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9. COLLABORATION AND COLLABORATING

People working together and interacting with each other is central to health practice relationships. Clinicians do not work in isolation; they work with patients and their carers, colleagues, other healthcare professionals and community services. Without collaboration healthcare services struggle to be effective, timely, safe and appropriate. In this chapter we are focusing on the notion of collaboration and the acts involved in collaborating as part of health practice relationships. Based on doctoral research (Croker, 2011), we will explore the lived experiences and humanity of collaboration. While the health literature often presents relationships as ordered, controllable and measurable, those involved in collaboration often describe relationships as messy, evolving and unpredictable. This was the case in Anne's doctoral research (ibid.). In this chapter we argue that in human healthcare systems contexts, the privileging of the visible, measurable, predictable and controllable by management should be questioned. Greater appreciation of the need to recognise the variability and importance of individual human interests, approaches and needs is essential to make collaboration truly effective. While recognising the importance of the role of patients and carers in collaboration, we focus on collaborative relationships among health professional team members as part of the delivery of patient-centred care.

BACKGROUND

From a structural perspective healthcare systems are built around teamwork, from a small group working directly with patients to increasingly complex departments and administrative frameworks. *Collaboration* encompasses the notion of people working together for a shared purpose. It could be expected, then, that collaboration is desirable and pursued at all these levels. However, despite its accepted value to enhance working towards shared purpose, collaboration between health professionals does not necessarily happen easily and routinely in healthcare. Many factors in the real or clinical world compromise genuine collaboration. Consider, for instance, the impact of time pressures, staff shortages, organisational structures, reporting requirements, obstructive workmates and different expectations.

Embedded in the stories and literature of people working together in healthcare situations, are different conceptualisations of collaboration. The manager of a hospital, who views collaboration in terms of efficiency, seeks to assign a dollar value to collaboration. A health professional, who represents a particular discipline and deals with different discipline territories, professional boundaries and individuals, is enmeshed with the interpersonal and political intricacies of collaboration. The educator, who seeks to prepare novice practitioners to deal with the demands and

J. Higgs et al. (Eds.), Health Practice Relationships, 75–84.

uncertainties of working with others, is also required to evaluate and assess students' capabilities for collaborative or interprofessional practice in the future. At the centre are 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.

Due to different meanings given to the phenomenon of collaboration many questions are raised: "Do these variations in meaning represent different parts of the same phenomenon?", and, "if so what does the 'whole view' of collaboration look like?" To answer these questions, Anne's doctoral research, reported in this chapter, undertook an exploration of the "whole view" of collaboration. It aimed to see what collaboration looked like from different perspectives.

EXPLORING COLLABORATION AND COLLABORATING

Exploring the abstract phenomenon of collaboration (as a concept and noun) and the experience of collaborating (as an action and verb) provided a framework for understanding the multifaceted and interrelated nature of "knowing about" collaboration and the experience of "doing it". Higgs and Horsfall (2007) explain in Text Box 9.1 how nouns and verbs contribute different ways of viewing a phenomenon. As the act of collaborating involves *people* engaging with each other, including this notion strengthened the person-centred stance of Anne's research.

nouns are abstractions, symbols *promoting vision,* *representing things* *that are widely accepted* *they are more general, passive* *and distant, more finished*	*verbs are active* *immediate, particularised* *and person-based* *they represent experiencing and* *understanding of being in the midst* *of the lived experience*

(Higgs & Horsfall, 2007, p. 239)

Text Box 9.1

The research involved two studies. In the first a philosophical hermeneutics approach was taken to explore collaboration (the noun). A set of texts from an array of organisational, educational, research and healthcare literature was constructed and then systematically interpreted. The second study was a hermeneutic phenomenological one exploring the experiences of collaborating (the verb) in rehabilitation teams. See Croker (2011) for more detailed explanations of the research methods used in the research. The key findings arising from these studies and the model developed will be explained in the remainder of this chapter.

STUDY 1. COLLABORATION: *ORDERED* AND *ORGANIC* MODES

From the first study (analysing texts from the literature) collaboration was interpreted to involve *ordered* and *organic* modes of working with others. *Ordered modes of collaboration* (such as would occur in formal teams like appointed ethics committees or in meetings of healthcare service department heads) are driven by efficiency, cost-effectiveness and discipline power relationships. These modes emphasise what is predictable, replicable and measurable. The often less explicit *organic modes* (such as might occur with an outpatient clinic area where variable groups of practitioners are rotated through this work area) are founded upon relationships and mutuality between people rather than being led by bureaucracy and systems. These *organic modes* of collaboration enable the inherent uncertainties of the people-focused dimensions of healthcare to be embraced and provide scope for dealing with the different collaborative needs that arise from the many different situations that people encounter in healthcare.

Four domains were interpreted to operate across these ordered and organic collaboration modes: *place* (the situation of collaboration)*, people,* (those involved), *purpose* (the goals or intended outcomes) and *process* (ways of communicating and interacting). These domains provide a framework for understanding the characteristics and implications of *organic* and *ordered* modes of collaboration, see Table 9.1.

Table 9.1 Characteristics of ordered and organic modes of collaboration

Dimensions of collaboration	**Ordered modes of collaboration**	**Organic modes of collaboration**
Place	Collaboration occurs in teams with stable membership and discernible boundaries that are isolated from complexities of context.	Collaboration occurs in evolving networks, informal groups, teams of varied nature that are part of a wider societal context.
People	Team members represent discipline clinical roles and organisational roles.	Team members are seen as unique individuals with varied socialised discipline characteristics and personal and professional experiences.
Purpose	The drive for collaboration is externally established. Coordination and integration are sought.	The drive for collaboration originates internally. Synergy, innovation and learning are sought.
Processes	Interactions are directed predetermined, trainable, reproducible, measurable.	Communication and interactions are opportunistic, evolving, situationally specific and based on developing relationships.

i) Ordered Modes of Collaboration

Ordered modes tend to focus on collaboration within demarcated territories, such as teams with clear boundaries and stable memberships. The context of collaboration is circumscribed. In these settings collaboration can be planned for, monitored and measured, and tends to be isolated from complexities of context.

In *ordered modes* relationships between individuals are not necessarily visible or prominent. Rather it is the amalgamations of people and collective entities that are easily seen. Collaboration occurs, for instance, between disciplines, organisations, agencies and other groups. The focus is removed from particular individuals who are interacting and placed on the role of entity the individual represents (e.g. discipline). In doing so it is typically the socialised characteristics of the role or entity that are valued in *ordered modes* of collaboration, rather than interpersonal characteristics of individuals.

Collaboration in *ordered modes* tends to be externally instigated. Responsibility for initiating collaboration lies with others, often through policy changes and management directives. Financial incentives can be used to encourage those involved to participate in the collaboration. The outcomes of the collaboration are often predetermined, for instance the expectation that the group will produce items such as strategic plans, team budgets, or patient management plans. Prescribed or expected patterns of interaction, such as following meeting procedures, tend to dominate collaborative processes in *ordered modes.* These structured and predetermined interactions provide predictable means of communication, for example regular team meetings and clear lines of communication. Having a framework to guide and monitor interactions can be beneficial in lessening the impact of disruptive or negative factors; for example a team meeting agenda can schedule time for all team members to have input, regardless of the person's position in the team's hierarchy.

ii) Organic Modes of Collaboration

In contrast to *ordered modes of collaboration*, aspects of *organic modes* tend to be less visible to those outside the collaboration. Evolving networks, informal groups and loosely structured teams are a common context for *organic modes* of collaboration. These groupings are woven into and across their wider organisation and societal environments, with organisational structures, discipline traditions, social issues and interpersonal factors shaping the nature of the group and interactions. Being embedded in wider social and organisational contexts, collaboration in this mode is influenced by contextual factors, for example individual preferences and capabilities, community values, financial constraints, and organisation and discipline cultures and territories.

The unit of interactions within *organic modes* of collaboration is largely the individual (or perhaps small groups or partnerships). Although individuals might represent a discipline, department, organisation or agency, interpersonal interactions are the focus of *organic collaboration*. In this mode, particular individuals bring their personal qualities as well as the perspectives and conventions from their organisation and their discipline socialisation.

Collaboration in *organic modes* tends to seek synergistic outcomes that are not particularly predetermined. The outcomes can be unexpected and creative. They are often internally instigated, resulting from individuals identifying common purposes and taking initiatives. Such collaboration can originate when individuals seek to work together and take responsibility for doing so in a mutually advantageous manner.

Communication strategies are variable, following individual and group preferences, rather than being expected or prescribed as in *ordered modes* of collaboration. These strategies are founded on personal qualities, such as willingness to work with others, respect, trust and mutuality. They require resources such as time and proximity and can respond to rapidly changing situations.

Figure 9.1 depicts a diagrammatic portrayal of ordered and organic modes of collaboration. In this diagram the organic mode of collaboration is represented by the inner, subtly shaded triangles and black font for labels, and the ordered intention is depicted by the more definite shades of the outer triangles and white font for labels.

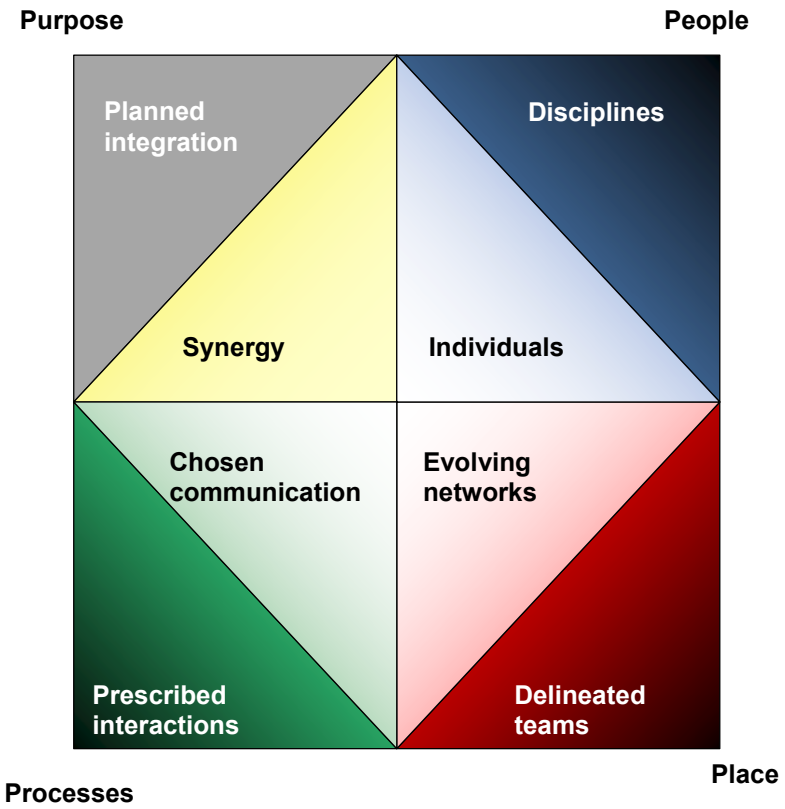

Figure 9.1 Ordered and organic modes of collaboration

iii) Value and Limitations of Different Modes of Collaboration

Based on this interpretation of collaboration, ordered modes of collaboration typically demonstrate organisational commitment and support in terms of structures, frameworks and resources. However, an over dependence on ordered modes with their focus on measurable and predictable aspects of healthcare (systems) could lead to support for mechanistic systems in which relationships between individuals are largely unrecognised and repressed. Concentrating on discipline characteristics could overshadow the individuality, cultures and contexts of the individual people within the discipline, and seeking to protect professional territories can narrow the collaborative focus. When preferable, using organic modes of collaboration (particularly in more informal or transorganisational situations) brings the benefits of increased focus on individuals and their interpersonal relationships to provide a more versatile and person-centred rather than task-centred frame of reference for people who want (and pursue) choice and agency to interact and work responsively with each other. However, a sole focus on individuals could risk collaboration becoming meaningless to wider organisational purposes, being inadequately resourced, or having an undue focus on the "wrong" people (e.g. staff instead of patients). In essence, both modes are needed.

STUDY 2. COLLABORATING: ENDEAVOUR AND REVIEWING DIMENSIONS

In Study 2 of the research, the lived experience of collaborating was explored in rehabilitation teams; these settings representing (ideally) patient-centred, team-facilitated endeavours undertaken within healthcare institutions. Health professionals from a range of rehabilitation teams across rural, regional and metropolitan settings, participated. As well as more "ordered" integrated teams with managers and budgets, there were also less defined teams that were "organic" in nature, as explained in the following quotes: "The rehab team is very sort of vague here … It is not a defined boundary" [P72]; "There are not a lot of structured processes" [P17]; and "I don't really feel that there's anyone who sort of stands out as the leader of the team" [P71].

By exploring the experience of *collaborating* across this range of rehabilitation teams, the research was able to illuminate what happens across the boundaries of *ordered* and *organic modes* of collaboration. In doing so, the process and experience of collaborating was seen to involve five *intentional interpersonal endeavours* and three *reviewing (meta) behaviours* to monitor the nature and success of one's behaviours or endeavours in the pursuit of effective and person-centred collaboration, as shown in Text Box 9.2. The dynamic, layered and responsive nature of collaborating integral to these dimensions is illustrated in the quotes below:

> So if someone [a patient] is being seen by all the people who they need to be seen by, and all of those people are communicating, and are aware of all the other problems and issues that are going, and everyone has a clear idea of what everyone else thinks and where we're headed and what we need to do to get there, and you can help each other out, make suggestions to each other and pick up on problems that other people might have missed, that sort of thing, [then] I

> think it can only benefit the patient and their family if you're working towards that together. [P1]
>
> Different teams work in different ways and one thing might work in one place but [in another team] it doesn't seem to work as well. There doesn't seem to be an absolute model [of working together] that fits everywhere. [P45]
>
> Getting to know the system and how to approach people was a little bit daunting. [P40]

Participants did not experience collaborating as static or predictable but rather as a response to people (team members, patients), situations and organisational influences.

Endeavour and reviewing dimensions of collaborating
Dimensions of interpersonal endeavour
– ***Engaging*** positively with each other's diversity (which is accompanied by a respect for others and a willingness to learn from or manage differences); – ***Entering*** into the form and feel of the team (which is influenced by the nature of people's entry to teams, together with their personal experiences and role expectations); – ***Establishing*** ways of communicating and working together (where interrelated use of a range of structured and opportunistic communication is required); – ***Envisioning*** together patients' rehabilitation frameworks with others (where clinical information is often interwoven with stories about the patient's situations and aspirations); – ***Effecting*** changes in people and teams (which relates to working with others in organisational contexts to effect change in patients' capabilities, to deal with system requirements and to develop and sustain teams).
Meta-behavioural reviewing dimensions
– ***Reflexivity*** involving critical reflection and development of self in relation to others – ***Reciprocity*** enabling collective mutuality to develop healthcare roles – ***Responsiveness*** facilitating situationally appropriate and contextually relevant adjustments.

Text Box 9.2

See Croker, Trede and Higgs (2012) for quotes illustrating these dimensions.

The dimensions of collaborating provide a sense of the temporal (time) and situational (place) elements of healthcare practice. Views and experiences of collaborating are never "whole" or complete; rather, they are like snapshots that capture a particular perspective in a moment and situation. There is scope in the *experience* dimensions of collaborating for embracing the changes that team members bring about and that organisations require.

RESPECT MODEL OF COLLABORATION

From the findings of this research on collaboration (as a noun) and collaborating (as a verb), a model was developed, embracing the *ordered* and *organic* modes of collaboration together with the endeavour and reflexive dimensions of collaborating. This model is the RESPECT model, coined by Anne and her supervisors, to highlight the key ingredient and purpose of good collaboration and to represent the findings of this research that collaboration and collaborating is about:

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

This model is depicted diagrammatically in Figure 9.2. This model captures and combines theoretical and organisational concepts of collaboration with the dynamic experiences of collaborating in a context of ongoing change. Respect encompasses intentions, attitudes and behaviours towards people (including the self, others involved in healthcare, patients and carers) and their diversity (such as discipline knowledge and socialisation, capabilities, experience, needs, fears and aspirations), as well as the uncertainty, complexity and specificity of the situations they face.

This model positions the temporal and iterative nature of collaborating (as represented by the circular motion of the meta-behavioural *reviewing* arrows and the fluidity of the *endeavour* dimensions) within a clearly shaped composite, systematic view of collaboration. *Ordered* modes of collaboration (with outer darker triangles), and the less visible *organic* modes of collaboration (in lighter shades) provide the framework upon which (through *endeavours* and *reviewing*) the collaborators "dance and weave" their unique collaborating pattern to suit the context, situation and people.

The RESPECT model presents collaboration as actively engaging-entering-establishing-envisioning-effecting together to achieve person-centred teamwork and collaboration for the provision of patient-centred healthcare services which occur within the context and framework of people-places-processes-purposes and operates in a way that requires meta-cognitive and meta-behavioural pursuits of reflexivity-reciprocity-responsiveness. In summary, collaboration is inherently about RESPECT.

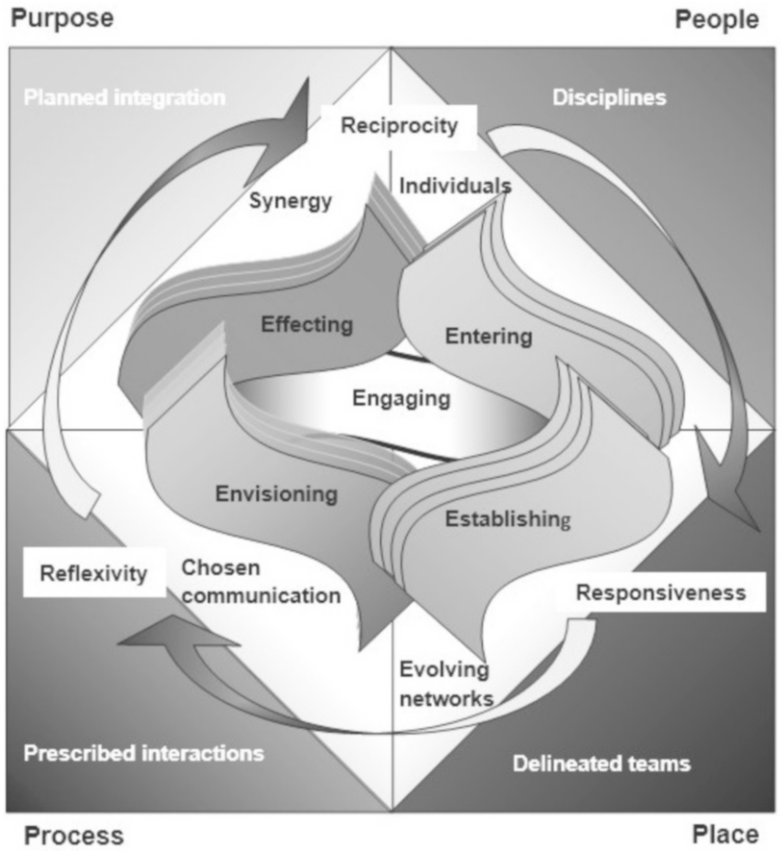

Figure 9.2. The RESPECT Model of Collaboration

USING THIS MODEL IN PRACTICE

The RESPECT model can be used as a guide to both establish new health practice teams and evaluate the processes and products of existing teams. It is most effective when it is applied at macro, meso and micro-levels simultaneously. At the macro level, while focusing on the *ordered* modes of collaboration, managers can become aware of the need to also enable *organic* modes of collaborating. Time needs to be allowed for teams to engage with each other and establish how they can best collaborate. At the meso level, team leaders will find in the RESPECT model useful reminders to encourage and model collaborative health practice relationships grounded in responsiveness, reflexivity and reciprocity. At the micro level, the RESPECT model is a guide for health professionals to focus on and value interpersonal professional relationships. People at all levels should keep sight of what is probable and possible within given healthcare structures and ordered models of

collaboration. Realisation of the full potential of the RESPECT model requires each level of organisation and each team member to work genuinely towards shared purposes and goals, learning from experiences to continuously improve collaboration and collaborating. All domains of this model need to be kept activated and deliberate decisions need to be made on how to proceed in each clinical situation. Respect cannot be demanded, but it can be earned.

CONCLUSION

Collaboration and collaborating are complex phenomena. Even with increasing conceptual interest, research and policy support collaboration can remain an elusive concept for many health professionals and patients, and those involved in collaborating can find the experience intensely interpersonal and dynamic. In this chapter we have argued that healthcare systems and practice require both *ordered* and *organic modes* of collaboration The RESPECT Model of Collaboration provides a contextually relevant and situationally appropriate basis to inform the development of collaborative relationships that embraces organisation support for robust yet responsive and respectful collaborating relationships.

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