstrated through the seating patterns commonly adopted by teams (for instance the dominant or senior person sits in the designated or accepted 'leader's chair', with the 'note taker' or support person alongside). Seating arrangements are seldom random, they speak to individual and group acceptance and reinforcement of societal norms enacted within their particular practice context. Norms such as these are thought to reinforce internal differentiations in society.

Increasing differentiation and specialisation, as has occurred in health, results in rising numbers of discrete entities or roles. How might this influence the roles within HCTs? Structuralists such as Parsons (1951) contended that society predetermines roles with each individual having defined rights and obligations within a group. He also held that the group would have a set of values which all individuals adopt. The difficulty with this for HCTs is that each member would have defined rights and obligations that relate to their professional group, requiring multiple, differing sets of rights and obligations to be integrated within a HCT.

Social action perspectives on roles differ from structuralists in that they believe that roles are not fixed. For social action protagonists roles change during the course of human interaction. Mead (1967) described a process known as '*role-taking*', where people frame their own behaviour by putting themselves in the position of others in order to interpret the intention and meaning of the symbols and actions adopted by other people. Mead's concept of '*role taking*' needs to be understood within the framework of his theories about an individuals' development of a concept of self. He maintained that the self consisted of the *I* and the *me*, where *I* is impulsive and uncontrolled and the *me* is the censor or the social self (Mead, 1967) . The *I* is a person's view of him/herself as a whole and is developed through interpretation of the reactions of others, whilst the *me* defines the person in a specific social role (Mead, 1967). The *I* wields considerable influence over a person's behaviour (Mead, 1967). For instance, if previous social interactions have led a health worker to see him/herself as being unsure in team situations, this is likely to result in a lack of self-confidence working in the HCT. Mead did not intend for this to be seen as a battle between the *I* and the *me*; once the *I* acts it becomes the *me*, and is the way that people express their uniqueness (Mead, 1967). Mead (1967) believed that people responded practically to environmental demands. That is, through the concept of '*role taking*', knowing and acting were integrated. Mead thought that '*role-taking*' and cooperative action stemmed from an awareness of the expectations of society (Mead, 1967). Societal control is exerted as individuals become aware of the expectations of others and modify their actions in response. In effect, control is exerted through socialisation.

It can be seen that both the structuralist perspective and the social action perspective centralise the importance of socialisation and its contribution to social order. Structuralists contend that individuals cooperate because they have been socialised into believing that it is right to obey the rules of society (Durkheim, 1974; Parsons, 1951). According to Durkheim's (1974) theories, health professionals' behaviour and consciousness would be shaped by socialisation from a range of sources, including HCTs, individuals' childhood, professional groups, work and environment. As with the structuralists, an important facet of the social action perspective is socialisation, that is, how people learn to behave in society (Mead, 1967). Mead linked socialisation to individuals' development of a concept of self. Social action protagonists believe that it is through social dialogue or interaction that society is formed. Blumer (1969) argued that the meanings that people have for objects determine the way they act towards those objects and that social interaction refines people's interpretation of these objectives. Essentially, from a structuralist perspective individuals in HCTs would learn how to respond in predetermined patterns. Whereas, from a social actionist perspective individuals' responses would be mediated by their interpretation of social interaction, that is, that there is a fluid nature to the society found within HCTs.

HCTs, individuals and their affiliations

Rather than viewing an organisation such as a hospital as having a distinct unified culture, current thinking sees organisational cultures as fluid and unstable (Chan, 2000). Within organisations there are cliques, cabals and groups; these are subcultures, with clearly articulated cultures of their own (Gagliardi, 1990). Organisational cultures are thought to be simultaneously integrated, differentiated and fragmented (Martin, 1992). Contributing to this cultural melange in the health care sector has been the shift towards a “knowledge-based” society with increasing specialisation of the workforce (Wilenski, 1964) and the emergence of professional groups. As a result, HCTs in hospitals are made up of representatives from a range of professional groups.

Belonging to any group provides people with comparators and a context through which they may develop an understanding of who they are (Ashforth & Kreiner, 1999). Through collective values and meanings individuals construct their sense of self-worth (Hogg & Terry, 2000). For people to engage in collective action (as may occur in HCTs) they need to strongly identify with that group and its members (Kramer, Hanna, Su & Wei, 2001). In this way, engaging in collective action as a member of a HCT seems to run counter to belonging to a discipline-specific group.

Social identity theory encompasses a body of ideas that combine to form an approach to understanding social identity and intergroup relations. This approach builds upon the pioneering work of Taifel from the 1970s. Taifel (1979) theorised that social behaviour could be viewed on a continuum from interpersonal behaviour to intergroup behaviour. At the extreme of interpersonal behaviour, interactions are determined by the personal relationships between individuals. At the extreme of intergroup behaviour, interactions are determined by individual’s membership of social groups. This theory has been used to explain the different ways people react when beliefs about the social structure or their social status challenge their social identity (Turner, 1999).

Social identity theory was further developed by the addition of the self-categorisation theory (Turner & Oakes, 1989) that contended that behaviour along the interpersonal and intergroup continuum could be explained by a distinction between two identities: one personal and one social. Personal identity defines what makes a person unique and individual from other people, including those who are in the group. Social identity defines individuals according to characteristics they share with others in a group. These group characteristics are in contrast to characteristics of other groups, and identify the group as “us” in contrast to “them”. For health professionals working in hospital HCTs, social identity would encompass their membership of the HCT as well as their membership of other social groups to which they belong, such as being a physiotherapist, or being a woman or a man, Australasian or Eurasian. Sense of identity with a group is considered to be dependent upon the balance between an individual’s personal and social identity (Turner & Oakes, 1989).

Three key principles underpin self-categorisation theory. First, when social identity has greater saliency than personal identity people switch from individual behaviour to collective behaviour (Turner, 1999). That is, the more strongly they identify with a group the more likely they are to adopt the behaviours and norms of the group. Second, when the saliency of social identity is greater than personal identity this leads to self-depersonalisation, where people accentuate attributes that make them similar to the group (Turner & Oakes, 1989). Third, the level of identification a person has with a group varies, being dependent upon the context and the values and expectations of the person (Turner & Oakes, 1989). High levels of identification with a group depend upon the level of similarity people perceive they have with group members, their perception of interdependence with group members, and the degree to which they value membership of the group (Turner, 1999).

When individuals' social identity has greater saliency than their personal identity they transfer from individual behaviour to collective behaviour (Turner, 1999). This process, known as the depersonalisation of self, is the central hypothesis of the self-categorisation theory (Turner & Oakes, 1989). When health professionals self-categorise as a member of a specific hospital group their personal identity has less saliency to them. For instance, self-categorisation as a physiotherapist would require them to perceive that they had similarities with other physiotherapists, that they were interdependent with other physiotherapists and that they valued the physiotherapists as a group. Importantly, once they identified with the physiotherapist group these features would be heightened through self-depersonalisation as they formed a group of "us", in contrast to "them". In identifying with the physiotherapists they would accentuate their similarities and reduce personal attributes that made them different. This process would also increase, perceptually, their difference from other cultural groups such as doctors or porters, through self-stereotypes. The more strongly they identified with the physiotherapist group the more membership of the group would shift from being a label to being a psychological reality.

Self-categorisation is reinforced when the group is central to a person, is valued and is ego-involving (Doosje & Ellemers, 1997). As health professionals are generally educated in relative isolation from other health workers it is likely that they would perceive many similarities with their peers and few similarities with other health professionals. Cumulative professional enculturation during training may result in strong identification with their professional group and perceived interdependence. Of importance, perceived interdependence can cause self-categorisation and lead to psychological group formation even before positive experiences reinforce the perception (Turner, 1999).

Self-categorisation subjectively changes people's relations according to judgements of whether someone is one of "us" or one of "them" (Turner, 1999). Perceptions of attraction or dislike, agreement or disagreement, cooperation or conflict would be dependent on perceptions of similarities

or differences. Recategorisation results from the need to resolve uncertainty about judgement of whether someone is one of “us” or “them”. Recategorisation of one’s own membership of a group results in reduced identity and affinity with the original group and strengthened identity with a different group. Just as people perceive themselves as members of different groups in different contexts, they perceive others as different in one context but similar in another (Turner, 1999). Recategorisation of another’s membership of the group results in people shifting others out of the “us” group into a “them” group. So how does this interplay with known models of HCTs formed from representatives of different professional groups?

Professional groups are the protectors of a body of knowledge and skills that is generally not shared with others (Higgs & Bithell, 2001). In addition, they are said to possess a specific set of attributes that define them: “altruism, honour and integrity; caring and compassion; respect; responsibility; accountability; excellence and scholarship; and leadership” (Inui, 2003, p. 12). High levels of expertise and autonomy are integral to professional identity (Raelin, 1986). Therefore, it is no surprise that the dominant themes evident in analyses of professionalism are privilege and power, themes that run counter to the idealistic attributes of Inui (2003) listed above. The key resource of professional groups is that they alone are able to perform specific tasks (Freidson, 1993). The degree of uncertainty and complexity that is associated with such tasks perpetuates the need for the professional (Southon & Braithwaite, 1998). High levels of uncertainty and complexity require individual assessment by the professional in order to achieve the outcome desired. As a task becomes less uncertain, it may be handled by standardised procedures even though it may still be complex, and it could therefore be handled by a technician rather than a professional (Southon & Braithwaite, 1998). Thus professionals retain autonomy through ownership of specific knowledge and skills. Power and privilege may be built through protection of that knowledge as others come to depend upon the ability of professionals to handle specific tasks.

Professionalism would seem to progress individualistic rather than cooperative tendencies as professionals seek to protect specific tasks and craft knowledge which may determine the type of team practice. Three key classifications predominate in HCT classification; they use the prefixes, multi-, inter- and trans and describe a continuum of team practice with multi- at one end and trans- at the other. Common descriptors for multi- can be found to involve the inclusion in the team of different professionals who work separately and who either report information or share information. Essentially the prefix multi- denotes the retention of role boundaries by the professions with individuals practising in parallel models of practice. The definitions of inter- exhibit the most confusion in the literature with professionals sharing roles (Sorrells-Jones, 1997; Masterson, 2002) or working separately (Stepans, Thompson, & Buchanan, 2002), retaining boundaries (Paul & Petersen, 2001) or merging (Masterson, 2002). It is only when trans- is used that consensus clearly appears with an

emphasis on shared roles, role blurring and even role exchange. In HCTs it may be that professionals with high levels of professional identity and protectionism would fall into multi-disciplinary models of team practice whilst those who can relinquish control over set tasks may be able to practise in a trans-disciplinary model.

There have been two scholarly departures from these three classifications of HCT. The first is Øvretveit's classification based upon team organisation (1996) using five dimensions. The second is Boon et al's (2004) description of the range of integrated practices found along the pre-existing continuum of team-oriented health care practice.

Øvretveit (1996) described five dimensions based on aspects of team organisation to classify HCTs. These dimensions were: the degree of team integration; resource management; membership; decision making; and leadership. Each dimension was expressed across a continuum that captured the spectrum of teamwork. For instance, the team integration continuum moved from a low level of integration with a 'loose knit association' to a high level of integration with 'collective multidisciplinary policy' and 'decisions made at team meetings' (Øvretveit, 1996). The spectrum of practices that may describe the level of team integration lay in between. When this approach to classification is used to address all five dimensions, it is unlikely that a HCT would fit each element at the same relative point in the range; it may be classified in the high range for integration, the low range for resource management (in that the HCT has no control over its own resources), and middle of the range for leadership. Whilst Øvretveit's (1996) classification system is better placed to capture the uniqueness of a HCT its focus on organisational dimensions limits its scope because for a number of dimensions, such as level of trust or respect, are not addressed.

Boon et al (2004) define "seven different models of team-oriented health care practice: parallel, consultative, collaborative, coordinated, multidisciplinary, interdisciplinary and integrative" (p. 2) that range across the continuum of health care practices. These models were based upon their understanding of the key components of integrative health care practice: philosophy or values; structure; process; and outcomes. Boon et al (2004) believed that on one side of the continuum, where parallel and consultative practice models reside there is a predominance of the biomedical model of health. As one moves towards the other end of the continuum greater emphasis is placed upon holistic models of client care with the psychosocial determinants gaining emphasis. Structure varies across the continuum with hierarchical models disappearing as the emergence of trust and respect developed in the team. They felt that communication would increase as teams move towards more integrative models because the number of members increases in response to more holistic models of care. Finally, Boon et al (2004) believed that the 'complexity and diversity of outcomes' (p. 2) would increase as teams move towards more integrative models of care. They believed that the choice of practice model

was determined by clients' needs rather than team members' behaviour. For instance, they contended that a client presenting with an acute myocardial infarction was better managed in practice models on the left of the continuum. They believed that their classification system could be used by emerging health practitioners to decide which practice settings best suited their interpersonal and professional needs. In addition, the authors recommended that health care managers should recognise the different structural styles, from hierarchical to integrative, that would need different funding and leadership training. Essentially, there are a range of factors that would seem to play a role in influencing individual professional's decisions to work with others. There are also different ways of viewing HCTs.

Research exploring influences on professionals' decisions to work with others in HCTs?

This final section presents findings from doctoral research, (undertaken by the lead author with supervision from the co authors), into Australian physiotherapists' perspectives and experiences of working in HCTs. In this research the differences between teams and teamwork was illuminated by findings which emphasised the importance of trust, security in team membership and the challenge of juggling multiple team memberships.

Given the complexity, dynamism and situated nature of the phenomenon of teamwork, the research was necessarily contextualised and interpretive in orientation using multi-source data collection methods including semi-structured, in-depth interviews and participant observation. Following recruitment, ethics approval and informed consent processes, six physiotherapists agreed to participate in the study which had a duration of 18 months. Gender-neutral pseudonyms were assigned to ensure the anonymity of the participants: Alex, Chris, Jo, Kim, Pat, and Sam.

Data analysis was guided by principles described by scholars of hermeneutic phenomenology (Heidegger, 2005; Gadamer, 1975). Three reflective approaches as described by van Manen (2001) were used in the analysis of the data: the wholistic approach, the selective approach and the detailed approach. These strategies helped to uncover thematic aspects in the data. The process of interpretation continued until a point was reached where further interpretation proved to be redundant, the point of theoretical saturation.

HCT structure, the environment and the impact of trust

It is a common practice in the literature to classify health workers' team membership in a simple model based purely on their clinical affiliation, that is, that they are on the rehabilitation team, or the orthopaedic team. However, in this research the reality for the participants was considerably more complex. Service delivery in the participants' hospitals depended upon the work of multiple intersecting teams formed from a range of different professional groups. Some professional groups

formed distinct teams (for example, the hospital physiotherapy team and the orthopaedic and rehabilitation teams); others formed less distinct, loosely connected teams (for example, the acute care team and the sub-acute care team). Participants' concurrent membership of multiple teams can be seen in the excerpt from Chris's interview in which we were discussing meetings.

We have an inpatient physio meeting, we have an inpatient allied health meeting, and once a month the business unit manager attends that from up on the ward. Then we have patient-based team meetings, including case conferences and the family meetings. Then we have our neuro admin meetings. So lots of meetings and lots of teams within teams, but its good and somehow it works. (Chris I1: 321¹)

Essentially, the participants' teams could not be seen as separate entities because the different teams were interconnected. As teams often shared responsibilities and frequently shared members, the participants needed to learn to effectively balance and juggle their responsibilities and relationships in order to become empowered practitioners in their HCTs.

It was evident in this research that the physiotherapists engaged concurrently in a range of practice models from separate models of practice as seen in multi-disciplinary teams, to integrated practice models as seen in trans-disciplinary teams. Integrated practice models emerged with participants who were able to more fully appreciate the value others added to patient care. The ability to adopt such models has been found to require professionals to blur roles, to accept differences and to have a shared vision of service delivery (Boon et al., 2004). As these requirements needed high levels of trust and respect, integrated practice models occurred only with the participants' most trusted colleagues. Invariably this was with occupational therapists.

They are all probably different relationships, but the OT [occupational therapist] ... we were similar in our frustrations and difficulties at times so we had that common link. The OT and physio goals often overlap and kind of work together. They've been working on doing breakfast group in a standing position and that correlates with my goals of increasing standing balance and standing symmetry. So we often liaise and try and make sure we are on the same track and what we're working on is either complementing or working towards the same thing. (Chris I1: 112)

In spite of the different professional philosophies and approaches to treatment, Chris sensed a commonality with occupational therapists. This feeling was repeated across participants. Contrary to anecdotal evidence that these two professions are often in conflict, in this research it was evident that there was a complementary and synergistic relationship between them.

Youngson (1999) described the complex and seemingly chaotic social construction of their role for practitioners who were dealing with sector changes, practice challenges, uncertainty and confusion. Such complexity mirrors the findings of this research where the participants worked in a complex, fluid environment dealing with multiple layers of change and complexity. However, in contrast to the literature that states that complexity increased professional territorial protection (Jones 2005), in this

research complexity actually fostered closer integration and interdependence, that is, less conflict and less territorial protection. Simplifying and controlling their complex, fluid environment was crucial to participants' capacity to complete their work. To this end, participants solve established links with their most trusted colleagues to form small informal teams. They used these teams to informally bridge professional separation that they confronted within the organisation.

Core teams were small, generally involving no more than three health workers, and had predictable patterns of membership. The participants' preference was to establish stronger relationships with those people who could be trusted to respond in similar ways to the participant and with whom they shared similar values and expectations. In this way, membership of the core team was exclusive, being reserved for people who consistently showed that they were trustworthy. Core teams varied according to the context of their work and the level of trust participants had for workers around them. Core teams reduced the number of people with whom they needed to interact, and provided a safe environment in which there was reciprocal support, respect and reliance. As they worked with these people they recognised and developed greater similarities, which strengthened their affinity with their core team, making it even more valuable. In this way they significantly enhanced participants' practice and were distinctly different from their other teams.

Core teams broadened their perspective. Core teams were problem solving teams. The members of these teams united to develop a stance on a patient's capacity to achieve an outcome or determine timelines for patients to achieve outcomes. Meetings of these teams showed a flat hierarchy with shared decision making. It was evident that team members valued individuals when their input led to modification of team decisions. In addition the combined knowledge of team members was used to develop strategies to work more effectively with powerful health workers, the senior doctors.

It was apparent in this research that the physiotherapists concurrently identified with multiple teams. They also shared an identity with representatives from different professional groups, through the establishment of and participation in their core teams. There is congruence between these findings and a modification to social identity theory known as *crossed categorisation* (Turner, 1999). Crossed categorisation involves a person identifying with multiple groups simultaneously, and has been found to weaken group boundaries by enhancing a person's perception of similarities rather than differences between groups (Gaertner et al., 1993). As argued in crossed categorisation theory, when the participants in this research shared an identity with representatives from other professional groups it helped to limit conflict between these professional groups. In this research the formation of relationships with their fellow core team members was founded strongly on participants' levels of personal affinity for these people as individuals. Essentially, participants' sense of value for people in their core teams did not extend to the professional groups from which core team members arose.

The influence of trust on physiotherapists' decisions to work with others

A feature of participants' behaviour in HCTs was seeking to manage risk within a framework of trust. Fukuyama (1995) defined trust as "The expectation that arises within a community of regular, honest and cooperative behaviour, based on commonly shared norms on the part of other members of that community" (p. 26). Learning to trust meant that participants had to have sufficient empathy with their colleagues to believe that they were working to capacity, that all were pulling their weight. In turn, participants built trust through being reliable, that is, by not adding to others' workload through failure to do their own. The importance of the reciprocal nature of this element of trust was apparent when Kim described the way that two physiotherapists working in the same unit handled the workload.

What doesn't get done gets done by someone else. So you just have to trust that everyone within the team is working to what they can. I think that's true. If they can't get it done they can't get it done. I'm not sitting there thinking "she should have". It's the same as there being another new patient to see today, and there may be more admissions after lunch, there'll be a limit to what I can do. If I can't get it done I can't get it done. My expectation is that other people will say well, you know, that's as much as could be done. (Kim I2: 135)

Believing that all will work to their full capacity enabled Kim to accept additional work without judging others or thinking badly of them. In return Kim expected others to understand that work left undone reflected time constraints rather than laziness. Inter-reliance helped foster their understanding that they were "pulling together", supporting each other. Trust relied upon them having empathy with others, being able to put themselves in another's place. Believing that others were working to their capacity meant giving them the benefit of the doubt if work was not done, behaviour that would help prevent conflicts within the team.

Being reliable was not just doing what you said you would do, but doing it within a stated time-frame. Participants expected others to share their sense of urgency about their work, expecting them to handle matters in a timely fashion. However, the importance of good communication was apparent, as people who were responsible for delays were not necessarily deemed unreliable.

I'm expecting them to give me a response that will tell me when. It doesn't mean that they have to do it straight away, but I expect that they will let me know when, yeah, basically when. Generally if I'm not happy with that then I can negotiate from there, but I don't want to be sitting around waiting. If it is going to be the end of the week, I would just rather know that it is going to be the end of the week, that's fine. (Kim I4: 188)

Participants' appreciation that all were working to their capacity helped them to attribute delays to heavy workloads, time constraints or staff shortages. Being reliable entailed keeping people informed as to when the matter would be handled. They appreciated it when others gave them honest and accurate estimates of the timing of action, as this prevented unanticipated delays. Being let down

repeatedly as deadlines came and went frustrated them more than the single disappointment of being informed about a lengthy delay. Perhaps this was because accurate communication of a delay enabled the participants to manage their work. Unpredictable timelines might reduce their sense of control, leading to a feeling of disempowerment. In addition, uncontrollable timelines that delayed the participants' work might result in themselves being deemed unreliable. Regaining control in such situations left the participants with two options: to accept the loss of trust associated with being seen as unreliable, or to blame the team member who put them in that position. Both of these had negative implications for the team.

Choosing to work with more reliable colleagues was associated with additional benefits that helped to build trust and participants' sense of security. When the participants repeatedly sought out a colleague they were selectively increasing their time with that individual, providing opportunities for better understanding of the other's roles. More time also gave participants a chance to get to know the colleague better, which could enhance their relationship. Choosing to work with specific individuals was driven by the need to save time. They chose people who had proved their capacity to enhance their work, or who assisted them to complete their work in the available time. Participants' preference was for people with proven reliability, as can be seen in the following excerpt from Alex's interview.

I suppose I tend to probably seek out the ones I know well and I know are good. Earlier on I had to talk to somebody. The one I needed wasn't there so I asked another to pass the message on, as I knew she was reliable. If there's a group of nurses and you know one of them well, you know is good, you go for her even though you know she may not be the right one. It's just human nature. (Alex I2: 595)

The act of preferentially seeking out a colleague was a way of showing that the colleague was valued and respected. This could serve to further enhance the relationship and develop a feeling of mutual respect, an important factor in trust. It can be seen in the excerpt from Alex's interview that colleagues who rejected the participants' approach were seen as unreliable. The participants choose not to work with such people. A refusal was seen by the physiotherapists not only as a lack of interest, but also as a mark of disrespect. People who did this ran the risk of being tagged as difficult to get on with and being avoided in future.

CONCLUSION

Developing a better understanding of HCTs and the behaviours that frame HCT practice is aided in this chapter by interrogation of theories relevant to groups, teams and human interaction. This understanding is also informed by research that provides insight into the realities of HCT practice. In combination these theories and research findings help illuminate the complexity and fluid nature of HCTs, and the impact that individuals have, in making each team unique.

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ⁱ This nomenclature indicates the source, within the research data, of this quote.

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Replace 'whilst' with 'while';

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