Collaborating in Healthcare
Reinterpreting Therapeutic Relationships
Anne Croker
University of Newcastle, Australia
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and
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This book is about a vital aspect of healthcare; that is, how people collaborate. At the heart of this book is the RESPECT Model of Collaboration in healthcare produced during a doctoral research project. Following this research, a number of practitioners have explored this model in their practice and they were invited to write up their experiences and insights in a number of chapters in this book.

The intended audience for this book includes healthcare practitioners, educators, managers and others with an interest in how people in healthcare collaborate. Readers will be invited to look at ways that this dynamic model can be utilised insightfully in their practice.

In the RESPECT Model, collaboration is presented as:
- Reflexive
- Endeavours (in)
- Supportive
- Practice (for)
- Engaged
- Centred-on-People
- Teamwork.

The title RESPECT reflects the goal and practice of patient-centred care. The model is not presented as a universal approach for people to adopt in their practice but rather it offers ideas to explore, expand and critique to build an even greater understanding of the complex phenomenon of collaboration and to create our own ways of practising respectfully. This reciprocal and synergistic way of working is exactly what respect and collaborating is about. By engaging with others’ experiences and conceptualisations, this book is an expanded version of the initial thesis. The model serves as a means of influencing other people’s practices which in turn can develop and challenge the model.

There are four sections in the book:
1. Professional relationships
2. A study of collaboration in healthcare
3. Applying the RESPECT Model of Collaboration in healthcare practice
4. Educational applications of the RESPECT Model of Collaboration.
Collaborating in Healthcare: 
Reinterpreting Therapeutic Relationships
Collaborating in Healthcare

Reinterpreting Therapeutic Relationships

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This series examines research, theory and practice in the context of university education, professional practice, work and society. The series explores spaces where two or more of these arenas come together. Themes that are explored in the series include: university education of professions, society expectations of professional practice, professional practice workplaces and strategies for investigating each of these areas. There are many challenges facing researchers, educators, practitioners and students in today’s practice worlds. The authors in this series bring a wealth of practice wisdom and experience to examine these issues, share their practice knowledge, report research into strategies that address these challenges, share approaches to working and learning and raise yet more questions. The conversations conducted in the series will contribute to expanding the discourse around the way people encounter and experience practice, education, work and society.

Joy Higgs AM, PFHEA
Strategic Research Professor in Professional Practice
Charles Sturt University, Australia
BOOK COVER ARTWORK

I thank Simon Munro for his vision and creativity in creating the artwork that is on the cover of this book. I am grateful for his permission to use his reworked etching on the cover. From my view, the etching captures and portrays the complexity of the collaborative space. The fluidity and flow of the details in this space resonates with both the beauty and messiness of collaborating in healthcare: there is always more to see and reflect on. The following paragraph is how Simon describes his work.

"Face to Face" (reprinted in Chapter 13 and reworked for the cover of this book) was originally etched and printed during a time of great personal self-reflection while undergoing my Bachelor Degree in Visual Arts at The University of Newcastle during 1994-1996. The etching (an intaglio process) was initially influenced by Danish psychologist Edgar Rubin's imagery, now commonly known as Rubin's vase. I intentionally bypassed Rubin's literal meaning and repurposed it to be the artist's self-reflection represented by the two opposing black profiles with a void between which is intended to represent the turmoil of personal doubt and uncertainty at that time of my life. Like all art I feel "Face to Face" may mean different things to different viewers and I hope that in the same way I have repurposed Rubin's meaning the viewer will do likewise with this print. (Simon Munro, 2016)

Anne Croker
This book represents a series of journeys. The first was my PhD research journey with my doctoral supervisors Joy Higgs and Franziska Trede. The second was, and is, my ongoing research and practice application, critiquing and further developing as well as applying the findings from my doctoral research. This second journey involved a number of researchers, educators and practitioners, some of whom joined me on a third journey. This third journey includes those of these “significant others” who have talked about, explored, provided feedback on, critically appraised, modified and enjoyed the ideas and the RESPECT Model that my research generated. This book is a reflection and celebration of all of these journeys.

Subsequent chapters will present information and appraisal of my research strategy but I will provide a brief overview here to set the scene for the book and its various chapters. The PhD research project investigated collaboration among staff in rehabilitation healthcare teams in several centres in Australia.

The research strategy incorporated philosophical hermeneutics to develop a deep understanding of the nature of collaboration and hermeneutic phenomenology to illuminate the experiences of rehabilitation team members when collaborating. From this research I developed the RESPECT Model of Collaboration, where collaboration is presented as:

- Reflexive
- Endeavours (in)
- Supportive
- Practice (for)
- Engaged,
- Centred-on-People
- Teamwork.

Outline of the Book

There are four sections to this book:

**Section 1:** Professional relationships: This section frames the complexity of professional relationships.

**Section 2:** A study of collaboration in healthcare: This section presents the research at the core of the book and introduces the RESPECT Model of Collaboration.

**Section 3:** Applying the RESPECT Model of Collaboration in healthcare practice: A range of narratives from people who have used and explored the model are presented in this section.

**Section 4:** Educational applications of the RESPECT Model of Collaboration: The narratives in this section relate to the experiences and reflections of students and educators.
Introducing the Authors

In the first two sections Joy Higgs and Franziska Trede, my doctoral supervisors and co-editors of this book, join me as chapter contributors. Their substantial experience with research methods and practice were integral to the development and portrayal of the RESPECT Model of Collaboration.

In the third and fourth sections are a range of authors. Some of these authors, as people close to me in my day-to-day life and practice, played key roles both as sounding boards and critical companions (as I wondered about and pondered upon various aspects of collaboration) as well as being sources of understanding for the complexity of collaborative practice in health (in their varied roles as health professional students, clinicians and educators).

Other authors have joined my research journey more recently, as co-workers and/or co-researchers exploring aspects of collaboration. Others still are people who, although met briefly through networking at conferences and through introductions from colleagues, have provided insights and inspiration for my ongoing understanding of the complex phenomenon at the core of this book. Common to all authors is wisdom arising from authentic engagement with and reflections on the complexity of collaborating in healthcare.

Focusing on Collaboration

The choice of collaboration as my research topic arose from my fascination with the complexity associated with people working together in healthcare. On the surface it might seem obvious that health professionals would work with each other and with patients and carers towards shared goals to facilitate healthcare that is integrated and situationally appropriate 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 extensive volume of literature on the subject of collaboration indicates that collaboration remains a challenge for practitioners, managers, policy-makers, educators and those receiving healthcare despite the increasing research, policy support and educational emphasis on interprofessional practice and shared decision making with patients and carers. I was curious to reflect upon what it was about collaboration that rendered it so complex and so elusive in successful achievement.

Collaboration has long been a key to providing a range of healthcare services. Throughout my varied experiences as a health professional and community member I have collaborated in a range of teams. For example, as a health professional I participated as a physiotherapist in rehabilitation teams and a lactation consultant on advisory committees, while as a community member I held the role of convenor of a local sporting committee and was the president of the board of a large national not-for-profit organisation.
My fascination with teams was heightened by my involvement in a particular health promotion team where I was aware of an almost exhilarating sense of “so-this-is-collaboration!” This was a different experience from 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, and more than 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 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 these stories were often tinged with frustration and scepticism. I heard that, despite the increasing emphasis on collaboration within healthcare, 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 diverse expectations of society, management, professions, patients and carers, and continue to develop their own professional practice capabilities. It appeared that some characteristics of healthcare 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 healthcare 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
PREFACE

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 collaborative 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 healthcare team’s collaboration as well as participants in their care.

I warmly invite you to engage in this discussion and discourse by reading the following chapters and reflecting on the relevance of this work for your future endeavours in life and work.

Anne Croker
**GLOSSARY**

**Collaboration**
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.

**E’s and R’s as Experience**

<table>
<thead>
<tr>
<th>E’s as Engaging, entering, establishing, envisioning and effecting.</th>
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<td>R’s as reflexivity, reciprocity and responsiveness.</td>
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**P’s as Domains of Collaboration**

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<th>P’s as people, place, process and purpose.</th>
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**Patient-centred**
is an adjective that embraces the notion of people in healthcare; 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’ healthcare, they are key players in patient-centred healthcare.

**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.

**The RESPECT Model of Collaboration**
presents collaboration as Reflexive Endeavours (in) Supportive Practice (for) Engaged, Centred-on-People Teamwork
SECTION 1

PROFESSIONAL RELATIONSHIPS
1. REINTERPRETING PROFESSIONAL RELATIONSHIPS IN HEALTHCARE

The Question of Collaboration

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

COLLABORATION IN HEALTHCARE MATTERS

With this book we are opening the door to an amazing, complex and dynamic landscape of collaboration and collaborating in professional practice and development. Though our contention that no single approach fits all circumstances and conditions, we recognise that collaboration, the phenomenon explored in this collection of research and practice-based journeys, is best if enacted as an inherently situationally appropriate practice. Collaboration is a lived phenomenon in that it is understood, enacted and experienced differently by different people. Collaboration among healthcare staff is the context for the various journeys reported in this book.

The doctoral research that serves as the basis for this book (Croker, 2011) was undertaken in the context of rehabilitation which serves as an excellent location to explore the multifaceted nature of collaboration in healthcare teams. Rehabilitation is ideally a patient-centred, team-facilitated endeavour undertaken within healthcare institutions where health professionals commonly work together and with patients and carers to coordinate and integrate perspectives, goals and treatments. 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 findings of this research and the arguments presented have relevance, we argue, across healthcare arenas and teams. We invite readers to interpret the arguments and models for their disciplinary and workplace situations.

Increasingly, both the image and role of practitioners are being modified by an emphasis on collaboration and recognition of the importance of health practice.
relationships. The impetus for this transition is multifaceted and is commonly linked to a wide range of contextual factors (as described in Croker, Croker, & Grotowski, 2014; Croker, Sheehan, & Iedema, 2014). These include:

- fragmentation of healthcare which results in different healthcare approaches (such as acute care, rehabilitation and preventive health) having different funding and operational structures for their delivery
- increased specialisation of staff and services, resulting in patients potentially being treated by many people representing a range of health professions throughout the course of their illnesses; for example, a patient may be assessed and treated by an emergency physician and a cardiologist before transfer to a team including rehabilitation specialists and a range of allied health professionals
- an aging population, 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 adequate communication
- a humanistic stance seeking increased involvement of patients in their healthcare and facilitation of an optimal experience of the healthcare system.

Healthcare policies and initiatives commonly call for increased collaboration among health professionals (e.g. WHO, 2010). Despite this, collaboration is not necessarily easy or straightforward to implement.

TAKING A NEW LOOK AT COLLABORATION

Embracing the breadth and complexity of collaboration enables professional relationships in healthcare to be reinterpreted. The research (especially Croker, 2011) presented in Sections 1 and 2 of this book has addressed this goal. The complexity of the phenomenon of collaboration precludes an easy grasp of its scope and depth and transferability across professional and organisational contexts. Particular settings and specific (patient-focused) situations play a role in shaping collaborative practice. People working in different settings and situations require and exhibit varied needs of collaboration.

Despite the increasing volume of research into teams and collaboration, such research has tended to inform understanding of particular aspects of collaboration without synthesis into a meaningful holistic understanding. Measurements of collaboration, such as team members’ attitudes towards collaboration may not capture the complexity and the varied meanings of the phenomenon. Although the dynamic nature of healthcare teams is acknowledged, research has tended to concentrate on identifiable teams. Further, the impact on collaboration, of frequent changes to team membership, remains unexplored. Despite most research exploring collaboration from narrow standpoints (e.g. collaboration within specific disciplines, patients interacting with one professional group, or collaboration within stable teams), the reality of collaboration involves a much
broader range of health professionals, teams with changing membership and the uncertainty often inherent in professional practice.

The notion of patients and health professionals as people is central to collaboration in healthcare. Patient-centred healthcare values people; that is, the totality of individuals and their values, situations and capabilities. With this stance, patients are viewed as people with will, agency, needs and preferences rather than disease entities or objects to receive cost-effective services. Those who deliver healthcare are integral to the practice and concept of patient-centred healthcare. Because health professionals and other staff are affected by and effect patients’ healthcare, they are persons of interest in collaboration. Recognising that healthcare involves a range of people, the use of the term “patient-centred” was chosen over the term “person-centred” to highlight that the ultimate beneficiaries are the focus of teams and collaboration.

**TAKING A NEW LOOK AT TEAMS, TEAM MEMBERS AND TEAMWORK**

Teams, team members and teamwork provide the context and means of collaborating. If the complexity of collaboration in healthcare is to be embraced and understood it is important to remain open to different conceptualisations of these notions beyond the existing literature. In this section we provide a brief summary of some key challenges linked to conceptualising teams, team members and teamwork in healthcare. We then reconceptualise each of these notions to reflect the complexity of collaboration in healthcare and set the scene for reinterpreting therapeutic relationships.

*Teams in Healthcare*

Comprehensive healthcare is commonly provided by teams of health professionals and involves collaboration between a variable number of health professionals from diverse health professions, and between health professionals and patients. Mickan (2005) describes the value of healthcare teams in terms of their benefits to (a) patients, by enhancing satisfaction and outcomes, (b) team members, through facilitating greater role clarity and enhancing job satisfaction, (c) teams, by maximising professional diversity, improving coordination of care and enabling efficient use of healthcare services, and (d) organisations, through reducing amount of hospitalisation and unanticipated admissions. Despite the clarity of these benefits, conceptualising healthcare teams and teamwork is not straightforward. What is meant by the term “team” is not always clear or consistent. 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, these authors varied in their interpretation of teams.
Table 1.1. Definitions of “team” (in healthcare)

<table>
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<tr>
<th>Definition</th>
<th>Key points</th>
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<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, Kramer, Waite, &amp; Rubenstein, 1996, p. 656)</td>
<td>Team location</td>
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<td>Team processes</td>
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<td>Team goals</td>
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<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 which 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</td>
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<tr>
<td></td>
<td>Team processes</td>
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<td>Team goals</td>
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<td>“An organizational work unit made up of at least three different professions” (Thylefors, Persson, &amp; Hellström, 2005, p. 105)</td>
<td>Team location</td>
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<td></td>
<td>Team member attributes and number</td>
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These definitions provide a useful starting point for conceptualising the complexity of teams, yet they assume a stability of team membership that is not necessarily present in all healthcare teams. In practice, teams demonstrate varied stability of membership, clarity of leadership and consistency of team processes. Team roles can often transcend team members’ discipline role categorisations. Some teams are diffuse entities with no readily discernible structures and membership boundaries, whereas others are discrete entities with clear structures and membership. Team membership in some teams has a transient nature. Health professionals can experience being part of “teams within teams”, interrelated team memberships, memberships of multiple teams, and competing team loyalties. Some teams (such as a group of health professionals working in a ward) have no formally designated team leader, allocated team budget, or team authority to appoint members or clear processes, while other teams do have a budget, clear leadership, and authority to appoint team members and direct team processes. The physical setting where the teams work can differ. Further, some team members (such as nurses on a ward) may work in close proximity while team members are dispersed (such as allied health staff working across a number of different wards and community centres).

Reconceptualising Teams in Healthcare: Arenas of Collaborating

It can be argued that the complexity and ambiguity inherent in healthcare teams needs to be encompassed in any conceptualisations of collaboration to deeply understand this
practice phenomenon. The model arenas of collaborating (Croker, 2011; Croker, Higgs, & Trede, 2009), as shown in Figure 1.1, provides a framework for conceptualising collaborating in settings (a) where team membership and team processes might lack clarity and stability (or alternatively exhibit flexibility and fluidity), and (b) situations where team membership is more stable and where there are clear leadership guidelines and team processes. This model recognises broad organisational influences such as healthcare team structures, and embraces the complexity and ambiguity inherent in these teams. The labels for these modes reflect a feeling of stability and completeness (integrated) or a sense of ongoing change and movement (intersecting).

This model reflects the different organisational contexts of teams. The organisational components (y axis) lie along a spectrum from centralised to dispersed. Centralised teams have dedicated team budgets, members who are employed to work as part of the team, and members who work in close proximity. Dispersed teams operate without a specific team budget and specific team appointments, and have dispersed membership. Team members are typically rostered by their various discipline departments to work in the team.

Teams vary in their organisation, communication and leadership roles, clarity and processes (x axis). In the intersecting arena, team members tend to have discipline-specific orientations, learn team processes “on the job” and manage often competing team and discipline loyalties. Without a dedicated budget, and being reliant on discipline department rosters for team member continuity, teams in this arena can face challenges to the security or maintenance of their service provision and resources. In contrast, teams in integrated arenas are more assured of having clear leadership,
orientation and management, adequate staff positions, suitable space and ongoing access to facilities. Their orientation to the team prepares them to work within their teams’ accepted norms and ways of practising. Teams in the hybrid arena have a mix of these various characteristics.

Reconceptualising healthcare teams in this way enables a broader view of teams and collaboration in teams. In this way professional relationships can be more deeply understood in the collective structures in which they tend to occur in practice.

Team Roles in Healthcare

Team members are often viewed in relation to the disciplines they represent (e.g. dieticians, nurses, doctors). These practitioners have recognised roles and responsibilities. For instance doctors commonly act as gatekeepers for admission of patients and attend to patients’ medical status; nurses focus on maintaining patients’ physical wellbeing, occupational therapists concentrate on patients’ self-care, productivity and leisure activities; physiotherapists facilitate physical recovery; social workers are involved in future planning for adjustments to disability and lifestyle changes; and speech pathologists aim to improve language and feeding. However, while the discipline view of team roles reflects the disciplines’ contribution to patient care, practitioners risk being viewed as interchangeable disciplinary representatives rather than individuals.

This discipline view of healthcare team roles is embedded in the commonly used descriptors of multidisciplinary, interdisciplinary and transdisciplinary teams. (Note that the descriptors -disciplinary and -professional tend to be used interchangeably.) Multidisciplinary teams are those where team members tend to concentrate on and set their own discipline-specific tasks. Interdisciplinary teams are those where team members interact and work reciprocally within blurred boundaries of their discipline roles to generate new perspectives. Transdisciplinary teams are those where team members transcend their discipline roles to complement and replace each other when necessary.

While highlighting different ways discipline team roles can interact, these descriptors tend to be poorly defined and can be adopted interchangeably and so have limited value for conceptualising how team roles are actually practised in healthcare. Table 1.2 provides an example of one particular conceptualisation of rehabilitation teams. This table is provided as an example to demonstrate how team members’ interactions and responsibilities vary between different team types.

Healthcare team members’ roles have also been viewed in relation to their influence on the team’s dynamics and function. For example, often used in healthcare management literature are Belbin’s (1993) team roles of: plant (creative problem solver), resource investigator (extrovert, enthusiastic communicator), coordinator (mature, confident chairperson), shaper (team member who thrives on pressure and challenges), monitor evaluator (strategic discerning team member), team worker (co-operative, perceptive diplomat), implementer (reliable, efficient team member), completer finisher (conscientious perfectionist), and specialist (single-minded, dedicated team member). Despite the value of these roles for ongoing stable teams,
they may be less useful in clinical practice where team memberships fluctuate and team timeframes and boundaries are variable.

Table 1.2. Rehabilitation team models (based on Zorowitz, 2006)

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<tr>
<th>Team model</th>
<th>Characteristics</th>
<th>Limitations</th>
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<tr>
<td>Multidisciplinary</td>
<td>Doctor controls team</td>
<td>Patients not involved</td>
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<td></td>
<td>Team meets to coordinate patient care</td>
<td>Services may be omitted, fragmented or duplicated</td>
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<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.</td>
<td>Team meetings require time</td>
</tr>
<tr>
<td></td>
<td>Team members work within their areas of expertise and coordinate with the work</td>
<td>Team members may need to be trained in team processes</td>
</tr>
<tr>
<td></td>
<td>of others</td>
<td>Individual team members need to cede some control to the team so that</td>
</tr>
<tr>
<td></td>
<td>Reports of functional progress, decision making and care plans are developed</td>
<td>patient care is driven by the team processes</td>
</tr>
<tr>
<td></td>
<td>at case conferences</td>
<td>The doctor needs to allow team decision making yet take medico-legal</td>
</tr>
<tr>
<td></td>
<td>The patient is the centre of the team’s focus and plays an important role in</td>
<td>responsibility for outcomes</td>
</tr>
<tr>
<td></td>
<td>goal setting</td>
<td></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></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 is</td>
</tr>
<tr>
<td></td>
<td>In the case of discrepancies, leadership may be provided by the most relevant</td>
<td>driven by the team processes</td>
</tr>
<tr>
<td></td>
<td>discipline</td>
<td></td>
</tr>
</tbody>
</table>

Reconceptualising Team Roles Beyond a Discipline Perspective

Looking past discipline-specific roles enables collaborating to be seen as it is experienced on personal and interpersonal levels. Collaboration can be seen from the inside out in relation to what it was like for team members as individuals, rather than looking at participants predominantly as members of their discipline. Rather than seeking to separate individuals from their socialised discipline roles, this view emphasises commonalities between individuals’ experiences of collaborating in teams. For example, in relation to rehabilitation, nurses’ principal roles in the team can relate to their specialist roles in patient education or discharge planning rather than direct patient care, or an allied health professional’s primary role might be as a team manager.
The roles of patients and carers as team members need to be recognised as being ambiguous. For example, rehabilitation can be a time of vulnerability for patients and carers. Their current situations and future life journeys can contain many unknowns as they simultaneously participate in rehabilitation and learn to understand and cope with disability (Dobkin, 2003). Further, as part of their disability, patients may experience cognitive and communication limitations which can also challenge their involvement with decisions and participation in treatments.

Patients’ limited agency and involvement in team development and maintenance issues, make it difficult for them to be considered as unambiguous and unequivocal members of the team. And, at the same time, having such responsibility may be beyond the challenges they can cope with at the time of their illness, considering their altered bodies and interrupted lives. In contrast, patients are clearly team members, in community mental health programs, where patients (or service users, as they may be referred to) participate in decision making about their healthcare program (see for example Ness et al., 2014). Thus although patients are integral to the focus and shared purpose of the team, it can be problematic to automatically including patients and carers as active team members. Taking a view of team roles in relation to individuals and what they can offer, the collective idea and practice of teams allows for patients and carers to be considered as team members when they have scope and abilities to contribute to the team.

**Teamwork in Healthcare**

The concepts of teamwork and collaboration are often used interchangeably in healthcare practice and literature. However there have been attempts to ensure more precise use of these terms. Mickan and Rodger (2000) identified characteristics of effective teamwork (see Table 1.3). Reeves, Lewin, Espin, & Zwarenstein (2010) promoted a typology related to interprofessional work; they distinguished teamwork as ranging from collaboration, coordination and networking. However, we argue that tight or shared understandings of terminology, do not necessarily provide an inclusive basis for understanding what it is like to work together in healthcare.

**Table 1.3. Characteristics of effective teamwork (from Mickan & Rodger, 2000)**

<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>
</tr>
<tr>
<td>Specified task</td>
<td>Commitment</td>
<td>Cohesion</td>
</tr>
<tr>
<td>Distinct roles</td>
<td>Flexibility</td>
<td>Decision making</td>
</tr>
<tr>
<td>Suitable leadership</td>
<td></td>
<td>Conflict management</td>
</tr>
<tr>
<td>Relevant members</td>
<td></td>
<td>Social relationships</td>
</tr>
<tr>
<td>Adequate resources</td>
<td></td>
<td>Performance feedback</td>
</tr>
</tbody>
</table>
Reconceptualising Healthcare Teamwork as Involving “Wicked Competencies”

Importantly a number of teamwork characteristics (such as trust, self-knowledge, cohesions and social relationships) take time to develop, have tacit qualities and elements of uncertainty and can be challenging to maintain. These characteristics defy easy description and assessment and have been described as “wicked competencies” (Knight & Page, 2007). Rittel and Webber (1973) introduced the notion of wicked problems that are unique problems that: have no right-or-wrong or true-or-false solutions; are symptoms of other problems; and whose solution leads to other different, interrelated problems. Embracing the “wickedness” inherent in the complexity of teamwork highlights the dynamic yet potentially fragile nature of teamwork in healthcare. Teamwork can therefore be viewed as needing to be nurtured and guided rather than imposed and planned. This complexity of teamwork is examined in a number of the following chapters.

COMPLEXITY OF COLLABORATIVE PROFESSIONAL RELATIONSHIPS

Health professionals can be understood as individuals who work within accountable systems and who bring to collaborative situations their profession-specific and individual abilities, needs, perspectives and qualities at various stages of their development. Thus collaboration can be seen as a component of professional practice. However this does not make collaboration easy; the complex nature of practice and the largely discipline-specific education of health professionals poses many challenges for individual practitioners and educators alike.

Complexity of Professional Practice

Practice has elements that can be learned and developed. However, some of these elements may not be explicit. Van Manen (1999, 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”. Using the notion of practice to reconceptualise teamwork and collaboration provides a means of framing tacit characteristics and highlighting the importance of teamwork accountability while simultaneously dealing with uncertainty that can be encountered in healthcare. These requirements have been identified as integral to 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, Tichen, & Neville, 2001, p. 4)
In another conceptualisation of practice, Higgs and Titchen (2001, p. 3) identified professional practice as an ongoing lived experience that involves practitioners “‘doing’, ‘knowing’, ‘being’ and ‘becoming’” in practice. These dimensions are important parts of the journey of novices 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 all play key roles in “professional journeys towards expertise” (p. 5).

A number of models of practice support a focus on relationships between people in healthcare. In the interactional professional model of professional practice, health professionals interact effectively with patients and their dynamic environment (Higgs & Hunt, 1999). This practice model acknowledges the importance of patient-centredness and the need for interpersonal communication in professional practice. Interpersonal communication requires the ability to use a range of communication media, negotiate meanings, build interpretations on previous interactions, 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 speech partners to speak and to 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 a receptive communication climate) (Croker & Coyle, 2008).

With a similar emphasis on communication, Clark (1997, p. 448) built on Schön’s (1987) reflective practitioner concept, developing a 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”. This discussion builds the argument for situated, “in the moment”, responsive, individualised care, the provision of which often requires health professionals to collaborate.

Growing awareness of the need to prepare health professionals for working with other disciplines is evidenced by the recent, widespread interest in interprofessional education. Interprofessional education (at times used interchangeably with the term interprofessional learning), has been defined as “those occasions when two or more professions learn from, with and about each other to improve collaboration and the quality of care” (Freeth, Hammick, Reeves, Koppel, & Barr, 2005, p. 15). This form of education developed in response to the traditional silo approach to health professional education where opportunities to understand other professional roles were sparse. Interprofessional education faces many challenges including the pragmatic issues of coordinating curricula and timetables. However, this form of education can be dependent on many variables including the quality of educators’ interprofessional rapport (Croker, Fisher, & Smith, 2015). The challenge is to
achieve the benefits of learning and practising together while ensuring sustainability and feasibility in curriculum implementation and workplace learning.

Recognising Individual Complexity within Collaborative Professional Relationships

Health professionals collaborating with each other are not interchangeable representatives of their disciplines. One health professional’s skills, knowledge and practice model are not necessarily the same as those of the practitioner he or she is replacing in a collaborative situation (such as a team meeting). The notion 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 et al., 2006, p. 1).

It requires the use of personal knowledge, practice-based, experiential knowledge (called professional craft knowledge) and research-based or propositional knowledge (see Higgs & Titchen, 2002). Beyond the different forms of knowledge are the different capabilities of using knowledge. Cognitive capabilities for clinical reasoning have been identified as involving critical, reflective, dialectic and complex thinking (Christensen, Jones, Higgs, & Edwards, 2008). The gap between knowledge and cognition is bridged by reflective self-awareness, also known as metacognition (Higgs & Jones, 2008). Expert practitioners are more able than novice practitioners to deal with uncertainty, are more adept in complex clinical reasoning and are able to recognise the interplays between numerous elements in a particular situation (Christensen et al., 2008). Thus, health professionals are likely to make unique contributions to collaborative situations across different stages of their development.

Complexity of the Organisational Contexts of Professional Relationships

Many forms of healthcare occur in organisational contexts. Organisations contain social units that are deliberately planned, constructed and reconstructed to fulfil particular goals, and are characterised by three key factors (Etzioni, 1964, p. 3). Firstly “divisions of power, labour and communication responsibilities” exist. Secondly, there are typically one or more organisational power centres “which control the concerted efforts of the organization and direct them towards their goals … review continuously the organization’s performance and re-pattern its structure, where necessary, to increase its efficiency”. Thirdly substitution of personnel is an inherent practice in order that unsatisfactory persons can be replaced. Each of these organisational parameters contributes to the complexity of collaborative professional relationships.

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 creates the need for collaboration. The location of power in different organisational centres may create challenges for collaboration between competing power players. 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 typically experienced in healthcare is the dynamic nature of the healthcare workforce. Substitution of one person with another is common place: healthcare staff commonly change positions due to rosters, career or lifestyle choices and personal interests.

Healthcare organisations have significant influence on the capacity for their people to collaborate by ensuring sufficient time, structures, guidance and opportunities for team members to interact with each other. Organisational and structural factors in healthcare give rise to (a) differentiations in the provision and funding of services that require health professionals to work across departments and agencies, (b) cost containment and financial accountability that may influence work responsibilities and compete with patient-centred perspectives, (c) changing structures that alter lines of communication and responsibilities between professions and departments, and (d) inequitable distribution of services that leads to gaps and overlaps in services, fragmented funding, changing structures and managerial requirements. The complexity of organisational contexts needs to be taken into account in order to more deeply understand collaborative professional relationships in healthcare.

CONCLUSION

Presented in this chapter is a broad portrayal of collaboration that embraces the multifaceted nature of this complex phenomenon. This portrayal is well placed to provide a contextually and situationally relevant basis to inform the development of collaboration as an important component of patient-centred healthcare.

NOTE

Although limitations with the use of patient are recognised, this term has pervasive if incomplete, acceptance by many users and providers of healthcare services, particularly in acute areas. Hence the choice of the term patient for this book in general.

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2. HEALTHCARE AS A CONTEXT FOR COLLABORATION

More Than We Can Easily See

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)

Healthcare is a complex, evolving concept, meaning different things to different people. Views of health tend to reflect socially acquired beliefs, values and attitudes and the social structures that reinforce and challenge them. The wide range of different understandings of healthcare have diverse implications for action. For example, a manager’s need for quantified information and efficiency of healthcare services may conflict with a patient’s valuing of personal experience as a source of understanding; or a social worker’s wish to expand understandings of social determinants of health may appear incompatible to a doctor’s preference for objective scientific evidence to support his current model of practice. At the heart of this chapter is my contention that in order to understand collaboration we need to recognise that there are diverse meanings used for the term healthcare which impact on collaboration. In this chapter the notion of healthcare is conceptualised as being located in a complex, socially-constructed set of systems, providers, approaches and views that provide the framework and drivers for implementing healthcare strategies. Rather than assuming shared understandings, the extent and implications of different meanings of health and healthcare are explored.

DEFINING HEALTHCARE

The way healthcare is defined and interpreted affects how healthcare is provided. Different understandings of health and healthcare can arise from discipline socialisation, personal and professional experiences, and organisational structures.

These different understandings of health afford opportunities for a range of healthcare 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 healthcare (Bandura, 1997) and can be the basis of the “healthy mix of disciplines and the corresponding different value sets” in healthcare teams (Williamson, 2004, p. 161). It
can be argued that by engaging with different understandings, collaborating practitioners can expand their perspectives of health and healthcare 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, different understandings may produce confusion and can be the source of ongoing disagreements and conflict.

People bring to collaborations their own meanings of health. With people from diverse backgrounds participating in healthcare, different understandings and expectations for health and healthcare can be encountered. Clarifying the purposes behind definitions of health provides a means of making sense of the various meanings and provides insights into (a) different understandings healthcare team members can bring to collaborative situations and (b) why they may encounter difficulties or strengths in working with others.

Swartz (1997) provided a useful way of interpreting the different purposes definitions might fulfil. His 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 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 of health which aims to reflect common usage, can be contrasted to that of the WHO definition that aims 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 preventive 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 healthcare 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’ (2000a, p. 165) thought-provoking experiential definition of health and illness as “homelikeness and unhomelikeness in our being-in-the-world” provides a deeper understanding of health and illness as an embodied phenomenon (Svenaeus, 2000b). 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.
### Table 2.1. Different purposes of definitions related to health

<table>
<thead>
<tr>
<th>Examples of definition of health</th>
<th>Purpose of definition</th>
<th>Origin of definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>“freedom from disease or ailment” (Delbridge &amp; Bernard, 2015)</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>“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>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>“The homelike attunement of the healthy person indicates that he is experiencing wholeness in his being-in-the-world” (Svenaeus, 2000a, p. 100)</td>
<td><strong>Experiential</strong> exploration (Swartz, 1997)</td>
<td>Proposed by a phenomenological researcher into the embodied experience of health and illness</td>
</tr>
</tbody>
</table>

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 healthcare services. Regaining “homelikeness” following illness or disability requires people’s adjustment to a new way of “being-in-the-world” (Svenaeus, 2000a, p. 100) and encourages health professionals to seek deeper meanings of what experiences of health and illness are like for individuals. By adopting a patient-centred focus, I contend that experiential definitions provide an important basis for healthcare.

Different stipulative definitions of health underpin different ways of interpreting the health status of populations, including how healthcare is measured. For example, the collection of statistics related to distribution, determinants and frequency of selected diseases might be 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. 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, preventive 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 overarching framework for health and healthcare in Australia, as identified by the Australian Institute of Health and Welfare (AIHW) 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 healthcare system a tension exists between this rhetoric of a broad conceptualisation of health that encompasses wellness and the economic reality of healthcare being primarily funded for illness-based care. Although Australia supports the WHO definition of health, the biomedical model of health is dominant in healthcare funding, with hospitals, medical services and pharmaceuticals accounting for the largest amount of recurrent expenditure (AIHW, 2014).

Collaboration occurs in a context where different meanings of health and healthcare underpin various yet often unstated purposes. In practice, those providing healthcare 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 healthcare system that seeks health as a source of wellbeing. An additional complication is the different language subsets used by professions to discuss health. Pietroni (1992) argued that professionals need to understand the languages of others to facilitate communication and to encourage creative reflective processes. Language differences further highlight the diversity brought to collaborative situations, and allude to the challenges these differences bring. The notion of shared understandings of health and within healthcare, as a foundation upon which collaboration is practised, is therefore unrealistic.

**DIFFERENT VIEWS OF 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 2.2. 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”.
Table 2.2. Characteristics of two views of professional practice  
(Fish & Coles, 2006)

<table>
<thead>
<tr>
<th>Aspects</th>
<th>Technical rational</th>
<th>Professional artistry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rules</td>
<td>Rules guide practice</td>
<td>Rules do not usually fit real practice; practice relies on 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 useful than knowing facts</td>
</tr>
<tr>
<td>Roles</td>
<td>Professional roles can be analysed in detail to provide job specifications, guidelines and protocols</td>
<td>Analysis of professional roles is subjective; practice requires scope for creativity</td>
</tr>
<tr>
<td>Improving practice</td>
<td>Skills training improves practice</td>
<td>Learning occurs from improvisation and reflection, collaboration 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; professionals are responsible for reflecting and refining their own practice</td>
</tr>
</tbody>
</table>

There are many situations in health where technical rational practice appropriately dominates, such as a medical emergency team’s response to a patient’s life threatening situation. Viewing professional practice as a technical and rational enterprise also suits bureaucratic needs for control of service delivery in health (Fish & Coles, 2006). However an over-reliance on this view prevents the appreciation of 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
artistry approaches contributes to the complexity and challenges of health professionals’ collaborative clinical reasoning and professional practice.

DIFFERENT APPROACHES TO EDUCATION OF HEALTH PROFESSIONALS

Education and socialisation of health professionals into their specific disciplines and workplace cultures provide the foundation for the rich heterogeneous understandings that underpin collaboration and teamwork. 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). However, different emphases on health professional education are evident. Some aspects of the curriculum have a particular focus on accountability and the fulfilling of course requirements through guidelines, others have a broader focus enabling health professionals to learn through reflecting on practice complexity, diversity and uncertainty.

A focus on accountability and regulation requirements favour measurable competency-based approaches supporting the use of assessments to ensure that beginning practitioners reach a certain standard of practice before graduation, and use measurement to validate and/or compare education approaches and strategies. However, despite acknowledging the importance of accountability and fulfilling course requirements, such approaches can be 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.

Approaches seeking to prepare for complex practice tend to focus on context-centred implementation, 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. Further, as the initial education of health professionals cannot provide all the skills and knowledge necessary for professional practice, professionals also need the capacity for ongoing development for future professional practice. This need for ongoing professional development supports the view of health professionals as individuals capable of working with others in particularised situations within dynamic healthcare contexts.

PATIENT-CENTRED PRACTICE TERMINOLOGY

Patients as individuals with worth and dignity who are part of wider societal contexts underpin patient-centred professional practice. However in discussing patient-centredness the contested nature of this term needs to be acknowledged. The terms patient, client, service user, consumer, participant and co-producer of health are labels that contain various connotations and implicit assumptions. 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 healthcare. 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). Interestingly, when given the choice of the terms patient, client, customer, consumer, partner and survivor a group of surveyed healthcare 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). With the multiplicity of health meanings it appears unreasonable to expect one term to suit all situations.

Beyond the debate about the term patient, a range of terms denoting active participation and a focus on the patient as a person has been introduced with the shift in healthcare from patients being “the somewhat passive target of medical intervention” to taking active roles in their care and decisions (Leplege, Gzil, Cammelli et al., 2007, p. 1560). These terms include “patient-, client-, person-, individual/-centred, -oriented, -focused, -directed” (p. 1556). 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 healthcare) was a term that was particularly associated with mental health counselling and was informed by a deep understanding of theories of Carl Rogers. While acknowledging the value of Freeth’s clear differentiations, I also recognise that other authors may not use the terms with such precision. Thus different nuances in terminology add yet another dimension to the complexities brought to collaborative healthcare practice.

CONCLUSION

Healthcare is rich in different 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 having heterogeneous understandings, varied ways of working and nuanced terminology, these differences can also challenge open communication between those providing, receiving and managing healthcare. Thus neither a “one size fits all” nor a “just do it” approach to collaboration can take into account the myriad differences arising from people dealing with specific situations related to particular settings within the broad context of healthcare. Collaboration needs 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 healthcare, and to recognise the uniqueness of the individuals involved.
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