Exploring the Interactional Determinants of Collaboration on Interprofessional Practice in Community-Based Geriatric Care

by

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Abstract

Collaboration is neither the ethos, nor the experience, of most professionals in health care. Nevertheless, the concept of collaboration has become increasingly popular in recent years, promising to enhance all aspects of work, academic, and political life. And while collaboration is a significant and complex phenomenon, it has not been clearly understood for its impact on health care professionals and their work, or for the factors that influence its success or failure.

The purpose of the study was to explore the meaning of collaboration, as conveyed by the lived experience of health care professionals, as well as the interpersonal and interactional determinants and their impact on the outcomes of their collaboration. The conceptual paradigm of phenomenology and hermeneutic phenomenological methods guided the research. In-depth interviews were conducted with 10 health care professionals engaged in interprofessional practice in a novel community-based geriatric care program. The interviews were audiotaped and transcribed verbatim. Ricoeur's procedural steps were used to analyze the transcripts.

Acquiring the 'real world' experiences of health care professionals enabled the emergence of six themes: engaging in collective thinking and action to produce best outcomes and optimize clients' health; responding to collaboration for self and other members as a continued work in progress; experiencing the personal and professional rewards as markers of success with collaboration; existing challenges create barriers that impede collaboration; experiencing the interactional dynamics of collaboration and their influences requires the interpersonal attributes of quality communication, openness, trust, and respect; and forming a common vision is necessary for collaboration but difficult to achieve.

The findings of this study suggest that collaboration is a genuinely experiential phenomenon: it is a human process that requires leadership on the part of all health care professionals to negotiate and agree upon the processes that will enhance their relationships and are necessary for collaboration to unfold. This study produced a number of recommendations that can be offered to multiple stakeholders in the geriatric care setting, as well as extended to those in the other domains of health care.

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Chapter I: Introduction

In recent times, interprofessional practice has gained popularity as a means by which members of differing health care professions respond collaboratively to patients' needs by sharing in the provision of efficient, patient-centered delivery of health care (Kenny, 2002). Collaboration can be considered an important concept for health care. Since the health care professional's primary goal is to assist patients in reaching their highest level of well-being, it is essential that health professionals learn to successfully collaborate on issues regarding patient care (Tschannen, 2004). In collaboration, members of various health care disciplines willingly share their expertise as they work together because they understand and appreciate their efforts help contribute to the whole (Henneman, 1995). Theoretically, interprofessional practice allows input from various professions and should, therefore, produce decisions that lead to better outcomes because the decisions are based on more complete information (Baggs, Schmitt, Mushlin, Mitchell, Eldredge, Oakes, et al., 1999). In short, collaboration can be seen as strategically central and conceptually essential to interprofessional practice, improvement of health care, and the enhancement of health outcomes.

Despite its theoretical and practical significance, collaboration is a complex phenomenon that has not been clearly understood for its impact on professionals, their work, and for the ethical consequences that arise when people work together. Additionally, collaboration has become a political slogan in that its meaning is variable and frequently referred synonymously to other concepts such as partnership (Stichler, 1995); joint practice (Gardner, 2005; Gordon & Brown, 2005; Henneman,

Lee, & Cohen, 1995); and coalition (El Ansari, Phillips, & Hammick, 2001). This lack of clarity has resulted in confusion over its potential impact such that, "it has hindered its usefulness as a variable in studies which attempt to evaluate its effectiveness" (Henneman et al., 1995, p.103).

According to *Funk and Wagnall's Canadian College Dictionary* (1989), the word "collaboration" originates from the Latin word "collaborare" which means to "work" or "labour" together. While this definition is host to a number of interpretations, collaboration is most commonly described as "what" it is in operational terms; as a process of exchanging information, altering activities, sharing resources, and developing the capacity of another organization or individuals for mutual benefit in order to achieve a common aim (Apostolakis, 2004; Bryne & Hansberry, 2007; Himmelman, 1996). The importance of achieving a common aim among the collective is reflected in Brandon's (as cited in Davoli & Fine, 2004) definition of collaboration as "bringing together individual providers and practitioners with a common sense of mission and the collective resources to achieve it" (p. 266). Gray (as cited in Davoli & Fine, 2004) similarly defines collaboration as "a process through which parties who see different aspects of a problem can explore constructively their differences and search for solutions that go beyond their own limited vision of what is possible" (p. 266). The aforementioned definitions of collaboration are like those found in the literature. While these definitions clearly emphasize the concept of "working together", they lack in describing the characteristics needed for achieving a common vision, which I believe is a necessary step for illuminating what working together entails.

Scholars have suggested it is most likely the formation of meaningful

relationships that facilitate the achievement of a common vision of collaboration and its ultimate success in a given context. For example, successful collaboration for Brown, White, and Leibbrant (2006) requires the formation of relationships be grounded in mutual recognition with an understanding of each other's needs, expectations, capabilities, and responsibilities. What is not apparent, in all but the rarest of circumstances where the relational aspect of collaboration is actually made explicit, is the articulation of "how" members achieve these features of the relationships. This part is often omitted in the current descriptions of collaboration found in the literature and, as a consequence, this important aspect of collaboration is currently the least understood.

The concept of collaboration has permeated all parts of academic and political life, but common usage does not mean that collaboration is clear, coherent, and well thought out among its members. Although it is reasonable to suggest that most people can relate to the concept of collaboration as working together, it is naïve to assume that a group of people working together to achieve a common purpose will, with minimal effort, be able to collaborate. There are instances in health care, as well as historically, as in the Holocaust, where collaborators have planned and directed evil acts. I am assuming in this study that the intentions, for the most part, are honourable. Nevertheless, there is always the possibility that even the good intentions of collaborators in health care may result in negative consequences. Failed collaborations in health care are as common, or perhaps even more common, than those considered to be successful, although the issues that have caused collaborations to fail are often not acknowledged (Beattie, Cheek, & Gibson, 1996; Gaskill, Morrison, Sanders, Forster, Edwards, Fleming, et al., 2003). Such variations in

success are puzzling and have ignited my curiosity as to why such variation exists.

Researcher's Narrative

I am an active member of the heath care profession, which may help to explain why I have taken a particular interest in collaboration. The need to collaborate with other health care professional has been, and continues to be, essential to the various roles I have undertaken in my longstanding career in nursing. Caring for patients and concern for their well-being has been and will continue to be at the forefront of all of my endeavours. Through the years, I have come to know health and illness with a heightened awareness that has been acquired from many experiences of having celebrated the success of collaboration, and of witnessing the consequences of non-collaboration or failed collaboration. A deep appreciation for the importance of collaborating with others has been the result.

While my collaborations with various members of the health care professions have, on the whole, been more positive and meaningful than not, success has not been achieved without a great deal of personal investment. What has contributed to the success of my collaborations is the formation of relationships with collaborators grounded in such relational characteristics as honesty, respect, and integrity, because it is the relational side of collaboration that I believe provides the necessary foundation for collaborators to achieve a common aim. Thus, all members involved must be willing to engage in such requirements as they are essential for building the foundation for collaboration and achieving its success. This foundation is built on mutuality and reciprocity from all members of the collective, and it cannot be one-sided or selfish as it will surely collapse and collaboration will fail usually with less

than favourable results.

I must, at this point, acknowledge that the characteristics I consider to be important for the success of my collaborations may or may not be viewed in the same way by others. Similarly, what constitutes success for me may actually be deemed of minor significance by another. A review of the health care literature in Chapter 2 will show that there are a host of circumstances that may interfere with the various processes that define collaboration. Rarely, however, has there been an in-depth exploration centered on how collaborators convey from their lived experience how the interpersonal and interactional side of collaboration affects the outcomes of their collaborations. This is what I want to achieve with my doctoral research.

In my opinion, most definitions of collaboration lean toward conventions of dispassionate objectivity; yet, it seems the notion of collaboration itself requires more subjective treatment. I believe it is possible to explore collaboration with more subjectively-based forms of reflective inquiry that encourage open and honest dialogue. More effort is needed to address this essential aspect of collaboration than is currently available in the literature. For health care professionals, can there be a separation between who they are as beings and the ways they attend to their work with others? To me, the answer lies in gaining a better understanding from practicing health care professionals who are willing to share their experiences.

I am fortunate that I have been granted an ideal opportunity to engage in research that allows me the freedom to pursue my curiosity, to invite others to share their perceptions, and to witness how others portray their experiences with collaboration. I tend to believe there should be no difference between who we are and how we conduct ourselves in our collaborations and it is always possible that this positioning

could result in biases for the inquiry. However, I will not impose an apriori assumption on the experience; but rather will allow the experiences of others to unfold and reveal the essential structure of collaboration from their perspectives.

Background Lending to Significance of the Topic

There has been significant emphasis placed on the need to transform the existing Canadian health care system and its multiple stakeholders to better serve the recipients of health care. Factors that have led to a need for change include: an aging population, the increasing prevalence of chronic disease, unacceptable wait times for care, patient safety concerns, and a relative lack of emphasis on health promotion (Kearney, 2008). Responses to the various issues require that changes to health and social policy and practices be made as such changes do result in the external drivers for rejuvenating an interest in how best collaboration amongst health care providers can be achieved (Yeager, 2005). Consequently, the growing popularity of collaboration has created an opening which Kingdon (1995) refers to as a "policy window" whereby, when the right issue aligns with certain political situations, the right policy change is possible.

Support for changing the practice and education of health care professionals to a collaborative approach can be found in the recommendations offered by leading authorities in government and other organizations in Canada and abroad. In 1988, the World Health Organization published the report *Learning Together to Work Together for Health*, which advocated interprofessional education as a key area for development. The need to improve collaboration is notably emphasized in defining interprofessional education as when "two or more professions learn with, from, and

about each other to improve collaboration and the quality of care" (CAIPE, 2002, as cited in Oandasan & Reeves, 2005, p. 24). Since that time, various organizations have made it a priority to learn how best health practitioners can acquire the knowledge, skills, and attitudes to practice together in an effective collaborative manner. Examples of such organizations who have taken on the challenge are: The Centre for the Advancement of Professional Education (CAIPE) in the United Kingdom, the Interdisciplinary Professional Education Collaborative (IPEC) in the United States, and the Centre for Professional Education Advancement (CPEA) in Australia.

Canadian government documents, such as the Commission on the Future of Health Care in Canada's (2002) report, *Building on Values: The Future of Healthcare in Canada*, have called for similar reforms to the health care systems. Subsequently, Health Canada's (2003) *First Ministers' Accord on Health Care Renewal* identified a need to change the way health care professionals are educated: through promotion of interdisciplinary provider education (p. 5). Future health care delivery models envisioning teams of health care providers working together to meet the patients' needs were among the recommendations of Health Canada's (2004) *National Expert Committee on Interprofessional Education for Collaborative, Patient-Centered Practice* (p. 33) and were later reinforced in the Health Council of Canada's (2005) report, *Healthcare Renewal in Canada: Accelerating Change* (p. 38).

In 2006, a steering committee comprised of leaders, health professionals, and key stakeholders from 10 national health care associations and coalitions across Canada, formed the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP)

initiative. Their proposal was to modify Canada's primary health care system so that it would facilitate more interdisciplinary collaboration. As a result, guidelines that suggested how health professionals can best work together to achieve optimal health outcomes for consumers of health care were outlined in EICP's (2006) *The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care.*

Commitment of funding was established through Health Canada's formation of the Interprofessional Education for Collaborative Patient-Centered Practice (IECPCP) Initiative. The IECPCP Initiative was implemented in two phases. Participants in the first phase of development from 2003 to 2004 explored the current national and international trends impacting interprofessional education approaches to primary health care; reviewed existing models of education and collaborative practice frameworks, and; provided an analysis of their findings in a summary report (Herbert, 2005, p. 2). The most relevant of outcomes achieved in this first phase "enabled Health Canada with the ability to determine what Canada must do to advance IECPCP in our health care system" (Herbert, 2005, p. 3). The focus of phase two on development from 2004 to 2008 was aimed at exactly that: proposals were received, and a number of projects were funded to explore interprofessional education in collaborative patient-centered practice, best practices in change management, and knowledge transfer (Herbert, 2005, p. 3).

In 2007, a locally funded project was initiated in Manitoba, entitled *Interprofessional Education for Geriatric Care (IEGC).* The project took place within the context of community-based geriatric care, and the IEGC interim report (2007) stated that its overarching objective was "to develop, implement, promote,

and evaluate a sustainable IECPC opportunity in the area of interprofessional education within a geriatric day hospital setting" (p.1). The IEGC project team included individuals of various academic, research, and practice specialities within the disciplines of pharmacy, medicine, nursing, physical therapy, and occupational therapy.

The rationale for the selection of a community-based geriatric care setting for a project of this kind was, according to the IEGC interim report (2007), expressed as the following: "Within the day hospital setting, older persons have access to a variety of health care specialists in one building. Also, a day hospital setting makes it conducive for delivering and teaching interprofessional education, as collaborative patient-centered care is the standard of practice" (p.4). To help substantiate these views, I engaged in a post-project discussion with one of the project team members, and I was able to confirm that the community-based geriatric care setting did indeed provide the IEGC project team ample opportunities for the accomplishment of its ambitious objective, as well as successful completion of the project. Typically, geriatric clients have a multitude of health issues that require the services from a variety of health care providers. With numerous health care providers involved, the need to collaborate is essential to achieve continuity of care for the client and minimize the duplication of services. In all likelihood, a geriatric setting would be a good choice given the significance of the topic so it was selected as background for the study.

Statement of the Problem

Collaboration is a complex phenomenon affected by numerous variables occurring within a political and ethical context. Additionally, while the idea of collaboration is frequently endorsed in health care practice my sense is that, as a genuinely experiential phenomenon, it is not well understood. The multitude of disparate views of various health care professionals as to what collaboration entails clearly indicates its complexity. In spite of the growing body of evidence in the literature of the benefits that can be achieved when health care professionals from various disciplines collaborate, frequent assimilations of collaboration to other similar concepts have created challenges for gaining a clear understanding of what collaboration means and how it can be successful in achieving its stated aims. Finally, although scholars most certainly have established that the formation of meaningful relationships among members is necessary for a common vision of collaboration, the interactional determinants of collaboration that play out between the collaborators and their influence on the collective itself have yet to be fully explored. These are the problems that the proposed inquiry aimed to address. The following section identifies more precisely the purpose of this study.

Purpose of the Research

The purpose of the research was to arrive at a better understanding of the essential meaning of collaboration for health care professionals and how it can be successful in achieving its aims. To conduct an inquiry of this nature required inclusion of participants who have experienced or experimented with the phenomenon. Particularly, the research explored the interactional determinants of collaboration on

interprofessional practice in community-based geriatric care.

Exploring the Interactional Determinants of Collaboration

An examination of collaborative practice in interprofessional health care teams conducted by San Martin-Rodriguez, Beaulieu, D'Amour, and Ferrada- Videla (2005) showed that interactional dynamics occurring among health care professionals, and particularly the formation of interpersonal relationships, were among the main factors in successful collaboration. The work completed to date has established that collaboration is very much an interpersonal process requiring, in addition to interpersonal skills, a general willingness on behalf of team members to achieve a common vision. Thus, this research focused on exploring what underlying meanings collaborators assign to the interactional nature of collaboration for themselves and for the collective, and how much of an impact the interactional determinants and their influences have on achieving the outcomes of collaboration.

Research Questions

The primary research question raised for the overall exploration was: What are the essential meanings of collaboration for health care professionals? To achieve a detailed description, the following questions guided the exploration with participants: i) Why is collaboration "in vogue," and what are its ostensible purposes and goals? ii) How have health care professionals responded and reacted to the current emphasis placed on collaboration? iii) What are your (i.e., the participants) impressions of successes, failures, barriers, and problems with collaborative efforts? iv) How might health care professionals better prepare themselves and others to work together to enhance collaboration?

The research question proposed for conducting an exploration of the interactional determinants of collaboration was: What underlying meanings do collaborators assign to the interactional nature of collaboration? To achieve a detailed description of the interactional nature of collaboration, the following questions were explored with participants: v) What are the dynamics that most often occur among or between health care professionals in their collaborations? vi) How do the interactional dynamics and their influences affect achieving the outcomes of collaboration? vii) What interpersonal attributes or processes are necessary for health care professionals to successfully collaborate? viii) How can collaborators best achieve the formation of common vision among the collective for their collaborative initiative? The research was undertaken from a qualitative phenomenological perspective. The philosophical assumptions of the conceptual paradigm of phenomenology are presented in the next section.

Conceptual Paradigm

Phenomenology is aligned with the worldview stance of individuals "who wish to seek understanding of the world in which they live and work" (Creswell, 2007, p. 20). Although Edmund Husserl (1859-1938) is widely considered to be the founder of a philosophy known as phenomenology, the phenomenological view was first described by Immanuel Kant (1724-1804) in a scientific context, as the study of "phenomena" or "things" (Cohen, 1987). Phenomenology, according to Greenfield (1974), "has its origin in the distinction Kant drew between the noumenal world (the world as it is) and the phenomenal world (the world as we see it). For Kant, a world of reality does indeed exist, but man can never perceive it directly; reality is always

glossed over with human interpretations which themselves become the realities to which man responds" (p. 4).

Although phenomenology became a significant movement in 20th century philosophy, it became quite amorphous as the major contributors such as Maurice Merleau-Ponty (1908-1961), Jean-Paul Sartre (1905-1980), Hans-Georg Gadamer (1900-2002), Martin Heidegger (1889-1976), and Paul Ricoeur (1913-2005), sought to cast their own views and develop phenomenology as a set of operational beliefs that helped to discover the experience of phenomena. Subsequently, phenomenology has been modernized from its earlier contributors of philosophy, to support various approaches of qualitative research in the arenas of social and health sciences, such as psychology, nursing, and education (Creswell, 2007).

The predominant focus of phenomenology is consciousness, human existence, or the very nature of being itself (Giorgi, 2005). In other words, this philosophy introduced a shift of focus away from things and nature and toward human beings and their worlds. Husserl reasoned, according to Giorgi, "that anything that had to be dealt with in the world had to come through consciousness and without consciousness, there is nothing to be said or done" (p. 76). Husserl set out to understand consciousness in all of its manifestations (Giorgi).

Within a historical context, phenomenology was viewed as a departure from positivistic science towards a return to the traditional tasks of philosophy (Stewart & Mickunas, 1990). By tradition, positivistic science concerns itself with observable and measurable data that are generalizable and reproducible with the same effect. Thus, phenomenology developed as a reaction to the reductionist approach of natural science.

Husserl opposed what he called "naturalism", or the view that empirical science is the sovereign arbiter of truth (LeVasseur, 2003). He believed in the primacy of lived experience, or "life world", as the real foundation for philosophic understanding and the primary context from which all other human endeavors, including natural science, take their beginnings and orientation (LeVasseur). According to Willis (1999), phenomenology can be described as being "not so much a particular method as a particular approach by philosophers who wanted to reaffirm and describe their 'being in the world' as an alternative way to human knowledge rather than through the objectification of so-called positivist science" (p. 94). In other words, phenomenology produces outcomes that are particularistic and not universalistic, nor necessarily reproducible.

A common assumption that underlies the philosophical basis of phenomenology is the intentionality of consciousness (Stewart & Mickunas, 1990). Intentionality means that acts of consciousness directed toward objects transcend, or go beyond, the acts in which the objects appear (Giorgi, 2005). The basic premise of intentionality means that "the very act of thinking is an act that affirms the union that exists between the thinking subject and the object of thinking" (Willis, 1999, p. 96). Giorgi offers an appealing summary of the concept of intentionality:

> By intentionality Husserl meant that every act of consciousness takes an object that transcends the act. Sometimes the object toward which consciousness is directed is in the world and sometimes it belongs to the same stream of consciousness as the act itself – for example, when we reflect on our dreams or on our own mental processes—but the object always transcends the act. This means that consciousness is, among other

> things, a principle of openness. Because of consciousness, we are open to the world, to others, and even to ourselves (p.76).

Husserl believed, according Stewart and Mickunas (1990), that there was "no thinking life apart from the context of consciousness" (p. 37). The act of thinking "is an act of reception which holds the thinking mind back from closure and returns again and again to behold the object, allowing words and images to emerge from the contemplative engagement" (Willis, 1999, p. 98). With intentionality, there is no subject-object dichotomy (Stewart & Mickunas). The next section shows how phenomenology can be applied to explore the concept of collaboration.

Applying the Phenomenological Assumptions to Explore Collaboration

There were a number of reasons why I believed a phenomenological approach was appropriate for exploring the meaning of collaboration. First, the use of phenomenology is ideal when the nature of the investigation calls for a deliberate movement away from quantifiable, observable, and measurable data in favour of the subject-based particularities associated with the primacy of lived experience. While substantial emphasis has been placed on identifying the processes and outcomes of collaboration, the relational aspects of collaboration have received far less attention. In my opinion, phenomenology will contribute a much needed philosophical grounding for this exploration of collaboration as opposed to the otherwise predominant empirical forms of inquiry that have been utilized extensively in the literature to examine collaboration.

Second, collaboration fits the criteria of a phenomenon. Collaboration is a genuinely experiential phenomenon for health care professionals and, although it is

not well understood, virtually everyone involved in health care is expected to collaborate in their working lives. Phenomena that are not well understood, even though they may be central to the lived experience of human beings, are appropriate for phenomenological research (Giorgi, 2005).

Third, the focus of phenomenology is on the individual perspective, as it is the individual who relates with intentionality to objects as they appear to his or her consciousness (Giorgi, 2005). I am of the belief that an act of collaboration is very much a function of each individual, whose unique perspective comes into contact with another, while the organization has much to do with providing the social, cultural, and political contexts that permit its actualization. Despite the influence of contextual factors, collaboration is undertaken by the individual and not by the organization itself. Greenfield (1974) had substantiated this view in his earlier work when he emphasized the essentiality of "viewing organizations not as structures who hold true universal laws but as cultural artifacts dependent upon the specific meanings and intentions of people who operate within them" (p. 2). Therefore, although organizations can be instrumental in supporting and/or influencing collaboration, they cannot necessarily ensure its success or failure. Since collaboration occurs between individuals, those persons alone will ultimately determine whether or not collaboration occurs (Henneman, Lee, & Cohen, 1995).

Moreover, when the investigation relies on human experience, it is impossible to separate knowledge from being (LeVasseur, 2003). This is, according to LeVasseur, "because human experience is derived from the interests and intentions that give it meaning" (p. 409). In an ontological sense, phenomenology allows us to discover the meaning of a phenomenon of which individuals are a part. Individuals have the

capacity to render their life experiences, both personal and social, in relevant and meaningful ways.

Finally, phenomenology is better suited to a search of a shared commonality of a phenomenon among several individuals (Creswell, 2007). For this, a prerequisite of already being immersed in the phenomenon is important, as having prior experience enables individuals to articulate their perceptions of the phenomenon (Creswell, 2007). Participants in the study were practicing health care professionals from specializations in pharmacy, social work, dietetics, medicine, nursing, physiotherapy, and occupational therapy. They were expected to function as a collaborative team of interdisciplinary health care providers in a novel community-based geriatric program designed to promote the health and well being of the elderly, not just work together.

Summary

There are benefits to be achieved by the utilization of phenomenology to explore the interactional determinants of collaboration in interprofessional practice. The humanistic values and beliefs inherent in phenomenology are congruent in both theory and practice of health care (Jasper, 1994). Given that the primary goal of quality health care is to assist patients to reaching their highest level of well-being, it is incumbent for health care professionals to carefully attend to and reflect upon the practices that comprise their collaborations. A more in-depth exploration of collaboration may result in the emergence of new knowledge that can contribute to the ideals of health care professions. Understanding how members can be better prepared for collaboration would aid in the development of current and future practices which is significant for stakeholders, such as government, health care, and

educational institutions. Above all, such improvements are significant for the patients; who are, and must always remain, central to health care.

The next chapter will show the positive outcomes that have been achieved when health care providers from various disciplines are able to successfully collaborate. The discussion will offer a review of the relevant literature and several determinants that have led to the success of, or constituted challenges for, collaboration in health care. The methodological applications utilized by various scholars to examine collaboration and the implications will be illustrated. While in the past, quantitative methodologies have been the preferred approach to study the complex concept of collaboration, I will offer my argument as to why a qualitative approach, particularly phenomenology, is best suited to address the research questions in this exploration.

Chapter II: Literature Review

Introduction

There is clear evidence in the literature to suggest that when professionals from the many disciplines of health care are able to effectively collaborate, a positive effect on patient outcomes is created (Zwarenstein, Goodman, & Reeves, 2009). When health care professionals attend to their work together with the common purpose of enhancing the quality of patient care, improvements can be made in levels of functioning in patients after undergoing rehabilitation for cardiac conditions (Brennan, 1997; Campbell, Grimshaw, Rawles, & Ritchie, 1996; Dafoe & Huston, 1997) and in musculoskeletal and orthopedic conditions (Di Fabio, 1995; Munin, Rudy, Glynn, Crossett, & Rubash, 1998). Morbidity and mortality have been reduced in patients with stroke (Kalra et al., 2000; Langhorne & Duncan, 2001); traumatic brain injury (Chesnut et al., 1999; Cope, 1995; Semlyen, Summers, & Barnes, 1998); and, coronary bypass graft surgery (O'Connor et al., 1996).

Positive patient outcomes in the specializations of palliative and critical care have also been found. For example, proactive communication among palliative care providers, patients, and their families, has led to reductions in length of stay (Lilly, Sonna, Haley, & Massaro, 2003). Structured communication amongst health care providers increased providers' satisfaction, improved patients' satisfaction, and the quality of care in the critical care setting (Beckstrand, Callister, & Kirchhoff, 2006; Henneman, Dracup, Ganz, Molayeme, & Cooper, 2001; Narasimhan, Eisen, Mahoney, Acerra, & Rosen, 2006; Varizani, Hays, Shapiro, & Cowan, 2005).

Despite a growing body of evidence in the heath care literature showing that

numerous benefits may be achieved when health care professionals are able to successfully practice together, failed collaborations do occur. One would be misguided to assume that a group of professionals working together for a common purpose will, with minimal effort, achieve successful collaboration. Gaskill et al. (2003) asserts that the challenge of bringing health care providers with diverse backgrounds together to achieve a common purpose is like "mixing water with oil" (p. 348).

Moreover, there seems to be a tendency in the health care literature to gloss over the individual, institutional, and political realities of collaboration without identifying or exploring the reasons of the failure with sufficient depth (Beattie, Cheek, & Gibson, 1996; Gaskill et al., 2003). To elaborate further, according to Gaskill et al., "authors generally outline achievements, present models for collaboration, discuss the benefits and, although they might identify issues, often gloss over the complexity of the negotiations required for successful collaboration" (p. 348). The reason why, explains Gaskill et al. is that "bad news or difficult scenarios make for unpleasant reading" (p. 348). And while this indeed may the case, not addressing the realities of collaboration and articulating the reasons why collaborations fail will not facilitate health care providers' understanding of the essential elements required for successful collaboration. As a consequence, patients may not receive the benefits that would otherwise be achievable if health care professionals were to successfully collaborate (Van Eyk & Baum, 2002).

There have been instances in the health care literature where non-collaborative work environments have contributed to: personal dissatisfaction routinely described by health care professionals, fragmentation of care, patient dissatisfaction, and the

frequent poor outcomes which plague the health care system (Henneman, Lee, & Cohen, 1995). Dissatisfaction among health care professionals may be attributed to a lack of involvement, insufficient guidance, limited access to information, and a lack of time and energy (LeGris et al., 2000). Certainly these limitations, as summarized from LeGris et al.'s published study, were the major barriers found to have had a negative impact on achieving an integrated service delivery system between a community hospital and a university-affiliated school of nursing in Southern Ontario.

McCloughen's and O'Brien's (2006) experience of collaboration in an initiative involving members of a university and three mental health service agencies in an urban setting in Australia shows that successful collaboration can be influenced by a wide range of determinants. A Mentorship Program was created that aimed to offer mentoring from experienced nurses to new graduate nurses moving into the specialty of mental health care over a 24-month period. Unfortunately, successful implementation of the Mentorship Program was affected by poor communication among members, a lack of attention to the various organizational structures, cultures and norms, and a perceived lack of influence or control by the stakeholders involved in the Program. These outcomes impacted the success of the Mentorship Program such that funding for the program was discontinued and the Mentorship Program was dismantled. Interestingly, it was noted in McCloughen's and O'Brien's discussion that, while the concept of supporting new graduate nurses was still important for the organizations involved in the Mentorship Program, the application of the concept would need to go in a new direction. Although the authors did not elaborate on the change of direction needed for supporting new graduate nurses entering the specialty of mental health, the message was clear that their attempts to promote collaboration

through mentoring was plagued by numerous challenges arising from the individual, institutional, and political realities of collaboration.

The outcomes of McCloughen's and O'Brien's (2006) and LeGris et al.'s (2000) studies align with a review of theoretical and empirical studies conducted by San Martin-Rodriguez et al. (2005) who found that the success of collaboration is affected by a host of determinants that have been categorized into three general contexts which are: conditions existing within the organizational setting; conditions existing outside the organization such as social, cultural, educational, and professional systems; and, the interpersonal relationships or the interactional dynamics occurring between members. It is the latter category, consisting of the more experiential and subjective nature of interpersonal and interactional components of collaboration that will be the focus of the research. A hermeneutic phenomenological approach, as utilized for this inquiry, suggests that there is a connection between the subjective and the external conditions that mark existence. Thus, I attempt to show, through an exploration of the literature, how the various determinants in each of these categories influence the success of, or precipitate challenges for, collaboration in health care. The characteristics of collaboration as identified by San Martin-Rodriguez et al., along with the findings of other scholars found in the health care literature, are showcased next in this review.

Organizational Determinants of Collaboration

Organizational determinants or the conditions existing within an organizational setting, such as the structure, values, and provision of resources, can have an impact on the outcomes of collaboration (San Martin-Rodriguez et al., 2005). Additionally,

in the more recent climate of health care where cost containment is emphasized, collaboration is regarded as a significant factor in the reduction of organizational stress caused by the pressures of an increased demand for services (Van Eyk & Baum, 2002). The demands of health care and the increasing awareness around the complexity of health care problems require capabilities and resources beyond those of a single organization (Stichler, 1995). In addition to downsizing, organizations are concentrating on their core competencies, thus creating a need for more interdependency among the various agencies that comprise health care (D'Amour, Ferrada-Videla, San Martin- Rodriguez, & Beaulieu, 2005).

As health care consists of a diverse network of organizations comprised of corporate bodies and academic, research, and clinical institutions, scholars in most instances concentrate on collaborative undertakings to achieve mutually relevant outcomes that will be of benefit to their specific domains. For members of academic and health care institutions, collaboration is often utilized as a method of achieving joint outcomes and uniting theory and practice (Gaskill et al., 2003; Gelling & Chatfield, 2001; McCloughen & O'Brien, 2006). For members of the research, academic, and clinical sectors of health care, collaboration is a cost effective and innovative way to investigate clinical practice issues, articulate clinical and teaching expertise, and extend professional practice knowledge (Paton, Martin, McClunie-Trust, & Weir, 2004). Collaboration between members of the clinical and research sectors is viewed as a valuable and constructive method for improving delivery, quality, and outcomes of care (Hamric & Blackhall, 2007; Henneman, Lee, & Cohen, 1995; Hunt, 2000; Kearney Miller, Sermeus, Hoy, & Vanhaecht, 2000; McCloughen & O'Brien, 2006; Schmitt, 2001; Van Eyk & Baum, 2002).

To further illustrate, Kearney et al. (2000) conducted a research project funded by the European Commission aimed at improving cancer nursing practices across Europe through the utilization of state of the art information technology. With the success of its collaboration, the Commission was able to demonstrate its results were clinically relevant, thereby making a significant contribution to the nursing knowledge base for improving patient outcomes. Kearney et al. maintained throughout their project that improving patient care and outcomes are the common ground that all researchers and clinicians of health care share, regardless of their different interests and priorities (p.1007).

In other examples, successful collaboration between research and academic institutions concerned with health care have produced mutually satisfying benefits, such as increased and more accessible funding, greater accessibility to practice settings and clients with diverse diagnoses, improved access and more efficient use of resources, and more possibilities to establish institutional links (Beattie, Cheek, & Gibson, 1996; Bryne & Hansberry, 2007; Kearney et al., 2000; McCloughen & O'Brien, 2006; Powell, Lloyd, & Olajide, 1999; Van Eyk & Baum, 2002; Woods et al., 2000). Woods et al. (2000) focused their collaboration on common critical care nursing issues in order to develop a community standard of care for orally intubated patients in three health care institutions centered in the Midwest of the United States. Success of their collaboration can best be summarized as having achieved a commitment from all members to the initiative, including co-operative sharing of resources and costs among the participating institutions.

On the other hand, institutional politics, value conflicts, competing goals, and a lack of involvement of key stakeholder representatives are identified as having

potentially debilitating effects on collaboration (Beattie, Cheek, & Gibson, 1996; Gaskill et al., 2003; McCloughen & Brien, 2006; Thompson, Socolar, Brown, & Haggerty, 2002; Van Eyk & Baum, 2002). To summarize, Beattie et al. associated the ramifications of competing interests, and their resultant tensions and conflicts, with the political nature of collaboration. Gaskill et al. reported that successful collaboration was difficult to achieve when organizations have opposing views on the investment of finances, priorities, and time constraints. Thus, conflicts arising from competing interests, conflicting expectations, communication issues, and a lack of resources create barriers for successful collaboration (Beattie et al.; Hamric & Blackhall, 2007).

Clearly, there are numerous conditions existing within an organizational setting that have the potential for impacting outcomes of collaboration. In health care, where there is a diverse network of organizations involved, the literature shows that organizational factors can be either contributory or detrimental to collaboration. However, exactly to what degree such organizational factors influence the development of interprofessional collaboration is a complex matter that, according to San Martin-Rodriguez et al. (2005), "has yet to be fully understood" (p. 144). Despite a need to understand the key characteristics of organizations that foster collaboration, this will not be the focus for this inquiry. However, findings pertinent to organizational characteristics that may be of relevance to my inquiry will not be discounted nor excluded.

Systemic Determinants of Collaboration

Environmental conditions existing in outside organizations, such as social, cultural, educational, and professional systems are found to have a profound influence on the development, achievement, and sustainability of collaborative practice among health care professionals (San Martin-Rodriguez et al., 2005). Social systems, for example, affect whether collaboration is achieved because they are "the source of power differences that may exist between health care professionals, and these factors have an impact on how collaborative practice develops" (San Martin-Rodriguez et al., p.134). Power differences are imbalances created by an exploitation of power, which can be used as a means of control to disqualify another and to isolate professionals from each other (Freeth & Nicol, 1998; Lockhart-Wood, 2000; Reeves & Pryce, 1998). Such imbalances are often promoted through professional role socialization, and embedded in gender-based stereotypical and hierarchical behaviours that have been propagated by the various professions of health care throughout history (Carpenter & Hewstone, 1996; Lockhart-Wood, 2000; San Martin-Rodriguez et al.; Tunstall-Pedoe, Rink, & Hilton, 2003).

Since collaboration is non-hierarchical in nature, attitudes that reflect prejudice and stereotyping toward others works against the contributions that can be made when health care providers make a concerted effort to work together (San Martin-Rodriguez et al., 2005; Silen-Lipponen, Turunen, & Tossavainen, 2002). When the various professions of health care such as physicians and nurses, make a concerted effort to work together, more positive outcomes can be achieved. Benefits such as patient and professional satisfaction, improved decision making, nurse empowerment, and more positive patient outcomes are the result (Aiken, Clarke,

Sloane, Sochalski,& Silber, 2002; Henneman, Dracup, Ganz, Molayeme, & Cooper, 2001; Krairiksh & Anthony, 2001; Larrabee et al., 2003; Laschinger, Almost, & Tuer-Hodes, 2003; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004; Zwarenstein, Goldman, & Reeves, 2009).

The attitudes that individuals possess are shaped by a complex mix of factors involving age, prior work experience, gender, and cultural background (Hammick, Freeth, Koppel, Reeves, & Barr, 2007). These attitudes, in combination with differing beliefs and opinions on topics such as politics, religion, and values, can result in conflict when people work together (D'Amour & Oandasan, 2005). One's cultural predispositions in particular are strong determinants for the outcome of collaboration, as opposing cultural values may result in conflicting views that impede a willingness to engage in collaboration (D'Amour & Oandasan; Gage, 1998; Mariano, 1989; San Martin-Rodriguez et al., 2005).

The educational system is a significant determinant for achieving success with interprofessional collaboration (San Martin-Rodriguez et al., 2005). Traditionally, the acquisition of skills and knowledge begins early in the educational experience and continues throughout the socialization process, whereby students are inculcated with the philosophies, values, and theoretical perspectives embedded in their respective professions (Clark, 1997; D'Amour et al., 2005; San Martin-Rodriguez et al.). As a result, professionals of health care emerge in socially constructed professions characterized by their occupational identity and the specialized nature of their work (Hall, 2005). While these features reflect the essence of professionalism, such aims keep the professions independent and separate from each other, without a clear appreciation for the knowledge and capabilities of other professionals in

different professions (McPherson, Headrick, & Moss, 2001; Steinert 2005).

It is possible for the educational system to promote the values of all interrelated professions through interprofessional education programs. While there is evidence to suggest that the development of interprofessional collaboration is likely to be enhanced when members value the roles of other members, it has not yet been fully substantiated (Arslanian-Engoren, 1995; Bags & Schmitt, 1997, Silen-Lipponen, et al., 2002). However, any effort to improve care, even if it starts with only one professional group, will not be successful without the involvement of the entire interprofessional team (Batalden, Ogrinc, & Batalden, 2006; Headrick & Khaleel, 2008; Schmitt, 2001).

Some possess a certain naïveté about collaboration, believing that the "good will" of members will overcome all (Beattie et al., 1996), while others hold an attitude of competition which denotes a strong element of 'them versus us' attitudes (Van Eyk & Baum, 2002). Such competitive attitudes can be a response to new and potentially threatening experiences or conversely, pre-existing views about other professional groups and agencies or their approaches (Van Eyk & Baum). Tensions are heightened, according to Van Eyk and Baum, "at times of budgetary difficulties, when services are overstretched and under-resourced, and when staff feel they are under threat because of the possible transfer of their responsibilities or services to another professional group or agency" (p. 268). I think it is reasonable to suggest that, for those of us in health care, these times are currently upon us.

The professional system has a significant effect on the development of collaborative practice (D'Amour et al., 2005; San Martin-Rodriguez et al., 2005). The ways in which the health care professions are structured and function works

against interprofessional collaboration and the integration of health care services (Gilbert, 2005; Lahey & Currie, 2005). Professional associations are structured, through their jurisdictions and regulations, to place professional autonomy and respect for their members ahead of any other interests (Oandasan et al., 2004). The heath care professions and medicine in particular, prioritize autonomy, individualism, and specialization (Henneman, et al., 1995; Lockhart-Wood, 2000). Under these circumstances, professionals who comprise the various professions are socialized to adopt a discipline-based vision of their practice, and have a tendency to function within their professional territories (D'Amour et al.). These characteristics run counter to a concept closely associated with collaboration, the concept called interdependency (D'Amour et al.; Henneman et al., 1995; San Martin-Rodriguez et al.; Stichler, 1995; Tschannen, 2004).

Interdependency has been suggested to be a means by which health care professionals "can attend to the increasing complexity of health problems together, and address the needs of patients through their collective input" (Stichler, 1995, p.54). Through the process of collaboration, professionals would be able jointly to create patient care solutions that reflect the combined wisdom of team members (Tschannen, 2004). However, interdependency among the professions is not easily attainable. The most significant challenge that can be summarized from Gilbert's (2005) discussion on interprofessional education for collaborative practice is that, regardless of the fact that diverse health care professionals work in the same spaces, a culture of health care silos remains prevalent within a system that would surely benefit from more interdependency among its professionals.

Gerardi and Fontaine (2007) point out that interdependency and teamwork among

physicians and nurses, "are not concepts the professions of medicine and nursing have agreed upon" (p. 11). This determination is empirically supported by various authors who have examined the differences in perception among physicians and nurses working in hospital-based acute care settings (Makary, Sexton, Freischlag, 2006; Thomas, Sexton, & Helmreich, 2003; Skjorshammer, 2001). Studies found that discrepancies in perceptions of teamwork and interdependence of physicians and nurses have resulted in poor conflict resolution, inadequate interpersonal communication, and avoidance of each other, which are factors that pose challenges for successful collaboration and are difficult to overcome (Makary, Sexton, Freischlag, 2006; Thomas et al.; Skjorshammer).

Acts of collaboration would require that professions shift away from a monopoly and insulation of autonomous practice, to address the difficulties lying beyond the bounds of uniprofessional activity (Sawa, 2005). Professionals must be willing to modify the sacrosanct concept of professional autonomy and their jurisdictional behaviours to recognize that there are valuable contributions that can be made when health care professionals work together (Rafferty, Ball, & Aiken, 2001). Sicotte, D'Amour, and Moreault (2002) recommend that more concentration on the rationale for collaboration, rather than on professionalism, may encourage more collaborative work.

Interactional Determinants of Collaboration

Unfortunately, even when changes to health and social policy provide the necessary structural conditions and standards for implementing collaborative practice, they are simply not enough to ensure that collaboration will occur among

health care professionals. San Martin-Rodriguez et al. (2005) suggest there are various interactional determinants, or interpersonal processes essential in the formation of relationships, which have a significant role in determining the success of collaboration. Among the first steps to be taken, health care providers must be receptive to the idea of collaboration, demonstrate a willingness that is conveyed through their commitment, and believe in the benefits of such collaboration (Baggs & Schmitt, 1997; Sicotte et al., 2002; Henneman et al., 1995; Stichler, 1995). Then there are the more frequently identified concepts linked to collaboration within a single context, or accompanying other frequently associated determinants: such as honesty and communication (Henneman et al.; Gaskill et al., 2003; Stichler; Sullivan, 1998; Yeager, 2005); and, mutual trust and respect (Alpert, Goldman, Kilroy & Pike, 1992; Gaskill et al., 2003; Henneman et al.,1995; LeGris et al., 2000; Siegler & Whitney, 1994; Sullivan; Thompson et al., 2002; Van Eyk & Baum, 2002).

Communication is essential for collaboration because it is a process that promotes cooperative decision-making and problem-solving among the collective (McCloughen & O'Brien, 2006). When communication is effective, members are more willing to listen to each other's perspective and, yet, negotiate constructively to produce the best outcomes (Henneman et al., 1995). Open and honest communication among members allows individuals to articulate their contributions freely (Gaskill et al., 2003), and facilitates an environment where anxieties and frustrations can be expressed and managed appropriately (Kearney et al., 2000). Communication also acts as a catalyst for other interactional determinants such as respect and trust (Henneman et al.; McCloughen & O'Brien). Conversely, problems with communication may be attributed to a lack of interaction skills (Coeling &

Cukr, 2000); can result in poor patient care (Freeth, 2001); and, inadequate articulation of treatment goals (Baggs & Schmitt, 1997; Lockhart-Wood, 2000).

Trust may be manifest in the degree of self confidence one possesses about skills and knowledge when one acts in the role of a professional, as well as how one perceives these same attributes in others (Henneman et al., 1995). To develop trust requires an investment of time to build rapport, patience, empathy, and prior positive experiences (Gaskill et al., 2003). Through communication and sharing, members are better able to become familiar with each other (Gaskill et al.). However, just as developing trust is essential for collaboration, effectively attending to elements of mistrust and tensions among members of various agencies and disciplines is equally important (Van Eyk & Baum, 2002). Henneman et al. point out that a lack of trust presents a significant barrier to the development of collaboration.

Respect for each profession's contribution to patient care is achieved when members understand and accept each other's expertise and role (Evans & Carlson, 1992; Martin & Coniglio, 1996). When members show respect for one another, they are better able to resolve conflict and alleviate anxieties and tensions resulting from opposing cultural values (Kearney et al., 2000). Conversely, a lack of respect creates challenges for achieving interdependency among the professions and creates problems for collaboration between health care professionals (Stichler, 1995).

A study undertaken by Baggs and Schmitt (1997) nicely illustrates the relational significance of collaboration. The authors used a grounded theory approach to explore collaboration between 10 intensive care unit nurses and 10 medical resident physicians working in a medical intensive care unit of a tertiary care hospital in the United States. From the interviews conducted with participants, Bags and Schmitt

were able to show that respect, trust, and communication were the essential elements that supported collaboration between nurses and physicians.

Respect among participants was characterized by active listening, politeness, manners, diplomacy, and pleasantness. Participants expressed a desire to be trusted by each other. Acts of trust were demonstrated by following through on mutually exchanged advice, and by responding to each other's requests. Communication was marked by sharing information and the physical duties surrounding the delivery of care, by listening, and by responding to each other with affirmation. The outcomes identified by participants as a result of their collaboration were improved patient care, feeling better in the job, and a tighter control over costs (Baggs & Schmitt, 1997).

The health care literature shows that the aforementioned characteristics as they apply to the relational context of collaboration have a significant role in determining outcomes. These attributes are either linked to collaboration within a single context, or they accompany other frequently associated determinants. The work that has been completed to date has surely helped to establish that collaboration is very much an interpersonal process that requires both willingness from members and the skills to be successful, but little has been accomplished to determine the depth of these influences on individual members or the collective. Often, there is substantial emphasis placed upon collaboration as a predictor of developing processes and for measuring outcomes, or both. While there are a number of determinants that have been shown to influence the success of collaboration, it is often viewed objectively and instrumentally with functional commodities that can be manipulated by adjusting the structural processes to achieve desired outcomes. Thus, my intentions were to

delve deeper into the interpersonal side of collaboration with the aim of achieving a better understanding as to how a more meaningful collaborative work environment can be created for interdisciplinary health care providers.

To my knowledge, there are few examples to be found in the literature where collaboration is explored with the depth to which I aspire. Gerardi and Fontaine (2007) have stated this to be "true collaboration which requires that we explicitly turn our attention toward the building of relationships" (p.14). Through the following illustration, so rich in context, one can appreciate how the interactional and relational characteristics of collaboration are enabled by the various attributes we possess within ourselves:

> Collaboration requires engagement across a continuum of interactions. Shifting our focus toward relationship and our interactions with others, how we communicate, how we negotiate, and how we resolve differences helps us to re-engage, to revitalize our spirit, and to return to those things that matter most to us—respect, trust, hope, camaraderie, and the joy of doing good work. (p. 14)

Dutton's (2003) portrayal of collaboration in a relational context was another rare find, albeit located apart from the health care literature. In setting up a collaborative practice coined the "CompassionLab" with other research scholars from various universities, Dutton experienced the benefits of collaboration as powerful vessels for joint growth and development amongst the members. Members of the CompassionLab describe their practice of collaboration with the proclamation:

> We create a safe and useful harbor for learning, for being, and for exchanging. We try on new identities in connections with others. We gain

> valuable advice, support, and instrumental and emotional help. We tell stories that carry wisdom and knowledge about our profession, our field, and our local contexts. These kinds of processes-in-connection are critical. (p. 9)

Members of the CompassionLab follow a host of life-affirming aspirations and practices which create the conditions for making their collaboration alive and meaningful. At the core of their beliefs is the idea that relational practice enables growth and connectiveness. Dutton's view suggests that collaboration is far more than the structural processes needed to achieve desired outcomes: it is "the practices we choose for our collaborations can actually enliven or deaden our growth as human beings" (p. 9). The scholar's vivid account stemmed from the need to make changes to the objective ways in which she approached her research practice in organizational behavior, to allow for a more subjective approach. Dutton characterizes these changes in her life and work as breathing life into organization studies.

Methodological Applications and Implications

The methodological applications most often been used by various scholars to examine collaboration result in a wide range of implications. Quantitative methodologies have predominantly been the preferred approach to study the complex concept of collaboration. Although an assortment of frameworks and models grounded in organizational theory, organizational sociology, and social exchange theory have been developed, D'Amour et al. (2005) point out that much of the focus of the various frameworks has been centered on producing input and output criteria and addressing processes. As Seymour (2001) suggests "the quantitative tool is

valued for its documental nature, its scientific objectivity, and its detachment from personal and bodily concerns" (p.157). However, D'Amour et al. note that a focus on these frameworks is less helpful for gaining an understanding of "what transpires in the working lives of a group of collaborating professionals or the nature of their interactional dynamics" (p.126).

Knowing the level of measurement with quantitative methods can be challenging given the numerous dimensions of collaboration (El Ansari & Weiss, 2005). Most instruments are not sensitive enough to distinguish among the various determinants without requiring excessively high measures of correlation and, therefore, the potential for overlap may produce varied results (El Ansari & Weiss). In addition, reliability of the various tools used for quantitative measurement, especially those consisting of multi-item scales, has not been available (El Ansari, Phillips, & Hammick, 2001). Respondent bias to questionnaires, resulting from respondents marking socially desirable answers in favour of truthful answers, is another concern (Halliday, Asthana, & Richarson, 2004).

To add rigor to the traditional positivist approach to collaboration, a mixed methodological approach incorporating both quantitative and qualitative methods has been recommended (El Ansari & Weiss, 2005). Combining methods offers completeness in that the researcher can bring together a more comprehensive account of the areas of inquiry. Quantitative methods alone do not take into consideration factors such as the nature of interactions, clarity of roles, and understanding between collaborating members (Bryman, 2006; El Ansari et al., 2001). Although a mixed methods approach takes into account the perspectives of members and the complexity of the phenomena under study they may, however,

produce contradictory results, leaving one to determine which method takes priority over the other (Millburn, Fraser, Secker, & Pavis, 1995).

Qualitative methodologies have become immensely popular and widely applied in the practice disciplines of health care (Sandelowski & Barroso, 2003). These forms of data are relevant for health care due to the fact that health care concerns itself with recipients' responses to actual and potential health problems, as well as with the providers of their care. The application of phenomenology as a qualitative approach has contributed extensively to health care, offering insight for a host of topics related to health, illness, and practice.

In assuming the role of researcher, Creswell (2007) advises that one must turn to the type of questions proposed for exploration to determine which approach is the most appropriate for the question type. Matching the type of research question with the correct choice of methodological approach is significant for the nature of the research question affects the outcomes of the research (El Ansari et al., 2001). According to El Ansari et al., "while quantitative research methods will statistically answer questions like 'who is doing what and where', qualitative methods are required to answer the 'why and how' collaboration works in certain situations' explorative inquiries" (p. 222). Theoretically, if I ask a quantitative question that relates either to frequencies or magnitude, then I would use a quantitative method. However, with phenomenology, if I ask a qualitative question, then I would use a qualitative method (Giorgi, 2005). Given that there is a need to elicit responses to questions aimed at answering the "why" and the "how" of collaboration, the use of qualitative methodologies to explore collaboration must be utilized.

Creswell (2007) maintains that the methods used in the design must be compatible with the research questions proposed for exploration. Clearly, this view supports the need to select the approach that is best suited for the aims of the inquiry. What is essential for phenomenological studies, according to Stubblefield and Murray (2002), is making a clear connection between the method used and its philosophical underpinnings to avoid research that is ambiguous in its purpose, structure, and findings. After taking into account these considerations, it is reasonable to suggest that the application of phenomenology would also be useful to elicit the responses of health care providers about their experience of collaborative practice in health care.

Summary

There is clear evidence from the health care literature that positive outcomes can be achieved when health care providers from various disciplines are able to successfully collaborate, however achieving successful collaboration is not so easily attainable. Part of the difficulty when researching a phenomenon such as collaboration, is the need to consider and include the many factors that can have an impact on collaboration, as well as its outcomes and/or whether or not it is achieved. San Martin-Rodriguez et al. (2005) identified a host of determinants that have led to the success of, or constituted challenges for, collaboration in health care. Various determinants were presented and discussed in the context of three general categories: conditions existing within the organizational setting; conditions existing outside the organization such as social, cultural, educational, and professional systems; and, the interpersonal relationships or the interactional dynamics occurring between members.

It is the latter category pertaining to the interpersonal relationships or the interactional dynamics occurring between members that holds particular relevance to the purpose and aims of the study. It was apparent, after reviewing the literature, that there was ample opportunity to expand on the work of previous authors. The most consistent patterns observed in the literature were the brief and somewhat limited attention authors had given to their findings. Often, there was little satisfaction that the true scope of the many issues surrounding collaboration had been explored and reported with enough depth that they warranted. And although some of the findings in the research on collaboration are certainly promising, focusing more attention on the experiences of health care providers as it pertains to their collaborations in interprofessional practice would garner more understanding of what is necessary for achieving success.

The methodological applications utilized by various scholars to examine collaboration and the implications were illustrated. The merits and the disadvantages of various applications were discussed. Although quantitative methodologies have been the more frequently implemented and preferred approach to study the collaboration, I had explained why it is imperative for the researcher to select the application that is the most suitable for the aims of the research. As such, I offered my argument as to why a qualitative approach, particularly phenomenology, was best suited to address the research questions in this exploration.

Chapter 3 outlines the methodology undertaken to explore the interpersonal side of collaboration. The study design and methods, the setting and sample, ethical considerations, and the procedures for data collection and analysis are described for exploring the interactional determinants of collaboration in interprofessional practice

with members of a groundbreaking new community-based geriatric health care program. A discussion of the two general divisions of phenomenology and their phenomenological values, knowledge claims, and the methods that have been suggested by their contributors are presented, as well as the various implications thought to be of significance for the design and analysis. Examples from the health care literature are provided to illustrate how each approach was constructed and how it focuses on the very essence of individuals' experiences of practice. Finally, the involvement of the researcher and the participants, as well as measures needed to promote the integrity of the research, are included. An explanation of the various terms found in the study is presented in Appendix A.

The final two chapters of the thesis are dedicated to the findings of the study. The findings are presented in Chapter 4. The outcomes of this exploration, the findings, and their implications for health care are discussed in Chapter 5. Finally, the limitations of the study are addressed, and the recommendations on this promising phenomenon called collaboration are shared.

Chapter III: Study Design and Methods

Study Design

Conducting a qualitative study most appropriately fits the nature of this inquiry for two important reasons: The first was that the qualitative approach is well known for the collection and interpretation of richer and deeper forms of data because of its ability to bring the perspective of the individual to the forefront (Popay, Rogers, & Williams, 1998). For this inquiry, it was essential that the focus be on acquiring the subjective views of the participants, in this case health care professionals actively engaged in interprofessional practice, to achieve a deeper understanding of collaboration. Secondly, on a broader level, the value of qualitative research lies in its exploratory and explanatory power (Attride-Stirling, 2001). Therefore, qualitative research has the potential to influence practice because it helps in the identification of strategies (Morse, 2003). Additionally, it can help to gain a better understanding of the influence of policy and the impact they have on both the individual and the institution (Eisner, 2007). In this study, participants were able to identify a number of recommendations for promoting successful collaboration. From the research experience and the interactions with participants, I too, was able to gain valuable insight on the topic of collaboration and offer my recommendations.

Having chosen to conduct a qualitative study, I then decided that the qualitative design most likely to help me achieve a deeper understanding of collaboration was phenomenology. There are two general approaches of phenomenology: descriptive, or eidetic phenomenology and interpretive, or hermeneutic phenomenology (Cohen & Omery, 1994). The primary differences between the descriptive and interpretive

approaches, according to Lopez and Willis (2004), "are in how the findings are generated and in how the findings are used to augment professional knowledge" (p.727). In this chapter, I discuss how each approach differs in terms of their methods, phenomenological values, knowledge claims, and the methods that have been suggested by their contributors. Examples from the health care literature are provided to illustrate how each approach focuses on the very essence of people's experiences of practice and how that experience was constructed.

Descriptive (Eidetic) Approach to Phenomenology

The descriptive approach to phenomenological inquiry was created from Husserl's ideas about how science should be conducted (Lopez & Willis, 2004). According to Lopez and Willis, "Husserl believed that subjective information should be important to scientists seeking to understand human motivation because human actions are influenced by what people perceive to be real" (p. 727). Reality of an object is embedded in one's awareness of it. Thus, reality is understood by the individual as truth because it exists in one's beliefs, ideas, and interpretation of the world (Greenfield, 1974).

Since the focus of descriptive phenomenology is on information gleaned from an individual's experience, the goal of the inquiry for researchers is to achieve transcendental subjectivity (Jasper, 1994). This means the researcher is careful to avoid influencing the collection and interpretation of the data, so that the conclusions reached are those that arise directly from the lived experience of the individual (Jasper). It is interesting to observe that, in some instances, a detailed literature review might not be conducted prior to initiating a study, and specific research

questions might not be formulated in favour of achieving a description of the lived experience of the participants in relation to the topic of the study.

Techniques such as “epoche”, “bracketing”, and “phenomenological reduction” are required for descriptive phenomenology, and are often referred to interchangeably (Stewart & Mickmus, 1990). All of these techniques suggest “the change in attitude necessary for philosophical inquiry” (p. 27). The act of cleansing the mind to ready it for the perception of meaning points to the epoche (LeVasseur, 2003). The epoche, according to LeVasseur, “consists of bracketing lived experience by suspending assumptions about the existence of things and shifting attention to the actual phenomena in their intentionality” (p. 413). As researchers, Linseth and Norberg (2004) maintained “we are careful not to invoke judgment and conclusion to our findings, and thus bracket ourselves in order to become open to our own experience and to the understandable meaning implicit in the experience” (p. 148). Essentially, prior knowledge of a phenomenon can be set aside so that fresh impressions can be formed without the interference of interpretive influences imposed by the researcher (LeVasseur).

Another component of descriptive phenomenology involves reaching a commonality of shared experiences by those immersed in the phenomenon. These are referred to as “universal essences” or “eidetic structures” (Giorgi, 2005). Eidetic reduction is the process whereby the researcher “expresses what is essential about the specific expressions used by the participant to arrive at the universal essence” (p. 80). Essences are considered to be representative of the true nature of the phenomenon being studied, and they provide more of an objective view independent of history and context (Lopez & Willis, 2004).

Del Barrio, Lacunza, Armendariz, Margall, and Asiain (2004) used Giorgi's (1985) descriptive phenomenology in their study that described liver transplant patients' experiences in the intensive care unit. The sample consisted of 10 patients who had each received a liver transplant in a teaching hospital. Data collection involved recorded interviews that were approximately one hour in duration. Participants were asked to speak about the experience of their stay in the Intensive Care Unit (ICU) at the hospital. Although the authors did not provide a rationale for their choice of method, they did support the use of the phenomenological method to gain in-depth knowledge of the essence of the experiences which patients go through and the meanings they attach to them (Del Bario et al.). Giorgi's method (as cited by Del Barrio et al.) is outlined as follows:

> The researcher reads the transcription of the entire interview to get a general sense of the whole. Once a sense of the whole has been grasped, the researcher goes back to the beginning of the transcript and rereads it to identify 'meaning units'. These are segments of data that will potentially reveal some aspect of the phenomena under investigation. In practice, the relevant meaning units are formed by a slower re-reading of the description, and each time the researcher experiences a transition in meaning in the description, he or she marks the place and continues to read until the next meaning unit becomes apparent, and so on. Once these units have been identified, they are re-examined and transformed into statements of meaning and grouped into wider subject areas called common themes or essential structures. Finally, the researcher writes the general description in language of the discipline which captures the essence of the participants' lived

> experience. This description contains, at least implicitly, all the meaning units and common themes. (p. 969)

Del Barrio et al. (2004) were also careful to point out that, as researchers, they bracketed all previous knowledge about the phenomena to avoid influencing the data obtained from the interviews. The researchers also used reduction and intuition to bridge the gap between the participants' descriptions and the essential meaning of the lived experience. The five themes to emerge from the analysis were: (a) predispositions marked the way participants approached transplant; (b) captured impressions of the ICU's environment and experienced sensations; (c) perception of caring behaviour of the nursing staff; (d) support from the social environment and religious beliefs, and; (e) preconceived ideas of ICU contrasted with their lived experience (Del Barrio et al.). Overall, Del Barrio et al. found the way they approached their study enabled them to gain in-depth knowledge of the liver transplant patients' experience in the ICU. The authors suggested that their results create possibilities for optimizing interventions and including them in future nursing care plans.

The phenomenological approach commonly associated with Moustakas (1994) focuses on the description of the experiences of participants. The advantages of Moustakas's approach (as cited in Creswell, 2007) are that procedures for data analysis are outlined, and the guidelines for assembling the textual and structural descriptions are systematically formatted. Researchers perform horizonalization of the data to highlight significant statements that "provide an understanding of how the participants experienced the phenomenon" (p. 61). From this, the researcher is able to "develop clusters of meaning from these statements into themes", which are then

used to "write a textural description of what the participants experienced" (p. 61). The textural description also leads to the development of a structural description, which is a description of the "content or setting that influenced how the participants experience the phenomenon" (p. 61). The textural and structural descriptions allow the researcher to form a composite description of a commonality of shared experiences of the phenomenon (Creswell).

Barry (2007) applied Moustakas's descriptive phenomenology in a study that explored individuals' descriptions of their experiences of best practice in mental health care. According to Barry, this approach "acknowledges the concept that people contemplate, interpret, and act within their environments allowing for multiple meanings to emerge which may not necessarily benefit from being condensed into a set of neat findings" (p. 560). The sample consisted of a consultant psychiatrist, a community psychiatric nurse, a therapist, a member of housekeeping staff, and three service users. Data collection involved recorded interviews that were approximately one hour in duration. The exploration centered on "describing the best moments of practice, progressing from an open stance to a more probing position, and included systemic, circular and appreciative inquiry style questions" (p. 560). Barry approached the data using a circular process that involved reading and re-reading the transcripts and listening to the audiotapes. Impressions were then recorded and categorized with more concrete coding as patterns emerged. Identified themes and quotes were checked and re-examined until three themes emerged: (a) relationship and expertise, (b) information and choice, and (c) co-constructed practice and responsibility.

Barry (2007) was able to conclude that applying Moustakas's approach helped to

focus on the very essence of people's experiences of practice and how it was constructed. Barry's view is summarized as follows:

> The meaning of best practice for people living through its everyday routines, structures, and codes of governance should receive ongoing and reflective attention if real user and stakeholder opinion is to become part of the co-construction of quality mental health systems and responses. The lived experience of stakeholders should gain recognition as 'expertise' moving away from the notion of the 'all knowing' professional. This will require a more inquisitive approach on the workings of everyday practice and reflection on what is working well and what might be improved in local settings. (p. 563)

Interpretive (Hermeneutic) Phenomenology

Hermeneutics is recognized as a philosophy that supports an approach to health research which focuses on meaning and understanding in context (Charalambous, Papdopoulos, & Beadsmoore, 2008). Hermeneutics goes beyond the description of core concepts and essences to look for meaning embedded within common life practices. Thus, hermeneutic inquiry is more focused on what individuals experience, rather than what they consciously know (Lopez & Willis, 2004).

The philosopher Martin Heidegger is considered to be among the main contributors of hermeneutic phenomenology for having launched his own theory of human understanding from the views of Husserl (Charalambous et al., 2008). Scholars such as Van Manen (1990) and Ricoeur (1981) have made the practice of hermeneutics more relevant to the human sciences. Van Manen's approach to

hermeneutical phenomenology is inclusive of the researcher's interpretations via methods such as taped conversations, formally written responses, and journaling (Creswell, 2007). Expressive forms found in poems, drama, film, and novels are also included. The incorporation of Van Manen's approach, according to Creswell requires that:

> Researchers turn to a phenomenon which seriously concerns them. In the process, they reflect on essential themes, what constitutes the nature of this lived experience. They write a description of the phenomenon, maintaining a strong relation to the topic of enquiry and balancing the parts of the writings to the whole. Phenomenology is not only a description, but it is also seen as an interpretive process in which the researcher makes an interpretation of the meaning of the lived experience. (p. 59)

LeVasseur (2002) selected Van Manen's approach for her study because his methodology was interpretive, open to innovation, and emphasized writing as a key element in the reflective process. The purpose of the study was to explore nurses' experiences of helping patients create coherence in their lives that had been disrupted by illness. LeVasseur relied on data collected from 20 tape-recorded interviews and field notes. Transcription of the interviews was read multiple times during analysis. Each interview was summarized to define what was most important in the narratives, while the analysis incorporated entire transcripts. Thick quotes were employed to make the data auditable and to lessen the chance of misinterpretation. Journaling was used to record insights during the research process. Participants were provided with a tape of their original interview so they could listen to it and amend or expand their comments.

Four distinct themes emerged from LeVasseur's (2002) review: (a) helping a patient to connect and trust; (b) helping a patient get through a hard time; (c) helping a patient see new possibilities, and; (d) helping a patient change and take charge. LeVasseur's findings suggested that the art of nursing is based upon a deep regard for the patient's experience of illness. For the patient, it was not just to survive the illness, but to transcend it. According to LeVasseur, if one can clearly define what it is that nurses achieve with patients from their experiences, it will be more likely that agencies and institutions will begin to value these achievements as significant health care outcomes.

Skei (2008) relied on Ricoeur's theory of interpretation to elicit meaning from registered nurses' lived experiences in their professional collaboration with orthopedic surgeons. Skei's study is particularly relevant because it applies hermeneutical phenomenology to explore the topic of collaboration that, aside from being proposed for this research, has seldom been done. The background suggested for the study centered the challenges of interprofessional collaboration between registered nurses and orthopedic surgeons; the conflict between reality and what theories on collaboration suggest; and, the lack of available research on lived experience in these settings. Narrative interviews were conducted with five registered nurses from two different acute care settings.

In conducting the analysis, Skei (2008) incorporated all three of Riceour's methodological steps. The author read the text several times and kept a record of her impressions. The text was divided into parts and compared to the impressions acquired from the first reading. Units of meaning were condensed into five themes that conveyed the meaning of the lived experience. The five themes to emerge were:

(a) disparate expectations and priorities, (b) feeling emotionally burdened, (c) keeping a distance, (d) accepting difficult relations, and (e) being confident in difficult relations.

Skei (2008) verified that comprehensive understanding was sought when the original text was re-read. Skei also relied on relevant literature for the analysis. The results of Skei's study showed that registered nurses expressed and emphasized disparate expectations and priorities when describing collaboration. Collaboration was perceived by the nurses as challenging from the perspective of relations with the surgeons. Skei concluded that the findings from the study provided useful insights for all healthcare workers for improving collaboration with colleagues, and that these improvements were necessary for enhancing patient care.

Heidegger's meaning of the term "life world" implies that the realities that individuals express are influenced by the world in which they live, just as the term "being-in-the-world" emphasizes that humans cannot remove themselves from the world (Lopez & Willis, 2004). It is everyday experiences as manifested from individual narratives that are the focus of hermeneutic inquiry. This is in contrast to the pure content of human subjectivity inherent in descriptive phenomenology.

There are two other important concepts that are associated with the hermeneutic approach to inquiry. The first is the concept of situated freedom (Lopez & Willis, 2004). Situated freedom postulates that there is a connection between subjective experiences and the social, cultural, and political contexts that mark existence. According to Lopez and Willis, "situated freedom is an existential phenomenological concept that means that individuals are free to make choices, but their freedom is not absolute; it is circumscribed by the specific conditions of their daily lives" (p. 729).

This notion lies in direct opposition to descriptive phenomenology and the belief that individuals, as free agents themselves, bear full responsibility for influencing their environment and culture (Lopez & Willis).

The second concept associated with the hermeneutic approach to inquiry is co-constitutionality (Koch, 1995). It is here that the act of interpretation in interpretative research is tied to separate and intersecting horizons of human beings (Geanellos, 2000). As a result, meaning is a blend of articulations by both the researcher and the participant. The integral role of the researcher is to serve as a guide in the inquiry.

Contributors to the interpretive approach to phenomenology, such as Heidegger, are opposed to the idea of bracketing as it is impossible to suspend one's assumptions and background of understanding that has led the researcher to consider a topic worthy of research in the first place (Koch, 1995; Lopez & Willis, 2004). It is permissible to have the researcher's knowledge of the relevant literature relied upon for the purposes of recognizing that certain topics require further exploration.

Rationale for the Use of Hermeneutic Phenomenological Methods

After consideration of the various approaches, phenomenological interpretive (hermeneutic) methods were used to explore the interactional determinants of collaboration with participants. The underlying basis for my selection was because the incorporation of interpretive methods encourages the researcher to go beyond the description of core concepts and essences to look for meaning embedded within common life practices (Lopez & Willis, 2004). As a result, mere descriptions of collaboration and associated concepts are transcended, and meaning that is rich and

deep in the context of human experience is achieved (Lopez & Willis).

The literature clearly shows that collaboration can be influenced by a number of determinants existing within or outside the organizational setting. The hermeneutic approach to inquiry, and specifically the concept of situated freedom, suggests that a connection exists between the participants' subjective experiences and the social, cultural, and political contexts that mark their existence. As such, the possibility of there being findings that connect some determinants of collaboration with others should not be discounted. It is important that all possible outcomes be considered and not viewed as separate from the inquiry.

The Setting: A Multidisciplinary Community-Based Program for Seniors

The setting, which will be referred hereafter as the Program, involved a groundbreaking new health care program specializing in community-based geriatric care. The Program has been in operation in Winnipeg, Manitoba for the past two years. The Program offers a range of services for elderly clients in the community. The Program consist of four core components: the day centre, the health clinic, after hours and weekend support, and access to inpatient admissions. Its aim is to assist those who require long term support to stay in the community as long as possible.

A case-managed integrated community care approach is utilized by a collaborative team of interdisciplinary health care providers from specializations in pharmacy, social work, dietetics, medicine, nursing, physiotherapy, and occupational therapy. These health care professionals work closely with the clients, their family members, and each other, to provide primary care, personal care,

socialization, rehabilitation, and respite services under one umbrella of care. Seniors have the option of attending the Program several times a week to receive assistance for helping them maintain and/or improve their health and functional status to delay or prevent unnecessary hospitalization or personal care home placement.

The Sample and Criteria

A convenient purposeful sample design was used for this study. Inclusion of participants was based on the following criteria:

i) Participants were accessible given their geographical proximity to the location of the research;

ii) Participants were practicing health care professionals. They were expected to provide an integrative and collaborative approach in the delivery of care to promote the health and well being of the elderly who were clients of the Program;

iii) Participants were representative of a cross section of health care disciplines that included pharmacy, social work, dietary, medicine, nursing, physiotherapy, and occupational therapy;

iv) Participants were heterogeneous in age, gender, profession, and years of experience in health care.

The Program is comprised of approximately 20 employees, 12 of whom are practicing health care professionals, while the remaining staff provides supportive services such as health care aide, reception, and housekeeping. While it was apparent that the contributions of the support service employees were valuable and aided in the day-to-day functioning of the Program, it was necessary for this inquiry to

include only those individuals with a clearly defined professional mandate, and whose responsibilities and expectations involved being an interdisciplinary team member and health care provider. The number of individuals who participated in the study as well as the characteristics of the sample are presented in the results section, in Chapter 4.

Ethical Considerations

An application to the Education/Nursing Research Ethics Board (ENREB) at the University of Manitoba was submitted in October, 2010. The Board's approval was received in early November, 2010. A copy of the approval letter is available in Appendix B. Permission to conduct the research at the health care facility was granted in early December, 2010. This step was necessary for obtaining access to the site and the employees of the Program before commencing the study. The Program and its employees had no prior direct association with the researcher. The researcher is not an employee of the study site.

Written informed consent was obtained from participants freely and willingly, without bias or coercion. A copy of the Research Subject Information and Consent Form Informed is available in Appendix C. During the consent process, participants were advised that they could withdraw their participation at anytime without penalty. In that case, their data would not be used. They were assured at the outset that the information they provided from the interviews would be kept confidential, and their identity would not be linked directly to the data obtained, or revealed in publications and presentations of the research. Reassurance was required for preservation of confidentiality on two additional occasions, for two separate participants, after they

had the opportunity to review their individual transcripts and contacted me with concerns that their comments would reveal their identity.

Procedures for Data Collection

Health care professionals of the Program were given information about the study in a letter of invitation distributed to them by the Program Manager (see Appendix D). The purpose of the letter of invitation was to provide the Program Manager with a script containing introductory information about the study to share with members of the Program. Members of the Program were given a copy of the letter as it contained a brief description of the study without being too lengthy. Incorporation of this approach also eliminated the potential for bias due to self-selection of the sample and appeared less coercive because the researcher was not approaching potential participants directly. My contact information was provided in the letter with instructions to contact me directly if candidates were willing and interested in proceeding with the next steps.

Since it was essential that sufficient time be allowed for decision-making regarding participation in the study, a copy of the Research Subject Information and Consent Form was also provided to candidates by the Program Manager. The advantage of providing potential participants with the Research Subject Information and Consent Form was that it thoroughly described the study and the requirements. With distribution of these documents, members of the Program were advised by the Program Manager to contact me directly, either by email or telephone, if they were interested in proceeding with the next steps. They were also advised by the Program Manager that anyone who wanted to participate in the study could be interviewed

during their daytime work schedule. The only caveat with this option required me to be mindful that participants had to return to their busy practice and, thus, it was important to finish the interview in a timely fashion.

Although participants identified themselves by name to me, they were each assigned an identification number to preserve their anonymity. Upon receiving notification from potential participants of their interest in the study, I advised the participants that participating in an interview would take approximately 60 minutes, and that each interview would be audio-taped to facilitate the analysis. With an indication of the participant's agreement to proceed with the study, I asked each participant to select a time and a quiet location to conduct the interview. I believed that allowing the participant to choose the setting offered the best opportunity for inducing feelings of relaxation and comfort which were essential for creating a climate that was permissive for self reflection. I was given an interview room on the premises of the institution away from the Program, and this proved to be the most convenient location for the participants. While most of the interviews occurred on the institution's premises, one participant opted to be interviewed offsite.

I chose to conduct face-to-face interviews with the participants for a number of reasons. In Seymour's (2001) discussion of the use of online techniques of qualitative data collection, she maintains that for most researchers, "the face-to-face interview is seen as the optimal way to actively engage with the research subject in a manner that maximizes the efficacy and equality of the data collecting enterprise" (p.188). Linseth and Norberg (2004) believe that interviews are most helpful to capture the lived experiences of the participants. What Dutton (2003) suggests from her discussion is that, as listeners, we are connected to the basic human experience of

social life.

Prior to the commencement of the interview, I reviewed the essential features of the consent form and obtained written informed consent from each participant. The essential features included a review of the purposes of the research and the procedures involved; a reminder that the interview would be recorded for the purposes of conducting the analysis; a review of the processes to ensure confidentiality; and, further reassurances of the participants' right to not proceed or withdraw at anytime without penalty. Participants were also advised that no form of monetary remuneration or reward would be provided. A copy of the participant's signed consent form was enclosed and sent out with the copy of the participant's transcript.

Upon commencement and throughout the interview, participants were encouraged to freely engage in self reflection. To acquire a description of the essential meaning of collaboration, the following questions helped guide the exploration with participants: i) Why is collaboration "in vogue," and what are its ostensible purposes and goals? ii) How have health care professionals responded and reacted to the current emphasis placed on collaboration? iii) What are your (i.e. the participants) impressions of successes, failures, barriers, and problems with collaborative efforts? iv) How might health care professionals better prepare themselves and others to work together and to enhance collaboration?

To achieve a detailed description of the interactional nature of collaboration, participants were asked the following questions: v) What are the dynamics that most often occur among or between health care professionals in their collaborations? vi) How do the interactional dynamics and their influences affect achieving the

outcomes of collaboration? vii) What interpersonal attributes or processes are necessary to for health care professionals to successfully collaborate? viii) How can collaborators best achieve the formation of common vision among the collective for their collaborative initiative?

During the interview, I used the techniques of clarification, requests for examples, and more description when it was necessary to do so. An interview guide was used for each interview to ensure that I had addressed all of the research questions. A copy of the interview guide is available in Appendix E. I included various prompts to help facilitate the interviewing process. When no further clarification was required, the interview was concluded. I thanked each participant for their time and contribution toward the inquiry. They were advised that they would receive a summary of the findings upon completion of the study.

Data Analysis

The procedural steps outlined from Ricoeur's interpretative hermeneutic methodology, such as naïve reading, structural analysis, and comprehensive understanding (as cited in Linseth & Norberg, 2004) were followed for analysis of the data. The first step, naïve reading, required that the text from each participant's transcript was read several times to grasp its meaning as a whole. The text was read with an open mind so that participants' perspectives could be understood on their own terms (Gilgun, 2006). Completion of this initial step was necessary before moving on to the second step of the process which was the structural analysis.

The structural analysis formed the basis of the interpretation. Units of meaning

derived from the text were developed, read through, and condensed into clusters from which themes emerged as objectively as possible (Linseth & Norberg, 2004). This process was repeated until naive understanding was validated through the structural analysis. A total of six themes emerged from the analysis. The themes were summarized and then reflected upon in relation to the research and the context of the study, as recommended by Linseth and Norberg.

Comprehensive understanding was achieved by reading the entire transcript again while keeping the validated themes in mind. This process required that the text be embraced with an open mind as suggested by Linseth and Norberg (2004). Returning to the relevant literature, especially that which was summarized in the thesis proposal, was helpful for facilitating an understanding of the text. According to Linseth and Norberg, "we do not force the literature's perspective on the interview text but let the chosen literature illuminate the interview text and interview text illuminate the chosen literature" (p. 151). The results from application of the procedures for analysis are best reflected in the subsequent Chapters 4 and 5.

Chapter 4 is dedicated to a portrayal of the participants' perceptions of their lived experience of collaboration. Significant statements were extracted from the participants' transcripts. Tables and figures were used to illustrate and summarize the significant meaning units and formulated meanings. Formulated meanings were then arranged into clusters which allowed the emergence and presentation of the themes common to all of the participants' transcripts.

In Chapter 5, I explore the participants' perceptions of collaboration and the common themes for a comprehensive understanding of the phenomenon of collaboration. The findings, or expressed perceptions of the participants still remain

at the core, but the discussion also takes into account my co-constitutional perspective and the occasional reference back to the literature. Accompanying the discussion are the various implications for future research, practice and education, as well as inclusion of the recommendations.

Soundness of Qualitative Research

Numerous criteria exist for establishing the soundness of qualitative research. Consequently, decisions had to be made among a vast array of approaches that have been offered by a host of authors with their stances and debates over issues such as validation, reliability, and standards of quality in qualitative research. In other words, there is not a single approach that can be used as the "gold standard". It is up to the researcher to decide which strategies are the most appropriate for the research, the type of methods used, and then ensure that they are articulated in the discussion. What follows, is a discussion of the measures I incorporated for ensuring the soundness of the research.

For ensuring rigor, which encompasses both reliability and validity of the research according to Davies and Dodd (2002), it was essential that strategies be built into the qualitative research process itself. According to Morse et al., (2002) an iterative process is more favourable that a linear process, whereby "the researcher moves back and forth between design and implementation to ensure congruence among question formulation, literature, data collection strategies, and analysis" (p. 10). This study was conducted using an iterative process, and I found it to be very helpful. Working back and forth between the analytic procedures, which are encouraged by Linseth and Norberg (2004) for achieving accurate results with

phenomenological analysis, was particularly useful. Resources to facilitate incorporation of the iterative process were to have the research proposal available for reference and to keep an account of the various stages of the research via journaling.

My engagement in journaling chronicled a personal progression of self expression throughout the research process and my interactions with participants. My reflections, together with those of the participants, resulted in research that was co-constitutional. Additionally, journaling, as suggested by Creswell (2007), enhances reliability because the researcher's experience of events as they occur during the research process produces a viable audit trail. But even more than providing an audit trail, journaling accounts for the decisions made during the research and, thus, they are made more transparent (Morse, Barrett, Mayan, Olson, & Spiers, 2002).

The strategy I incorporated is referred to as the "salience hierarchy" by Wolfinger (2002) in his discussion on taking field notes "to which researchers record their most interesting and the most telling observations that they find the most noteworthy" (p. 89). Using this strategy was not to adhere to a comprehensive and systematically proposed outline of documentation, or to analyze my reflections. Rather, my journal was written as an open expression of my views and experiences as they occurred during the various stages of the research. As the research process spanned numerous months, I found it helpful to return to my earlier reflections as the research progressed. I shall expand further how important this approach was for promoting soundness of the research.

Some authors, such as Davies and Dodd (2002) suggest that rules and standards applied with the use of rigor to the research process should be replaced with reflection and reflexivity. Reflection is the beginning aspect of self-awareness where

values, preconceptions, and behavior of the researcher help in determining how the researcher is positioned in the research (Jootun, McGee, & Marland, 2009). Reflexivity for the researcher is being responsive to how the subjective and inter-subjective elements influence data collection and analysis (Finlay, 2002). Together, they help remind the researcher to keep an open mind and avoid personal conjectures that can lead to narrow-mindedness and biases when conducting the analysis (Linseth & Norberg, 2004). Consequently, journaling provided an excellent platform for exercising reflection and reflexivity since I was able to re-visit my entries at anytime during the research process. In an effort to preserve the confidentiality of the participants, I felt it was necessary to keep it apart from the documents included in the thesis.

The parallel term more frequently used for attending to the more traditional form of rigor that many qualitative researchers have relied upon for content analysis, is Guba and Lincoln's (as cited in Morse et al., 2002) "trustworthiness", and the associated criteria consisting of credibility, transferability, dependability, and confirmability. These concepts and the strategies I employed are described as follows.

Credibility pertains to how well the data and processes used for the analysis address the intended aims of the research (Graneheim & Lundman, 2004) and whether the results are an accurate representation of the participants' views (Creswell, 2007). It begins with selecting the most appropriate method for the data collection, and then applying the best techniques possible for conducting the analysis, such as: finding the most suitable meaning unit; ensuring that the themes adequately reflect the data; and, judging the similarities and differences among the

categories or sub-themes (Graneheim & Lundman). The methods for data collection and the procedures for conducting the analysis, as proposed prior to the conduct of the study, were followed. The outcomes addressed the intended aims of the research, thereby addressing the issue of credibility.

The strategies used for ensuring an accurate representation of the participants' views was having participants review their transcripts to confirm or correct the data. Incorporation of this strategy helped to avoid misinterpretations and inaccurate results (Graneheim & Lundman, 2004). The raw data recorded from the interviews were transcribed verbatim. A copy of the transcript was sent in confidence to each participant with a written invitation to review the data and ensure that it accurately reflected his or her experiences. Each participant was encouraged to contact me if they wanted to provide input for changes they thought were necessary. Interestingly, only one participant contacted me to request that a few words be changed in the transcript. Participants were given the opportunity to corroborate his or her transcript before I embarked on the analytic procedures.

Transferability is a form of external validity for determining whether the findings can be applicable to similar settings or groups (Graneheim & Lundman, 2004**;** Rolfe, 2006). To ensure that the findings are transferable between the researcher and the participants, Creswell (2007) advises that "a thick description is necessary" (p. 204), a concept pertaining to thick description which originated with the notable anthropologist Clifford Geertz (1973). To achieve this, it was essential to provide a detailed account of the data collection procedures and the processes used in the analysis as described in this chapter. Additionally, a clear description of the characteristics of the participants and the use of quotations to substantiate a

discussion of the findings can be found in the next chapter.

Applying the concept of dependability, which is comparable to reliability (Rolfe, 2006), is to achieve stability for the duration of the study, and mitigate the risk of inconsistencies during data collection (Graneheim & Lundman, 2004; Meadows, 2003). Dependability was achieved given the range and relevance of research questions that were compatible with the study design. Having an interview guide available to follow was helpful for ensuring that all of the topics were addressed with each participant. Data collection occurred with a full range of participants and times, although the setting remained consistent.

Confirmability was achieved with the value of the data obtained (Creswell, 2007) and by ensuring that the data were free as possible of my unacknowledged biases (Meadows, 2003). While I concur with Morse et al.'s (2002) assertion that confirmability is challenging to achieve with some forms of qualitative methods such as phenomenology "where the researcher's experience becomes part of the data, and which perceptions of reality are dynamic and changing" (p. 14), having clearly delineated methods and procedures that have been followed aided me in achieving confirmability.

In judging the quality of a phenomenological study, Creswell (2007) suggests five questions for researchers as follows: i) Does the researcher convey an understanding of the philosophical tenets of phenomenology? ii) Does the researcher have a clear "phenomenon" to study that is articulated in a concise way? iii) Does the researcher use procedures of data analysis in phenomenology? iv) Does the researcher convey the overall essence of the experience of the participants? and, v) Is the researcher reflexive throughout the study? (p. 216). In response to these questions, I have

conveyed an understanding of the philosophical tenets of phenomenology. I have offered an explanation of how collaboration fits the criteria of a phenomenon. The procedures used in the analysis of the data were discussed as well as the strategies used to promote soundness of the research. Finally, I have discussed the importance of reflexivity and have done my very best to be reflexive throughout the study. The phenomenon of collaboration, as conveyed by the participants, is presented in the next chapter.

Chapter IV: Findings

Introduction

The purpose of the study was to gain an understanding of collaboration from the lived experience of health care professionals in a community-based geriatric care setting. The primary research question proposed for exploration was: What was the essential meaning of collaboration for health care professionals? This was followed by: What underlying meanings do collaborators assign to the interactional nature of collaboration? A description of the sample, followed by the participants' description of the Program is presented first.

Description of the Sample

The recruitment phase of the study was initiated over a 2-month period, yielding a sample of 11 health care professionals from 12 possible candidates. Of the 11 individuals who participated, one participant was lost to follow-up after leaving her position in the Program. Under this circumstance, the participant was withdrawn from the study and the data obtained from the interview were not included in the analysis. Consequently, data obtained from 10 participants who participated in the study were used for the analysis.

Characteristics of the sample were obtained from a self-reported description at the beginning of the interview. Nine participants were women, and one participant was male. Participants ranged in age, from 25 to 55 years. The various health care disciplines were well represented with participants having specializations in pharmacy (one), social work (two), dietetics (one), medicine (one), nursing (three), physiotherapy (one), and occupational therapy (one). All of the participants had

undergraduate degrees in their respective disciplines. Two participants had achieved graduate level education. All of the participants had prior work experience before joining the Program, although the number of years and type of employment was varied and dependent on age. For example, participants who were older in age had more varied work experience than those who were younger with a few years of work experience.

A total of eight participants had started in the Program when it was initiated, approximately two years ago. Six participants were employed on a full-time basis, while four participants were employed on a part-time basis. Four participants were assigned a dual role consisting of case manager, which required coordination of care for an assigned number of clients; and, health care provides, providing consultation to clients on a referral basis as a health care provider in a specialized area of health care practice. Five participants worked primarily in their specialized area of health care practice and provided consultation to clients on a referral basis. One participant was involved in the administration of the Program. Overall, the Program was an excellent model of health care and collaboration with a diverse sample of health care professionals engaged in interprofessional practice.

Meaning of the Program for the Participants

Participants were asked to describe the Program and what working in the Program meant to them. The Program was viewed as a good interprofessional opportunity to get to know the other disciplines, and a great learning opportunity for their clinical acumen because of the complexity of health needs surrounding the clients. The elderly clients who attended the Program were frail with multiple health issues.

Often, they were at the cusp of either, being well enough to remain in their homes with assistance from family members and external resources such as Home Care, or at the level of requiring institutionalization in a hospital or care home.

The Program was described by participants as clinically challenging since it required significant multi-tasking in the work day, especially for those in the combined roles of case manager and health care provider. And, although the care needs of the clients in the Program were significant since the clients were elderly and had multiple systemic issues, participants described their work as being very rewarding. The rewards came from a strong belief that their care enriched the lives of the clients and their families. Often the rewards came from the gratitude expressed to them from the clients. One participant's appreciation was expressed as follows:

> The clients here are so grateful. Their care is beyond what you could possibly imagine anywhere else and it's just a struggle to live at home, and that's the priority for the clients that come here. To have a place to help them do that and to help their caregivers help them live at home, like it's a privilege in that way too. (participant 02)

Participants' saw their roles as being meaningful since they were caring for the needs of the clients who had reached a significant health stage in their lives. They believed their greatest contribution was caring for the clients in the Program and helping clients remain independent as long as possible so they could remain in their homes. Their contribution to the overall health system was to lessen hospital visits, which reduced costs, while promoting continuity of care, and preventing clients from falling through the "cracks" in the health care system.

The remainder of the chapter is a presentation of the findings. A total of six major themes were identified from the descriptions participants provided when they were asked to describe the essential meaning of collaboration from their experiences of interprofessional practice in a community-based geriatric care setting. The themes are summarized and presented as follows: Engaging in collective thinking and action to produce best outcomes and optimize clients' health; responding to collaboration for self and others in the Program as a continued work in progress; experiencing the personal and professional rewards as markers of success with collaboration; existing challenges create barriers that impede collaboration; experiencing the interactional dynamics and their influences requires the interpersonal attributes of quality communication, openness, trust, and respect, and; forming a common vision is necessary for collaboration but difficult to achieve.

Engaging in Collective Thinking and Action to Produce Best Outcomes and Optimize Clients' Health

There was overwhelming agreement from participants that collaboration was indeed 'in vogue' or popular in health care. Responses centered largely on emphasizing the differences between practicing with autonomy instead of collectivism, and particularly, the belief that the needs of many of these clients cannot be met by a single discipline alone. Given the complexities of health care in the current environment, more input from the various health care professions was required to resolve complex health care issues for clients. There was also recognition of the limitations that can occur when there was reliance on a single discipline:

> Well I think, I think, we're beginning to recognize how complicated health care is. Like, it's not just – here we're dealing with the whole person and the family and what not. But even if – I know they're taking the concept of collaborative care into something like a single disease entity like diabetes for example, so I think we as in health care are beginning to recognize how complicated and multi-factorial anything to do with health care is, be it wound care, or diabetes, or kind of the whole bio-psycho-social picture that we're looking at here. And, I think, recognizing that different - not just one discipline can know everything there is to know about whatever that complicated, um, client population or issue is. (participant 02)

The notion of practicing as a collective was perceived more favourably than working in isolation or engaging in autonomous practice:

> Most people for the most part want to work well together I think, and their intent is for anybody who is professional, wants to do the best job for the client. (participant 09)

Another participant shared her views as follows:

> Probably what's been figured out is that when you've got potentially a group of professionals, and they're all working independently, they're not working towards the common goal, so somebody figured out along the way that was not a productive way to achieve a goal, to not collaborate: that we needed to somehow get together if we're going to try and solve a problem. (participant 07)

A schematic affirming the popularity of collaboration given the various responses from the participants are outlined in Figure 1.

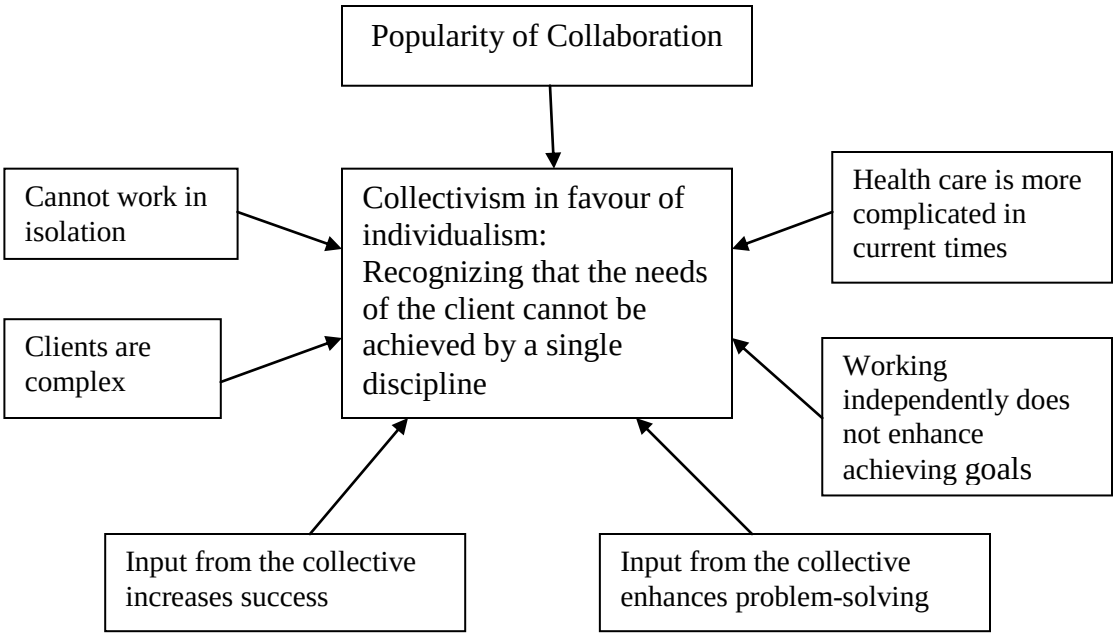

FIGURE 1: Schematic representation for popularity of collaboration

To gain an understanding of collaboration, participants were asked to draw from their experiences and describe the meaning of collaboration, its purpose and aims. Collaboration was emphasized by the majority of participants as being a collective undertaking, requiring both thinking and action behaviours. Much of the thinking activities had to do with contemplation about client issues when participants were in a group setting. Examples of captured meaning units (Creswell, 2007) expressed by participants to describe the thinking activities were engaging in brain-storming together, participating in decision-making as a team, and sharing opinions and ideas. The thinking component was nicely illustrated by one participant as follows:

> Each provider has their specialty and the area in which they work. So, what we need to do is first think of the person, who is the object of all that attention of all the care, and think what is best for that individual and then put all the heads together and come up with – it doesn't matter which person the idea is coming from or the goal is coming from, that's really irrelevant – it's just putting the thoughts together to come up with the most suitable, or most appropriate action, or intervention for that person. (participant 05)

Another participant added:

> The good part of collaboration, of course, is that you do get different input and when you sit around and you're discussing it, patient care, it opens up other ideas to you, or other points of view. (participant 09)

The action component was described most often as engaging in collective action to complete the care of the client. Examples of captured meaning units used to describe action was in terms of working together, working as a team, and achieving common goals. Collaboration, for participants, was perceived as being a collective

undertaking which involved all members of the Program. Collectivism was viewed as an essential ingredient for undertaking both the thinking and action behaviours of collaboration. One participant illustrated with the following example:

> I think collaboration is when you discuss ideas, clients, problem-solve, brainstorm, and develop a care plan so that there is just not one person who's deciding or making decisions about a client. It's that there is a whole team of people making decisions for a client or coming up with recommendations for a client. (participant 04)

Another participant added:

> To me, I guess it's identifying a problem or an issue, might be a better word, and drawing on not just one person's opinion of what should be done or not done about the particular issue but drawing on different people's perspectives and experiences to address the particular issue. (participant 02)

The purpose of collaboration, for the majority of participants in the Program, was to produce the best outcomes for the clients. Participants strongly believed that the client should be the main focus of their practice. One participant expressed placing the client at the forefront as follows:

> Well, I think essentially to me, everything should be client-focused, not what we think or we think we know what is, I guess, based on our experience, based on whatever we're practicing from. (participant 08)

Placing the client at the forefront was described by another participant. In this example, the issue of ownership was not a priority. Rather, the intent was to find the best options for the client:

> What I think it is? I'll try to be practical, so we have an individual who is

> receiving care from multiple providers even under one roof - multiple providers. And, each provider has their specialty and the area in which we work. So, what we need to do is first think of the person who is the object of all that attention, of all the care, and think what is best for that individual, and then put all the heads together and come up with – it doesn't matter which person the idea is coming from, or the goal is coming from, that's really irrelevant – it's just putting the thoughts and the resources together to come up with the most suitable or most appropriate action or intervention for that person. (participant 05)

The overriding goal was to optimize health and wellness for the clients. This response was consistently observed when participants were asked to respond to questions surrounding the purpose and the goal of collaboration:

> [The purpose of collaboration is] to provide the best outcome for the clients. To help them reach the best potential that they can achieve at this stage in their lives. That there are team members taking a holistic approach to a client's care. Everybody adds something to the benefit of the client, to reach the best outcomes they can for our clients. (participant 01)

Another participant's view of collaboration and its intended purpose was described as follows:

> Collaboration is that it involves discussion, it involves knowing that maybe we're both not going to have the same opinion. We don't have to walk away agreeing, you know, but the bottom line is, okay so what's in the best interest of the client? (participant 08)

Optimizing health and wellness for the clients was to enable clients to remain in

their homes, thereby reducing the need for hospitalization and utilization of hospital resources:

> I believe that the overall goal of collaboration is to optimize the client's experience while being involved with [the Program]. Uh, and that can take the form of optimizing their health, optimizing their wellness, hopefully potentially reducing their requirements for other health resources, i.e., reducing their need for having to go to the emergency department, the hospital. (participant 10)

Another participant added:

> I think in theory yes, like I think we could say our goal is to help people stay at home, support their families, and facilitate their transition to personal care homes so they don't have to go into an emergency personal care home - these sorts of things. (participant 02)

The meaning units and formulated meaning were used to arrive at the common theme for the meaning of collaboration: Engaging in collective thinking and action to produce the best outcomes and optimize clients' health, are presented in Table 1.

Responding to Collaboration for Self and Others in the Program as a Continued Work in Progress

To gain a sense of how health care professionals have responded to collaboration, participants were asked to share their views on the topic in general, those specific to their Program, and on a personal level. Their general perceptions of collaboration were that it was appealing in a broad sense. Participants could justify why they believed it was important to health care. Most health care providers did not work in

Table 1 Meaning units and formulated meaning representing the common theme: Engaging in collective thinking and action to produce best outcomes and optimize clients' health

Meaning Units	Formulated meaning
Discussing ideas Problem-solving Brain-storming together Decision-making as a team Sharing opinions and ideas Finding the best approach together Understanding what the other professions do	Engaging in collective thinking
Working together Achieving common goals Promoting a holistic approach to care Working as a team Teaching others something they didn't know	Taking collective action
Finding the best outcomes for the client Improving patient outcomes Serving the clients Acting on the best interests for the client	Producing the best outcomes for the client
Meeting clients' needs Improving care Improving outcomes Taking a holistic approach to care Implementing a client-centered approach Determining what's best/best answer for the client Optimizing the client's experience in the Program Optimizing health and wellness Keeping clients in their home Preventing the need for additional resources such as hospitalization	Optimizing health and wellness for the client

isolation; there was strong emphasis in the current health care system to be team players, and collaboration was viewed as an opportunity to have their voices heard. Participants' perceptions of health care professionals who have responded well to collaboration were more closely aligned with health care providers from the allied health professions, and especially those with a background in the specialty of geriatrics and those with positive past experiences of collaborative practice. The following example, drawn from one participant's interview text, illustrated the significance of collaboration in the specialty of geriatrics:

> I think it's just always been the way that it has been in geriatrics. Typically geriatric clients have a multitude of professionals involved, right? You've seen OT, you've seen physio, you need to see the speech therapist, and the pharmacist is involved. You've got a lot of people involved and I think it's just the norm that you come together to work together. Um, I think, you know, younger adults - you go see your family doctor and you might go to physio but there's really not a huge team involved. So, I think geriatrics has had to come together because there is a big team. That's the only way it would work. If we're all doing our own thing here, there, and everywhere, it wouldn't work for the client. Nor would it would work for us. We'd be duplicating or, um, whatever, working against each other so I think that geriatrics has learned to come together. (participant 04)

Participants also expressed a number of different issues pertaining to how well health care professionals have responded to collaboration in general. Many health care providers are still not interested in collaborating, thus making collaboration difficult or impossible to achieve. Collaboration for some required making changes,

especially if they wanted to improve their interactions with others, and some people do not like to change. There was also the issue of the predominantly existing hierarchy in the health care system, where the medical model still dominates. Physicians were situated at the top of the hierarchy and, as such, they are the individuals who made the decisions for the care of the client. Finally, participants believed that there was a lack of understanding of collaboration among health care professionals, even when they actually believed they were collaborating with a team:

> I think everybody likes the idea of collaborating. Whether it's actually put into practice I don't - I think people think, oh yeah, I'm collaborating with the team, but I don't think people really understand the concept of what collaboration really is. People see it as talking face to face at a meeting, or some people think it's really just a discussion, so yeah, people like the idea of it but I don't think people are actually getting it. (participant 03)

Another participant identified a number of the issues with this response:

> For those who are aware of it, I think a lot of them think that they probably are working in a collaborative manner. Whether it is or not, that question probably remains to be answered. So you have that group who think they are but they're not, and then you have the other group which probably thinks they are and are practicing collaboratively. So, um, some people they like the idea and some people don't particularly like working collaboratively. Um, there is still that thought out there both, from the public, and from within the health sector who feel, and I'm not sure what the percentage is, who feel that, um, you know that medical model where the physician dictates what should happen. (participant 05)

Collaboration was also considered to be dependent on whether individuals possessed certain characteristics related to personality and work style. While some individuals possessed the type of personality that was conducive for positive collaboration, and their work style exhibited a positive approach to collaboration, others simply did not possess similar characteristics in their personality and in their ability to collaborate with others. One participant made the distinction between an individual's ability to collaborate and work style as follows:

> I don't think everyone is meant to work within a team. Only certain people can. They may work better, you know, in their own setting where they do, you know, their own thing. But I think you have to want to work within a team. (participant 03)

The issues surrounding health care professionals' response to collaboration in general, according to the perceptions of the participants, are summarized in Table 2.

Participants' perceptions of themselves and how the other members of the Program have responded to collaboration were expressed as a "continued work in progress". Often, these views were expressed with the acknowledgment that the Program and its members were still relatively new; the Program having only been in operation for the past two years. Also accompanying the perceptions of collaboration as a continued work in progress was the expressed desire to want to improve their collaborations with the other members of the Program. However, to achieve better relations with the other members required that certain realities had be dealt with and eventually overcome. They believed that building a collaborative with the other members of the Program required more time. More time was needed to get to know the other members on a personal level to gain an understanding of what they

Table 2 Issues for health care professionals' response to collaboration in general

i) Some health care providers are still not interested in collaborating making collaboration difficult or impossible to achieve

ii) Collaboration requires making changes and people do not like to change

iii) The overriding medical model prevails where physicians remain at the top of the hierarchy

iv) Health care providers think they are collaborating but they are not

v) Collaboration is dependent on factors such as personality and work style

could offer in terms of their competencies as health providers from their respective disciplines:

> It doesn't happen just like that. You don't build a collaborative – no, it takes time. You have to get to know the other team members. You have to get to know what they have to bring to the table. (participant 05)

Some participants expressed optimism that their collaborations with the other members would improve as the Program and its members continued to evolve:

> I think from my perspective that the collaboration seems to be moving in a continued upward progressive fashion. Um, initially there's issues of trust, issues of competency, understanding what each other's competencies are, what each other's skill sets are. And you really don't know that until you work with somebody for awhile, and you kind of see how they react to the situations and react to the problems. What's their work ethic, you know, what's their conscientious factor - diligence, thoroughness, attention to detail, all of those things. You don't just wake up and start a program and say we're high functioning collaborators. So I think collaboration is still a work in progress, and it will continue to evolve. (participant 10)

In some instances, there were more cautionary views, given the participants' perceptions of how the other members had approached their collaborations. And yet they, too, were optimistic that collaboration would evolve with continued growth of the Program. Table 3 summarizes the statements of meaning (Del Barrio et al., 2004) for the common theme for responding to collaboration for self and others in the Program as a continued work in progress.

Table 3 Statements of meaning included the common theme: Responding to collaboration for self and others in the Program as a continued work in progress

Response: Self	*Response: Others in the Program*
Always seeking input from others	Some are more approachable than others
Needed for problem-solving	Dependent on past work experience
More time needed to work with people	Dependent on personality
Desire to work more collaboratively	Some just prefer not to do it
Enjoys working with other disciplines	Nobody knows what they are supposed to do

Experiencing the Personal and Professional Rewards as Markers of Success with Collaboration

The first step for understanding what the meaning of successful collaboration was for participants was to confirm whether they had experienced successful collaboration with the other members of the Program. All participants were able to confirm that they had experienced what they perceived to be success with collaboration. When asked to provide an example of successful collaboration that included the other members of the Program, responses consistently followed the same sequence of events. The participant was confronted with a medical problem or issue with a client. To help resolve the issue, the participant collaborated with other health care professionals in the Program. Success was achieved when the issue was resolved, the client and family experienced some form of positive outcome, and the collaborators experienced a sense of mutual satisfaction from the experience.

Participants were then asked to identify the factors they believed had contributed to their experiences of success. The markers of success were consistent with having attained some form of reward. Various examples of rewards enabled clustering of the responses into categories representing personal rewards, professional rewards involving the team, and professional rewards involving the client.

Personal rewards were those that participants experienced for themselves when they achieved success such as increased confidence, motivation to carry on, job satisfaction, and a sense of purpose for their role. As one participant suggested:

> When you have successes, it improves your confidence, right? It improves your confidence and sort of gives you that little extra reason to go on. I guess it gives you a purpose, right? So, it sort of justifies why you are here.

(participant 05)

Achieving a sense of purpose was also expressed as feeling good about one's quality of work:

> So, what is the impact of success on me [*when I am able to successfully collaborate*]? It just makes me feel really good. It makes me feel really good about the quality of my work. When collaboration goes well, it makes me feel like I have done really good work. Like, my quality is up here, or it's not half-assed. (participant 07)

Another participant added:

> If you're improving the quality of life for the client and you're doing good for that client, it makes you want to do more good. So, if we're succeeding as health care providers, and that includes collaborating, to get that, to achieve that success, then it's a good thing. It makes you want to strive for more for these clients. When you feel successful, I think it just pushes you to do, to continue on, to achieve more and more because you're seeing success for these clients. Yeah, it makes me feel good that I've done something. It gives me job satisfaction, and I like coming to work in the morning. If I'm making somebody's life better and they're feeling better, what could be better than that? That's what we're here for. That's, that's, why we work here. That's what this program is all about. (participant 01)

Professional rewards involving the team encompassed markers of success for participants in relation to the other members of the Program such as receiving a consult, job recognition, job satisfaction, reaching consensus, and working well with others. Participants believed that all members of the collaboration benefited from

outcomes that were similar to their own:

> I think we're glad to see the same outcomes and meet the goals of the client. It gives good job satisfaction. I would say for sure. You enjoy coming to your job every day. You enjoy what you do. You know that you're helping people. (participant 03)

Professional rewards involving the client encompassed markers of success for participants in relation to the clients and their families such as making an impact, meeting goals, and keeping clients in the community. When success was achieved, everyone shared the experience of having achieved something meaningful for the client and the family:

> To see that hopefully the changes you are making for the person. Personally it makes you feel good because you've done something - something where you can kind of share a success with other people. (participant 09)

Success was manifest in the body language of others, in the appearance of being more at ease, and in their interactions with each other, as described by one participant:

> I think they would feel good about it, too. I don't know why they wouldn't - in people's body languages, in interactions with each other, it just seems, you know, easier. After we've had a good interaction, people seem more at ease or whatever. (participant 02)

Participants believed that more benefits for clients were achieved when more health care disciplines were involved in the delivery of care, than for those clients who had limited exposure to the various health care providers. Success for the clients, according to most participants, meant greater health benefits, improved

quality of life, and more positive outcomes for clients and their families. Success was manifest in the clients' gestures of appreciation, when participants' recommendations were acknowledged by the clients and their families, and when the recommendations were implemented by the clients and their families:

> So when they say thank you, when I know they're appreciative, when I know that they're trying to make changes, that is success for me. (participant 01)

Table 4 presents a summary of the statements of meaning included in the common theme identified as experiencing the personal and professional rewards as markers of success with collaboration.

Participants believed there were more opportunities available for health care professionals who were able to collaborate. Their responses spanned a number of categories pertaining to client, personal, professional, and the system. For the client, there was more likelihood of achieving health outcomes and improving the clients' quality of life. On a personal level, there was more opportunity for achieving personal job satisfaction and experiencing personal rewards such as increased confidence, motivation, and achieving a sense of purpose. From a professional standpoint, the ability to collaborate opened up more professional opportunities given the movement of health care towards more collaborative models. Having an ability to collaborate was perceived as having an advantage over others who were unable or unwilling to collaborate. This, in turn, was perceived as increasing professional job satisfaction. Finally, the benefits to the health care system were deemed to be saving money and preventing hospitalizations and premature institutionalization of the

Table 4 Statements of meaning in the common theme: Experiencing the personal and professional rewards as markers of success with collaboration

Success is:	
Experiencing job satisfaction	Personal rewards as markers of success
Experiencing increased motivation	
Feeling a sense of purpose	
Performing good quality work	
Feeling satisfied	
Achieving a goal	
Receiving a consult from others	Professional (team) rewards as markers of success
Receiving job recognition from others	
Feeling a part of the team	
Receiving positive feedback from others	
Reaching consensus with another	
Working well together as a team	
Making a positive impact on the client	Professional (client) rewards as markers of success
Meeting goals for the client and family	
Helping the clients and families	
Problem-solving for the client and family	
Working for the client	
Keeping clients in the community	

elderly. Figure 2 shows the categorical representation depicting the various opportunities for health care professionals as expressed from the participants.

Existing Challenges Create Barriers that Impede Collaboration

Despite participants' perceptions of success, there were numerous challenges that confronted them and created barriers for collaboration. Although they did not view the challenges they faced in their collaborations as failures *per se*, it was apparent that the challenges they had experienced created barriers for collaborating with other members of the Program. Since collaboration was viewed as an ongoing work in progress, participants believed that they had yet to smooth out many of the processes. Among the most notable, was the perception that the other members of the Program possessed differing beliefs about collaboration. These perceptions included different definitions of what collaboration meant, not understanding what collaboration meant, and unrealistic expectations of collaboration:

> Yes, I don't think we'll collaborate together because we don't think it's the same thing, right? So, if we don't think it's the same thing, I don't how we'll get on the same page, right? Um, and I don't know how you change that because it's hard to put collaboration into words, right? Because when we talk about what we see as collaboration, they're like, 'Well, it's sitting around, it's talking, it's discussing clients.' Well we do that but there's not that, having to put it into words, right? We do sit at a table and discuss clients but still yet, still there isn't collaboration. (participant 04)

Participants believed that some members of the Program expected collaboration to exist, but it when it did not meet their expectations, they became frustrated and

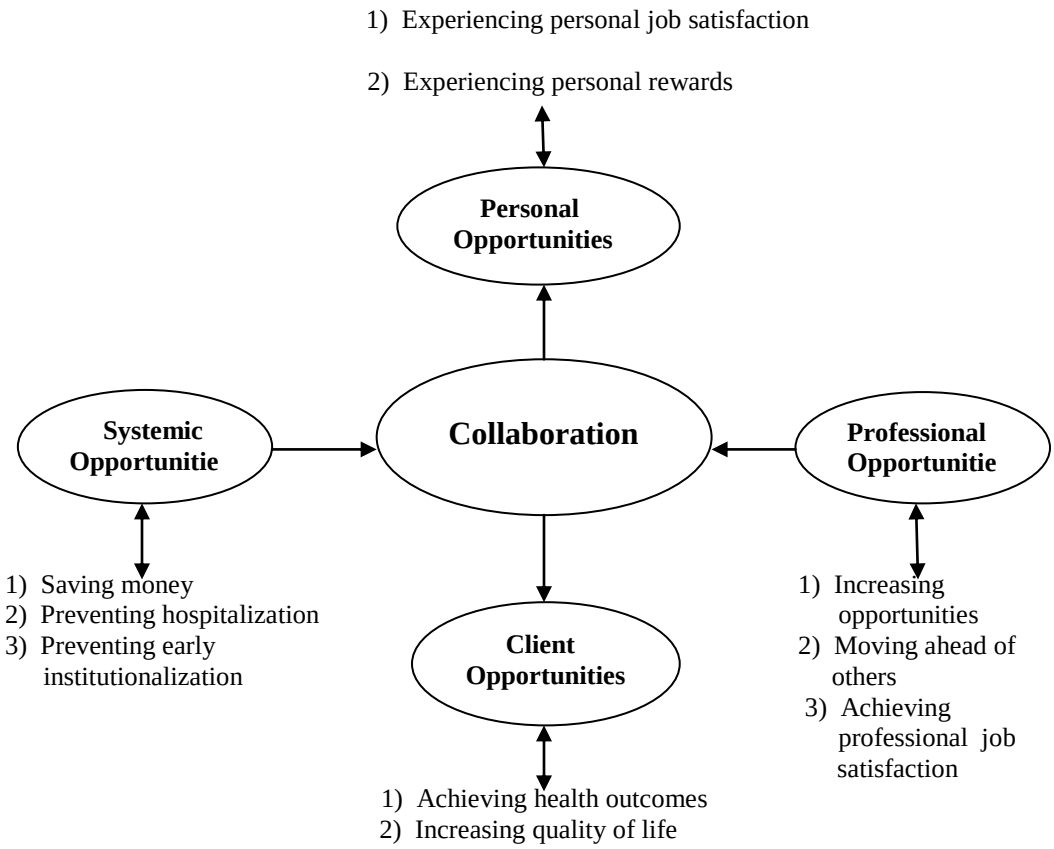

FIGURE 2: Categorical representation depicting the various opportunities for health care professionals

unsatisfied. Also, there were perceptions of some members believing they were collaborating when they were not. Some of the members approached collaboration with honest intentions but felt they were producing counterproductive outcomes:

> I really do, I really, really believe that because I see that and see they're not really being you know, flippant or whatever. In their own way, they're being very thoughtful, and doing hard work, you know, they're not lazy, or being whatever. They believe that they have done absolutely the very best for that client. Because if you're not looking at the other components, if you're just looking at your work, you haven't looked here. If you're not collaborating, you're not looking over here. Yeah, you don't even get it that stuff happened that really wasn't like, not to say this was bad, but it just didn't work in conjunction with the other things that were important in the mix of things for that client. So, you can fix this, but you broke that. Sometimes when you fix things, you break something else, right? You kind of have to look at everything together. So, yeah, you know, I think some people recognize that it does that, and some people don't recognize that's what happens for sure. They maybe don't get that that's the outcome. (participant 07)

Participants also believed that whether or not one could collaborate was closely connected to one's personality, values, and attitudes. Working in the Program comprised of different individuals meant encountering different egos, backgrounds, and experiences. Somehow, together, members were expected to collaborate to achieve a common goal for the client but that was problematic because there was an underlying belief that not every individual was meant to work in a team. Some

members were more suited to collaborate than others:

> I think people are who they are. And, some people are more suited for some things than other things. Health care requires - the first thing you have to do is you have to like people. Do you really like people? Do you like to talk to people? Do you like to listen to people? Do you like to be around people? Are you people-orientated? Like, let's find that out. They'll answer that probably in a way they think you'll want to hear, but that's what you want to try and get a sense of. Because if a person is satisfactorily orientated towards a good attitude, towards their fellow person, that will translate to not only to dealing with the patient, but will also translate into dealing with your colleagues. I mean, you can see that the person is trying to help. They're trying to do something, trying to be useful. They're not doing something that's purposefully trying to be unhelpful or not useful. Maybe they don't know. You know, maybe they just don't know, or maybe they're not sure, or maybe they just didn't think it through, but they're not trying to do things purposefully to try and make you upset. At least I find that. (participant 10)

Issues with personality, values, and attitudes were also attributed to the challenges participants experienced for achieving interdependence among members of the Program. Their beliefs were that some members valued autonomy more and thus, preferred to function independently rather than interdependently. This was evident even when there was recognition that being a team player meant not working in isolation:

> Well, I'm, I am very much a team player. I am. I know that I don't work in

> isolation. And I also work as a team player because people include me and they recognize my contribution. (participant 01)

Participants viewed some members' approach in their interactions as being directive rather than consultative and collaborative. As a consequence, they felt criticized and reacted defensively. These feelings were expressed by one participant, even with the belief that members were working with the best of their abilities:

> I think things are getting a little better but I think some of the team maybe feels put on the spot or they feel defensive. When it comes back, they may take it as more of a personal thing with their decision-making or judgment. But, that's a bit of a personality thing probably. I think that everybody feels that they are working their hardest, and to the best of their ability, and then things come back, or, I don't know if it's criticism, but things come back. (participant 09)

Participants who perceived themselves as good collaborators continued to develop their relationship together with those they believed were also good collaborators. Members who were perceived to not collaborate well were left out of the fold. The resulting effect was a noticeable division among the team.

Participants believed members who collaborated well were refining their collaborative relationships, while the division with the other members who had difficulty collaborating was getting wider. Members who were being left out were feeling more insecure about their abilities and, when confronted, that insecurity expanded to feeling criticized. In response to the criticism, members reacted defensively. Unfortunately, clients were getting caught in the middle of the divide, and they were not getting the full benefit of exposure to the health care providers

from the various disciplines.

Another significant reason for the division among members, according to participants, was attributed to two different approaches in the practice of health care. The differences were largely based on participants who perceived themselves as being aligned more with the practice of geriatric care and participants who preferred a primary care approach to their practice. Those aligned with the geriatric care approach perceived themselves as better collaborators since they had prior experience working with the various health care disciplines. In the geriatric setting, health care providers were required to deal with complex health issues of the elderly and, more often, this required the involvement and input from the other health care disciplines. Their philosophy of care was more maintenance-oriented given the fact that the clients were elderly, and they had chronic conditions that required ongoing monitoring. Maintaining the client's quality of life was the primary focus of care. In most cases, as with the geriatric population, assuming an aggressive approach might be overwhelming for the client and the family members, especially when it was necessary to attend a myriad of appointments for various tests.

Participants with a background in primary health care promoted a preventative approach in the care for the client, with an underlying need to optimize the client's health. Primary care, which follows the medical model, is one of the specializations that can be delivered more independently without necessarily requiring input from other health care professions. Apart from the medical decision-makers, the allied health professions were consulted only for the services believed to be needed for that particular client. Thus, the delivery of care for a client was often more directive than collaborative. One participant described the different approaches to health care

practice and the need to find a more common ground:

> I think we struggle with that - that we all come from, we come from geriatrics and this is how we focus, and this is how we should practice geriatrics, and the focus over here well, this is primary health and we're their medical doctors and this is how primary health practices. But we're not – we're all of those things and so, it has be a whole different way of looking at it as a program. (participant 08)

Despite having an affiliation to one side of the divide or the other, participants were equally troubled by these differences. They felt that it was too difficult to talk about it with the other members for fear of appearing as though one was challenging another's method of practice. They did not want confrontation or retaliation with the other members, although tensions occasionally arose among members when they were discussing the care of a client. Participants believed their collaborations would have been more successful if all of the members shared a similar background of specialization and a more analogous approach to care for the clients.

Participants believed that the impact these challenges had on the clients and their families was dependent on the clients' perceptions of care. Some clients and family members viewed aggressive treatment as necessary and rewarding. Others were resistant to attending a myriad of tests and procedures. Often, participants felt they were caught in the middle of another member's recommendations and the family's reluctance to follow through on the recommendations. Occasionally, clients did not get the benefit of input from all of the disciplines because members were left out of the decision-making process. Sometimes clients were caught in the middle of the divide or they received mixed messages, depending on which side of the divide they

were unknowingly on. Such outcomes were distressing:

> The people that we have here, they're here because they need help. And, they're looking for someone to do the work for them because they can't manage it. Their caregivers can't manage more than what they're already doing. And so, when we're all over the place, that doesn't work well for them. And, they don't have a lot of time. You know, it's not as if they have a lot of time. Like I said, they're fragile. Their health status is fragile so, they don't really need people fooling around with what should and what should not be. It's to their detriment for sure. (participant 05)

Issues with time presented additional challenges for participants. Some of the participants working in a dual role of case manager and health care provider were very busy, and not collaborating well was viewed as wasting time, creating overlap of care for clients, and confusion from not being included or aware of the client's ongoing care. Consequently, participants had to invest in additional time to attend to these challenges so they could keep abreast of the clients and their care. Conversely, some participants felt a reluctance to invest in the time they believed was needed to build a positive collaborative relationship with the members. Because they were so busy, taking the time to update and inform the other members about a client's care was just too time consuming.

Ineffective communication among members was also expressed as a significant barrier. A lack of communication, often referred to as 'bad' communication, was depicted as occasions when there was misinterpretation of the sender's message, not hearing what the sender had to say, and selective hearing and interpretation of the message if it was not what the recipient wanted to hear. There was also a lack of

communication, whereby participants felt that they were not receiving updates on their clients when the other members were involved in some aspect of the client's care. Information was received but there was little opportunity for exchange:

> It's not-there's no back and forth. It's one way. The information comes this way to me, and it's not even information – well, sometimes it's information, sometimes it's direction. But there's no back and forth. (participant 04)

The methods participants used to deal with these issues also created barriers for productive collaboration. One participant described being frustrated when members were 'putting up blocks' or when someone was trying to be nice to circumvent discussion of an issue by not saying what they meant. Some participants found it challenging to communicate their issues with the other members without being perceived as being too critical. It bothered them to be perceived this way because they did not want to give the other members the impression that they were being unapproachable. They were very aware that if the other members thought they were being criticized, they would shut down, and the issued would not get resolved.

Some participants expressed resentment toward some of the other members' preferences for use of the computerized electronic mode, commonly referred to as email, to communicate. The meaning of communication, for participants who opposed the use of email, was to engage in face to face exchanges. The use of email was perceived as simply sending information with little or no opportunity to engage in a discussion, share ideas, or participate in problem-solving:

> I see communication as having a discussion whereas a lot of people see communication as sending me an email, and figure it out for yourself kind of thing. Yeah, I see communication, talking about issues, and trying to

> problem solve together as not just sending someone a sheet - this is my report - or whatever the issues are. (participant 03)

Another participant expressed her views as follows:

> No, I'm not collaborating with human beings. I'm getting my information from a computer. (participant 01)

Communicating via email was unidirectional when information was sent to them. It was often felt to be directive in nature, and there was no opportunity for exchanges between members. There was always the risk that communicating by email would reach some members but not everyone, participants would feel embarrassed from being left out of the loop, and, often times, meaning was lost in the translation. The fear of being left out or misinterpreting the message was expressed this way by one participant:

> I'd least like communicating by email. I do not like it. But I find that a lot of people in this setting will choose that option, and, um, sometimes I may get left behind. I think it is so easy to lose, or misinterpret the message when you are not speaking with the person. That's the reason. I'm really hung up on accuracy. That's just my way. (participant 05)

Table 5 provides the meaning units and formulated meaning for the common theme identified as existing challenges create barriers that impede collaboration.

Table 5 Meaning units and formulated meaning representing the common theme: Existing challenges create barriers that impede collaboration

Meaning Units	Formulated meaning
Differing definitions Inconsistent views Unrealistic expectations Counterproductive outcomes	Differing beliefs about collaboration
Difficulty achieving interdependence Appearing territorial Wanting control Preferring autonomy Practicing in isolation	Differing personalities, values, and attitudes
Working with some instead of others Not taking advantage of others' expertise Feeling insecure Feeling criticized Getting caught in the middle Reacting defensively	Creating divisions among the team
Favours geriatric practice (maintenance-oriented) Favours primary care (prevention-oriented) Influencing prior experience and background Input from other disciplines Independent	Differences in approach to practice
Wasting time Creating overlap of care Creating confusion with clients' care Time consuming	Issues with time
Misinterpreting the message Not hearing the message Selective interpretation of the message Not receiving updates on clients Putting up blocks Sounding critical Feeling criticized Shutting down Relying too much on computerized technology (email) Not enough face to face interchanges Sharing information Being directive Being out of the loop Meaning is lost	Ineffective communication

Experiencing the Interactional Dynamics of Collaboration and their Influences Requires the Interpersonal Attributes of Quality Communication, Openness, Trust, and Respect

Participants strongly believed that the interactional dynamics and their influences played a significant role in achieving the outcomes of collaboration with the other members. Many of the experiences they shared were of the interpersonal encounters with the other members of the Program. The interpersonal attributes and processes perceived as essential for successful collaboration were quality communication, openness, trust, and respect. Seeing themselves as exhibiting these attributes and processes was as important as seeing them in others.

Good quality communication for some participants was when they felt they had effectively delivered their message to another person, and the person was able to interpret it as it was intended. For others, it was being able to deliver a thought, an idea, or a suggestion, and having it affirmed by another through feedback. Communication was thought to encompass both talking and listening. It was sharing ideas but also listening to others. One participant described the importance of understanding communication as follows:

> Well, I guess for sure, when you process the information that's coming in, you have to understand it. You have to understand it. It seems so fundamental, but you have to understand it. You have to understand what the motivation for the person telling you is, like, what's going on for them? Is it the client? Is it the client's family? Where is the information coming from? Why is this information important to relay at this time? That's one

> thing. It's fundamental, and we don't even give it a thought but its there. (participant 10)

Communication was also about understanding the intentions of another, even if one was not in agreement with what was being said. One participant's description of accepting another member's views was associated with possessing the attribute of humility:

> Communication and really gaining an understanding I think is important. Um, where that other person is coming from even if you don't agree, it doesn't matter, that's not part of that. Hearing and really trying to understand why that is important. I see that as sort of humility. It's not about me, it's about it, the process. It's kind of getting off of me and me kind of being humble about it. (participant 07)

Openness was generally described as being receptive to others and their ideas. Receptivity toward others was apparent in one's body language, especially in one's gestures towards another. Being receptive to ideas involved listening to others' concerns and their views with patience and tolerance:

> First you're going to listen. You're going to listen to the other point of view. You are, I mean, if you're closed or whatever, you're not going to even hear it. It may be said, but you won't even – you're not even going to hear it, let alone, you know, think it through and try to see what the logic, or reasoning, or value is in it. That's the difference to me. So, if you're not willing to listen, um, and be accepting of what they have to say, you'll never know if there is or not. If there is a better way, if there is an alternative, if there is something that could work best for the person. (participant 05)

In some cases, participants believed that openness helped achieve a heightened awareness of opportunities and solutions that they would not have otherwise thought of themselves:

> Everybody brings their personality right, and some people are very private in both their personal and work life. They kind of keep to themselves and that's just their work style, whereas, some people are just more open in general and more friendly and outgoing. I think collaboration comes more naturally for some of the people who work well with others. I think for others, they work better in jobs where it's just them. (participant 03)

Openness was also perceived by participants as being approachable to others:

> I think you know when you meet people, there's people who are more closed off than others and who are less approachable. Um, it doesn't take long when you enter the space here or in general, in all sorts of areas, right? Where you know you can go to them, and there's people who are more closed off for whatever reason, and you know that they are just that. They are at work, they're professional at that's it. You know, you do your job and whatever. But, I think you can tell. You know when you meet somebody who is open and who is not. Some people you got to get to know to know that they are open. That there is more openness to them but I would say that you just kind of know that about people. (participant 08)

If a participant was considered to be approachable, the other members felt that they were going to be respected and supported. Being approachable required having a sense of security about oneself. Good collaborators, according to participants, were people who were secure within themselves and conveyed an open stance toward

others. Perceptions of openness were aligned with a willingness to relinquish control over another:

> It takes a secure person just to really be able to listen, to truly listen. Really listen and understand. Uh, and not feel that it's anything bad about themselves. They contributed the best they could. They brought their expertise and somebody else brought their expertise to the table. In the group, you all come with expertise, that's why you're there. If you all did the same thing, you probably wouldn't need to get together. (participant 07)

In that example, the participant did not believe that it was necessary to be in agreement with all members at all times. The act of being open was making an effort to listen and understand another's point of view. The same participant elaborated further:

> Um, I think a lot of security. Like, I think a person that is a good collaborator is probably a pretty secure person. Collaborating well is when you're open to hearing, you don't have to say I agree with you, just have to be open to hearing. You have to kind of be a secure person in your own boots, to actually be able to do that. Instead of arguing, or making it a competition, or making sure you win. I think it takes a lot of being a really solid person. That's a hard one for people. (participant 07)

Trust was often described by participants as not feeling judged by the other members of the Program. They were also careful to say that to earn the trust of the members required no judgment on their part as well. They were the first to admit that they were not perfect. They were as capable as the other members for making mistakes:

> None of us are perfect. We all make mistakes or we all even, not necessarily mistakes but would go back on an issue and think gee, I would have done that differently. If I had to do it again, I would have done that differently, and I think there's, um, you have to respect that in yourself and other co-workers as well, and you know, not hold it against them as in they don't know what they're doing. (participant 02)

Trust was demonstrated in the words and the actions shown by the other members. It was in knowing which members the participants could turn to with their issues because they felt they could trust them implicitly. The majority of participants described trust as feeling safe and comfortable with others, without feeling criticized or dismissed. More importantly, it was having a sense of comfort knowing that their concerns would be addressed.

All of the participants wanted to be respected by the other members. They wanted to feel valued by the other members. Feeling valued consisted of being recognized as having made valuable contributions toward the collective and a positive impact on clients and their families:

> I think when you know you can go to somebody, and yeah, they're going to be open, they're going to be respectful, they're going to be supportive, and they're going to be empathic. They're going to be some of those things that depending on what you're going to them for, you know you're going to get. You're going to feel that way. You're going to leave that interaction knowing that those things are going to occur, whereas, when you have to interact with somebody and they're not always respectful or tactful, that it feels like it is sort of one-sided. (participant 08)

Participants wanted to show their respect towards others. They believed respect was evident when members were valued for their different ideas and opinions:

> I think just, you know, again kind of going back to people who have different opinions, come from different places, different ideas, and I think regardless of how you feel about things, it's important just to be respectful, to appreciate that and to be able to listen to it. To not take what you want out of it, but, um, to feel valued, um, that they are important, and they are an important part of things. (participant 08)

Respect was recognition that all members had something offer. Even if participants felt they were not in agreement with members' views on all occasions, or if they had different opinions on everyday issues, it was important to them that they showed respect towards others.

Respect was also viewed as an engagement between both parties; with self and another. Engagement was marked by mutual reciprocity and a genuine interest in each other. This was as significant as having mutual appreciation for each other's role in the delivery of care for a client:

> Well, I think respect is, first of all, providing the opportunity for the individual to have an appropriate forum with you. You think enough of them as professionals that you are genuinely interested in what they bring to the table, and you want to hear it, you want to understand it, and you want to think about in terms of your own framework. So, it's called providing the time, it's eye contact, it's not looking at something else, and doing something else, and listening to them. It's providing - it's doing that. I think respect is also shown in your demeanour. I think respect obviously

> works two ways. If you're going to have a respectful relationship with somebody, they have to provide a respectful relationship to you. It's part of the relationship. (participant 10)

Another participant added:

> Yeah, I think it goes both ways. That I would hope that people would think I am respectful. There might be times that I'm not. Um, but I would hope someone would even feel okay to tell me that, um, because I would definitely not want to be that way. But obviously it's important too that I'd want it for me, but also to perceive me the same way. (participant 08)

A summary of the meaning units and formulated meaning included in the common theme for experiencing the interactional dynamics of collaboration and their influences requires the interpersonal attributes of quality communication, openness, trust, and respect are summarized in Table 6.

Forming a Common Vision is Necessary for Collaboration but Difficult to Achieve

Finally, the topic of forming a common vision of collaboration was explored. Participants were first asked to describe what forming a common vision of collaboration meant to them. Participants' perceptions of forming a common vision were representative of client-centered, practice-centered, and team-centered approaches to collaboration. Responses aligned with the client-centered approach were similar to the overall goal of collaboration which was to optimize the health and wellness of the clients. Participants believed that the common vision of collaboration should be client-focused. Forming a common vision meant wanting the best quality of life for the clients. In the perceptions of one participant, optimizing the quality of

Table 6 Meaning units and formulated meaning representing the common theme: Experiencing the interactional dynamics and their influences requires the interpersonal attributes of quality communication, openness, trust, and respect

Meaning Units	Formulated meaning
Effectively delivering a message Effectively interpreting a message Affirming through feedback Delivering a thought, idea, or suggestion Engaging in talking and listening Sharing ideas Listening to others Experiencing humility	Interpersonal Attribute #1: Requiring Quality Communication
Being receptive physically (body language, gestures) Being receptive to ideas Listening to concerns Showing patience and tolerance Achieving heightened awareness of opportunities and solutions Being approachable Experiencing security Relinquishing control Understanding another's point of view	Interpersonal Attribute #2: Requiring Openness
Not feeling judged or criticized Accepting mistakes Demonstrated in words and actions Feeling safe Experiencing comfort	Interpersonal Attribute #3: Requiring Trust
Feeling valued Recognizing another's contributions Accepting different ideas and opinions Exchanging views Experiencing mutuality Showing interest in others	Interpersonal Attribute #4: Requiring Respect

life for the clients meant keeping them in their homes as long as possible. Responses representing a practice-centered approach meant that a common vision of collaboration involved engagement with members to achieve the same beliefs about collaboration. Reaching an understanding of collaboration among the collective was important and necessary for collaboration to be reflected in practice:

> A common vision is having the same ideas and not having someone thinking it's one way while someone else is thinking it's another way. (participant 02)

Another participant's view is expressed as follows:

> As a group, we would all understand and practice in a way that truly means so. So, instead of saying we want to collaborate, you have to understand what collaboration means. Uh, and then try to practice that. So, it's one thing to say how great collaboration would be, but how do you do it? What does it look like at the end of the day? (participant 08)

Assimilating collaboration to reflexive practice required ongoing contemplation and refinement in practice:

> I think it's a reflective, um, practice, um, concept that has to be visited again, and again, and again, and adjusted as you go along. Really, we need to revisit this concept of collaboration, and how are we achieving it and um, what are the good things about it, and what are the bad things about it. And can we, is there something we can let go of. Um, is there something else that we need to bring into this collaborative. (participant 02)

Perceptions of a team-centered approach to forming a common vision were related to practice as well, but with more emphasis on the Program and its specific goals.

It meant sharing the same ideas about the Program and working as a team to fulfil the Program's goals.

When asked whether members of the Program had formed a common vision of collaboration, all of the responses from participants were that they had not. Since participants believed that each member had his or her own beliefs about collaboration, the notion of collaboration would be a difficult concept to express in words. Even in some cases, when collaboration was felt to have occurred, it was quite likely that there would be differing views:

> I think we have to kind of all understand what collaboration is because I think if – even if everybody said, 'Yup, we all think collaboration is important.' Okay, that's good. But, if people aren't thinking of collaboration in the same way as each other, or at least close to each other, then it's probably going to be hard to be collaborative. It's one thing to say, 'I know what collaboration is, but honestly it's not going to happen here because I'm here to make a decision. It's not a collaborative process. I'm going to tell you guys what to do, I'm running the show.' Or, whatever, let's say the doctor or someone says, 'I'm going to tell you what to do. It's great that you're all here. We've got a fabulous team. We're going to kind of go ahead, but I'm going to call the shots.' So, you could have a team where maybe not everybody believes that collaboration is part of the process. But let's say you did have a team where they said, 'Yeah, collaboration, yeah, we all like that word and it's great.' I do still think that everybody's idea of collaboration could be different. The common vision probably has to at least start with the assumption that we are not all

necessarily talking about the same thing. (participant 07)

For some participants, there was an underlying assumption from members that they possessed the same vision but, to them, it clearly was not so. Members believed they were practicing collaboratively but, to others, they were not. This resulted in disparate views of collaboration and members practicing in different directions. When this occurred, collaboration became disjointed, productivity was reduced, and success was more difficult to achieve.

All of the participants did agree, however, that forming a common vision was indeed necessary for successful collaboration. Participants found it difficult to articulate how the process of forming a common vision of collaboration would unfold for their Program, likely because they had not engaged in the formation of their own common vision of collaboration for the Program. Upon further contemplation, the same participant offered the following suggestion:

Well maybe we've got to start not here, come on let's collaborate, but here, what is collaboration in people's minds? What does collaboration look like? You know, what are the components of collaboration? (participant 07)

A summary of the meaning units and formulated meaning included in the common theme for forming a common vision is necessary but difficult to achieve are summarized in Table 7.

In the final chapter, I respond to the research questions posited for the inquiry. I include a descriptive narration of the findings, derived from the participants' experiences of collaboration. Support from the literature is integrated in the discussion to substantiate the findings. Together, they offer what I take to be comprehensive understanding of the phenomenon of collaboration. The limitations

Table 7 Meaning units and formulated meaning representing the common theme: Forming a common vision is necessary for collaboration but difficult to achieve

Meaning Units	Formulated Meaning
Wanting the best quality of life for the client Keeping clients in the home as long as possible Optimizing the life of clients Focussing on the clients	Forming a common vision is client-centered
Reflective practice Sharing the same belief in approach Practicing in a true way Putting it into practice	Forming a common vision is practice-centered
Understanding the Program and goals Having the same ideas Working as a team	Forming a common vision is team-centered

of the study are also addressed. The recommendations that have been proposed incorporate suggestions by the participants for promoting successful collaboration as well as my contributions as the researcher. The various implications for future research, health care practice, and education are included.

Chapter V: Discussion, Implications, and Recommendations

Health care professionals were asked to describe the essential meaning of collaboration from their experiences of interprofessional practice in a community-based geriatric care setting. Several themes were identified from the descriptions they provided. Participants believed that engaging in collective thinking and action was essential for producing the best health outcomes and optimizing clients' health. Collaboration was viewed as a dynamic and evolving process to which ongoing adjustments would be made over time, and continued effort was necessary for improvement. The outcomes for participants when collaboration was successful were the personal and professional rewards they experienced. However, there were challenges as well, and these challenges were problematic for their collaboration. The interpersonal attributes of quality communication, openness, approachability, trust, and respect were felt to be significant for the development and sustainability of relationships participants had with the other members in the Program. Lastly, the notion of forming a common vision of collaboration was thought be a significant contributor to the success of collaboration but, difficult to achieve. It was clear from the views expressed by participants, and the themes that were identified as a result, that collaboration is an interesting and complex phenomenon comprised of many factors that simply cannot be assimilated to any other concept.

Theoretical and Practical Significance in the Meaning of Collaboration

Interprofessional practice in theory, according to Baggs et al. (1999), leads to the production of improved client-outcomes because input into decisions from various health care professions results in more complete information. Participants' views

of interprofessional practice in this study were similar. They believed that the complexities arising from the multiplicity of health issues often experienced by elderly clients could not be managed by a single health care discipline alone. There were more advantages to clients, in terms of improving their health outcomes, if members from the various professions were able to collaborate and produce decisions as a collective rather than isolating themselves in autonomous practice.

Tschannen (2004) suggests the overriding goal for all health care professionals is to assist clients in reaching their highest level of their well-being and, for that reason, health care professionals needed to learn to successfully collaborate. Unquestionably, for Program participants, the purposes and goals of collaboration were to produce the best health outcomes and optimize the health and wellness of the clients. In this case, producing the best health outcomes and optimizing health and wellness were inherent in the participants' values: self-determination and choice in health care decision-making; respect for human beings; the primacy of caring and advocacy; and finally, the obligations they felt toward the clients and families, which were to have clients remain in the community and avoid hospitalization or institutionalization.

Participants believed there were more opportunities available for health care professionals who had an ability to collaborate. There was more potential for achieving a sense of personal fulfilment from their work given their beliefs that collaboration produced positive outcomes and enhanced clients' quality of life. Having an ability to collaborate resulted in more professional opportunities and the likelihood of experiencing more job satisfaction. And, there were positive effects on the health care system such as cost savings from preventing hospitalizations of the

elderly and premature institutionalization. The responses from participants confirmed what was anticipated at the outset of the research: that collaboration is an important topic that is strategically central and conceptually essential to interprofessional practice, the improvement of health care, as well as the enhancement of health outcomes.

Collaboration was described by participants as a collective undertaking among members, requiring both thinking and action. Thinking behaviours were characterized as brain-storming, decision-making, and sharing opinions and ideas. Action, on the other hand, was described as the contributory behaviours required to complete the care of the client. The notion of action was marked by collectivism such as working together, working as a team, and achieving common goals. Collectivism was viewed in a positive way as the essential platform for thinking and action to occur among members of the collaborative. Participants wanted cohesiveness among members of the team, but they did not expect members to relinquish their individual perspectives. It seems reasonable to assume that participants understood that members of the collaborative placed their own unique meanings to things based on prior experience, values, knowledge, and skills. This assumption proved to be true, as participants made it quite clear that an important feature of the collective was not to rely on any one member's perspective but, rather, that different perspectives were welcome and necessary. It was important for members to share their perspectives and to participate in the process of negotiation so they could jointly decide on the best approaches of care for the clients.

Gardner (2005) suggests from her experience that collaboration initially begins with individual thinking among members of the collaborative. It becomes a shared

enterprise when the members of a collaborative are able to engage in a process of sharing that achieves a commonality of goals, expectations, or outcomes. However, as will be seen, reaching a commonality of understanding from individuals who possess their own unique perceptions of reality is challenging for achieving satisfying and successful collaboration.

Response to Collaboration for Participants and Other Health Care Professionals

I had made the assertion at the outset of the inquiry that collaboration is an important concept for health care. In my narrative, I had explained why the topic of collaboration was of particular interest to me and why it had been at the forefront of my longstanding career as a health care professional. Here was my opportunity to explore how other health care professionals had responded and reacted to the notion of collaboration in health care. I found their views to be very interesting.

The overall consensus from participants was that the concept of collaboration is important for health care. However, the reactions to collaboration from health care professionals were varied. Participants' responses were closely associated with a number of the systemic determinants of collaboration San Martin-Rodriguez et al. (2005) identify such as social, cultural, and professional systems. These systemic determinants were found to have a profound influence on the development, achievement, and sustainability of collaborative practice among health care professionals.

Allied health care professionals in general were considered to be the best responders to collaboration. At the social level, they were considered to be better responders because they tended to be perceived by other health care professionals

as being situated at the lower, more supporting level of the medically dominated hierarchy of health care. Their expertise was consulted only after a referral was made by the physician making the medical decisions for a client. With these observations in mind, one could suggest that it was the circumstance of socially constructed professions, and not necessarily a willingness to collaborate, that created the conditions for collaboration to happen. This assumption became more apparent when participants identified the prevalence of the medical model and the existing hierarchy in the health care system as obstacles they believed interfered with health care professionals' responses to collaboration in general.

Participants believed the characteristics of one's personality, which are closely aligned with the cultural system, also set the stage for determining one's response to collaboration. If a health care professional possessed the interpersonal attributes of trust, respect, and openness, as well as willingness to work within a team, then his or her approach was thought to be conducive for collaboration. However, participants believed there were health care professionals who did not possess these characteristics in their personality, and what was lacking in personality was also evident in their work style. Moreover, personalities such as these that were considered ill-suited for multidisciplinary practice was a major factor that stood out for participants in their determination of health care professionals' responses to collaboration.

Prior positive experiences of professional practice were also believed to be a contributing factor for health care professionals who have responded well to collaboration. This finding is supported by Herbert et al.'s (2007) outcomes from their study which showed that having positive exposure to collaborative

environments influenced health care professionals' choices to practice collaboratively. While participants in that study described a number of different practice settings, participants in this study emphasized that those having prior positive collaborative experiences in geriatric practice in particular, responded well to collaboration. Health care professionals with a specialization in geriatrics were more inclined to function interdependently since they attended to the complex health issues of the elderly clients.

Participants' perceptions of collaboration as a continued work in progress correspond to D'Amour et al.'s (2005) notion of collaboration as an evolving process for interprofessional practice. And, while these views are similar, most definitions of collaboration found in the literature omit this important feature. Perceptions of collaboration as a continued work in progress also supports the assertions made at the outset of the research, that collaboration is not always clear, coherent, and well thought out among its collaborators. That is because collaboration is a phenomenon that can progress in evolution, and to which meaning cannot simply be implied with finality. Consequently, the processes collaborators rely on for their collaboration must be envisioned, and then cultivated and nurtured, to enable their growth and development over time.

Without being made explicit, participants' perceptions of collaboration as being a continued work in progress suggested that they were willing to be flexible. They took into consideration that the Program was a unique contribution to health care, having been in operation for a short time and, as such, participants understood that ongoing adjustments had to be made. Time is needed to get to know the other members on an interpersonal level and to gain a better understanding of what the

members could offer in terms of their professional competencies from their respective disciplines.

Perceptions of collaboration as an evolving entity also signified hope. Participants were hopeful that their collaborations with the other members in the Program would improve over time. While they did not overlook the fact that certain realities had to be to overcome, they believed in the merits of the Program and their contributions toward the clients and their families. They were optimistic that their collaborations with the other members would continue to evolve in a positive way for their personal and professional benefits.

Personal and Professional Rewards of Successful Collaboration

The question of success with collaboration was explored by initially questioning whether participants had experienced successful collaboration. Participants were asked to illustrate their experiences of successes by providing examples that included the other members of the Program. After participants offered their examples, they were asked for their impressions of the impact their success had on themselves, for the other members involved in the collaboration, and for the clients and their families.

All of the participants felt fortunate to have experienced successful collaboration. It was interesting to observe that their examples consistently followed the same sequence of events. Success was perceived as a mutually satisfying experience when they were able to collaborate with the other members of the Program on health issues affecting the client; they were able to resolve issues and produce positive outcomes for clients and their families. Their impressions regarding the impact of success on

the participants were categorically representative of personal rewards, professional rewards involving the team, and professional rewards involving the client. At the professional level, when their collaborations were successful, participants experienced increased confidence, increased motivation and job satisfaction, and a fulfilling sense of purpose. Professional rewards involving the team were evident as role-recognition, consensus, and achievement of good working relationships with others. Professional rewards involving the client meant meeting the goals of the clients and their families, and making an impact like maintaining clients in the community.

Achieving positive outcomes for the client and improving patient care was what Kearney et al. (2000) suggested as the common ground for health care professionals. In this study, when success was achieved, everyone shared in the experience of having achieved something meaningful for the clients and their families. Success was manifest in the body language of the members, in their interactions, as well as an overall sense of team cohesiveness.

Participants believed that clients benefited when members of the various health care professions collaborated. Success was achieved for participants when clients and their families showed their appreciation and the recommendations they offered were acknowledged and implemented. Participants could see when successful collaboration made a positive impact on the well-being of clients, and they were very aware of the consequences for clients when issues arose among members and collaboration became problematic. These participants are the health professionals at the front lines of care in the health care system and, as such, their experiences reflected the realities of practice and, ultimately, the real value of collaboration.

Challenges of Collaboration for Interprofessional Practice

Despite the successes experienced, there were issues with collaboration that created challenges for participants in the Program. This was a significant finding considering that the literature on collaboration often emphasizes either the successes or the challenges of collaboration. The literature rarely suggests that both successes and challenges can occur together and, at the same time, as was the case for participants in this study. It is quite possible that these variations in outcomes occur as a result of the evolving nature of collaboration for health care professionals in interprofessional practice.

While participants were reluctant to express the challenges they experienced with collaboration as failures *per se*, it was evident that they were troubled by issues identified in their collaborations with the other members of the Program. The fact there were challenges for participants in their collaborations is not an uncommon result given what has been identified in the literature. As to what was pointed out earlier, failed collaborations are as common, perhaps even more common, than those considered to be successful, although the issues that have caused collaborations to fail are often not acknowledged (Beattie, Cheek, & Gibson, 1996; Gaskill et al., 2003). In this study, participants were able to articulate their issues, and their responses were found to be consistent. The challenges they experienced were a result of differing beliefs about collaboration; differing personalities, values, and attitudes; a marked division amongst the team; different philosophies in approach to care; issues with time; and, ineffective communication.

The perception of members having differing beliefs about collaboration was not surprising given that collectivism, which is the hallmark of collaboration, is difficult

to achieve without making an effort to address individual differences. Without members making an effort to define and agree upon the processes they will use for collaboration, different perceptions can result in a variety of challenges. A number of participants attributed the challenges they were currently experiencing to the ongoing nature of their collaboration, as they had yet to smooth out and agree on their processes.

Non-collaborative work environments, according to Henneman et al. (1995), have created a number of challenges for health care professionals such as personal dissatisfaction, fragmentation of care, and the frequent poor outcomes which plague the health care system. The issues for participants in this study stemmed from having differing views of collaboration. They included having different definitions for the meaning of collaboration, not understanding what collaboration meant, having unrealistic expectations of collaboration, and having the belief that collaboration was occurring when it was not. These issues made participants feel dissatisfied and frustrated. Often, it resulted in counterproductive outcomes.

San Martin-Rodriguez et al. (2005) found that differing personalities, values, and attitudes among health care professionals were issues that affected the outcomes of collaboration. Participants' views were similar in that they believed collaboration was strongly tied to one's personality, values, and attitudes. It was interesting to note that the topic of personality was brought forward again, as it had been earlier, when participants expressed their beliefs that personality was a factor for determining how well health care professionals respond to collaboration.

Although the common goal for all participants was to optimize the health and wellness of clients, they believed that some members possessed personalities that

were more people-oriented, valued interdependence and team work more, and had more positive attitudes. These characteristics were better suited for collaboration. Other members valued autonomy, and thus preferred to practice more independently. Some members were perceived as territorial in that they were reluctant to share and wanted control. Their approach was directive rather than consultative. As a consequence, some participants admittedly felt criticized and reacted defensively.

The preference for autonomy and territoriality rather than interdependence speaks to the power differences that can occur among members. Some of the participants from the allied health professions were particularly sensitive to imbalances created by power differentials. They had experienced the negative consequences of positional power when it was used by some health care professionals in the more dominant health professions to exert their power and authority in the management and care of the clients.

Participants who perceived themselves as good collaborators continued to develop their relationships with those they believed were also good collaborators. Members who were perceived as being too challenging were left out of the fold. The resulting effect was a noticeable division among members. It did not help that this division was also marked by a noticeable difference in the participants' approach to health care practice which resulted in an even more pronounced separation among members. The differences in approach were largely found with participants who perceived themselves as aligned more with the practice of geriatrics, than with primary care. These differences were described by participants in the prior chapter. Clearly, finding a common ground of practice agreeable for all of the members was required.

Tschannen (2004) had suggested that collaboration emphasizes the ability of professionals to jointly create patient care solutions that reflect the combined wisdom of team members. But sadly, this was not the case for many participants in this study. Those on either side of the divide were equally troubled by these differences. Unfortunately, the clients were getting caught in the middle of the divide, and they were not getting the full benefit of exposure to health care providers from the various disciplines.

Existing philosophical differences among professionals from the various health care disciplines have been reported elsewhere in the literature (Henneman et al., 1995; Van Eyck & Baum, 2002). Those differences have been known to propagate distrust and disrespect among individuals, resulting in very real challenges for achieving successful collaboration. It was not that participants wanted to intentionally inhibit achieving interdependence; rather, it was an obvious division brought on by the disparate views of practice that interfered with the members' abilities to function interdependently.

According to LeGris et al. (2000), collaboration is a time-consuming enterprise and, for most health care professionals, taking time away from their busy schedules to facilitate collaboration can be an issue. It was interesting to observe that, for participants in this study, not collaborating well was perceived to be more time-consuming, especially when there was an overlap of care for the clients and the resulting issues consequences had to be sorted out. The necessity of expending more time to deal with a variety of challenges prevented participants from investing the time they needed to build more positive collaborative relationships with each other. Conversely, some participants were excluded from receiving updates concerning a

client's care. Extra time was needed to follow-up with the other members of the Program. Additional time to deal with these issues was required when their collaboration was ineffective.

Ineffective communication has been identified as a barrier for collaboration in the health professions by a number of scholars in the literature (Baggs & Schmitt, 1997; Beattie et al., 1996; Coeling & Cukr, 2000; Freeth, 2001; Gaskill et al., 2003; Hamric & Blackhall, 2007; Kearney et al., 2000; Legris et al., 2000; Lockhart-Wood, 2000; McClougen & O'Brien, 2006). In some instances, ineffective communication was associated with a lack of interaction skills among health care professionals (Coeling & Cukr), poor patient care (Freeth), and inadequate articulation of treatment goals (Baggs & Schmitt; Lockhart-Wood). In most cases, however, the factors contributing to ineffective communication and the consequences of the fallout that occurs among health care professionals when communication is ineffective are not reported.

Participants in this study identified a number of issues pertaining to ineffective communication such as misinterpretation of the sender's message, not hearing what the sender had to say, selective hearing and interpretation of the message if it was not what the recipient wanted to hear, and not receiving updates on clients when other members were involved in some aspect of the client's care. The methods participants used to deal with the issues of communication were equally ineffective. Frustration often ensued, there was circumvention of the discussion through avoidance, and there was an overriding concern of being perceived as too critical or unapproachable. As a result, participants would shut down and the issues would not get resolved.

Some participants expressed their resentment toward a reliance on the use of email to communicate. Certainly for other types of collaboration, such as inter-agency and inter- organizational collaboration, email was thought to be a useful tool for keeping collaborators updated on the progress of an initiative (Kearney et al., 2000). However, this was not the case for some participants in this study who believe that communication was best facilitated through face-to-face exchanges. The use of email was perceived as being unidirectional, directive, and simply sending information with little or no opportunity to engage in a discussion, share ideas, or participate in problem-solving. There was always the risk that communicating by email would reach some members but not others, and that participants would feel embarrassed from being left out of the loop. More often than not, meaning was lost in the translation.

Interactional Dynamics and their Influences

Interactional dynamics of collaboration was given particular attention in this study to determine their impact on the participants of the Program. The work completed by San Martin-Rodriguez et al. (2005) has helped establish that collaboration is very much an interpersonal process requiring, in addition to the interpersonal skills of members, a general willingness on behalf of members to achieve a common vision. The interactional dynamics occurring between any given participant and the other members of the Program had a significant role in achieving the outcomes of their collaboration. Interestingly, there were similarities in the dynamics participants identified when they interacted with the other members of the Program. They identified the interpersonal attributes and processes they believed

were necessary for successful collaboration. As a result, the underlying meanings participants assigned to the interactional nature of collaboration provided an interesting and detailed description.

The interpersonal attributes and processes participants believed to be essential for successful collaboration were: quality communication, respect, and trust. As pointed out earlier, communication, respect, and trust are among the most consistently identified concepts that have been linked to collaboration in the literature. For participants, exhibiting these attributes and processes was as important as perceiving them in others.

Communication is essential for collaboration because it is a process that promotes decision-making and problem-solving among the collective (McCloughen & O'Brien, 2006), is helpful in constructively negotiating best outcomes (Henneman et al., 1995), and act as a catalysts for other interactional determinants that enhanced collaboration, such as respect and trust (Henneman et al.; McCloughen &O'Brien). Participants in this study described what they believed to be essential features of quality communication. Quality communication for some participants was feeling that they had effectively delivered their message to another person, and that person was able to interpret it as it was intended. For others, it was being able to deliver a thought, an idea, or a suggestion, and have it affirmed by another through feedback. Communication was thought to encompass both talking and listening. It was not only sharing ideas, but also listening to others. One understood the intentions of another, even if one was not in agreement with what was said.

Trust had no association to the level of self-confidence one possessed about skills and knowledge as Henneman et al. (1995) had suggested. Trust was more often

described by participants as having a sense of not feeling judged by the other members of the Program. Participants were also careful to say that to earn the trust of the members required the others not be judgmental on their part as well. They were the first to admit that they were not perfect. They were just as capable as the other members for making mistakes.

Trust was expressed in the words and actions of the members. It was knowing which members participants could turn to with their issues because they felt they could be trusted implicitly. The majority of participants described trust as feeling safe and comfortable with others, without feeling criticized or dismissed. More importantly, it was having a sense of comfort knowing that their concerns would be addressed.

All of the participants wanted to be respected and valued by the other members. For the majority of participants, feeling valued consisted of being recognized for having made valuable contributions toward the collective and positively impacting clients and their families. Participants wanted to show their respect towards others. They believed respect was evident when members were valued for their different ideas and opinions. Respect was closely aligned with the recognition that all members had something offer. Even if participants felt they were not in agreement with members' views on all occasions, or if they had different opinions on everyday issues, it was important to them that they showed respect towards others.

Respect was also viewed by some participants as an engagement between both the self and another. Engagement was marked by mutuality and a genuine interest in each other. This was as significant as having mutual appreciation for each other's role in the delivery of care for a client. These views correspond with earlier

observations made by Evans and Carlson (1992) and Martin and Coniglio (1996) that respect for each profession's contribution to patient care is achieved when members understand and accept each other's expertise and role.

The notion of receptivity is described by various scholars (Baggs & Schmitt, 1997; Henneman et al., 1995; Sicotte et al., 2002; Stichler, 1995) as demonstrating a willingness that is conveyed through commitment and the belief in the benefits of collaboration. It was interesting to observe that this was not expressed as an interactional determinant of collaboration by participants in this study. A willingness to collaborate was associated more with the commitment participants felt toward the aims of the Program and obligations of duty they felt toward the clients and their families. The benefits of collaboration were more aligned with how they and their colleagues had responded to collaboration and in the opportunities that existed for health care professionals who could successfully collaborate.

Receptivity was more aligned with the attribute participants identified as openness. The notion of openness was an important attribute for participants, and it encompassed a number of defining characteristics not found in the current literature. Openness was generally described as being receptive to others and their ideas; and apparent in one's body language, especially in one's gestures towards another.

Being receptive to ideas involved listening to others' concerns and opinions with patience and tolerance. In some cases, participants believed that openness helped achieve a heightened awareness of opportunities and solutions that they would not have otherwise thought of themselves. Openness was also perceived by participants as being approachable to others. If a participant was considered to be approachable, the other members felt that they were going to be respected and supported. Being

approachable required having a sense of security about oneself. Good collaborators, according to the participants, were people who were secure within themselves and conveyed an open stance toward others. Openness was perceived as a willingness to relinquish control over another. While it was not necessary to be in agreement with all members at all times, the act of being open was demonstrating an effort to listen and understand another's point of view.

There was no question that participants believed their interpersonal relationships with the other members of the Program to be essentially linked to collaboration. There were moments during the interviews when participants appeared struck by the realization that the interpersonal relationships they had formed with the other members had a substantial impact on the processes and outcomes of their collaboration. It was, in fact, their ability to create and sustain their interpersonal relationships that determined the quality of their collaboration.

Forming a Common Vision of Collaboration

While most definitions of collaboration emphasize the need to achieve a common aim (Apostolakis, 2004; Bryne & Hansberry, 2007; Himmelman, 1996) or a common sense of mission (Davoli & Fine, 2004) among the collective, they lack in describing the characteristics needed for achieving a common vision. Moreover, while scholars such as Brown et al. (2006) have suggested that it is most likely the formation of meaningful relationships that facilitate the achievement of a common vision of collaboration and its ultimate success in a given context, little progress has been made examining this connection, especially for health care professionals engaged in interprofessional practice. There have been only a few scholars, to my knowledge,

such as Gerardi and Fontaine (2007) and Dutton (2003) who have moved the practice of collaboration beyond the mere structural processes needed to achieve desired outcomes, to more life-affirming aspirations and practices that create conditions for making their collaboration more alive and meaningful.

When participants were asked to describe what forming a common vision of collaboration meant to them, it was obvious from their perspectives that this aspect of collaboration was the least understood. For some, forming a common vision was similar to the goals they had identified for collaboration, as well as the overriding goals they expressed for the Program, which was to optimize the health and wellness of the clients. For others, a common vision of collaboration involved a necessary engagement with members to achieve the same beliefs about collaboration.

Reaching an understanding of collaboration among the collective was both important and necessary for collaboration to be reflected in their practice. The consensus was, however, that the members of the Program had not formed a common vision of their collaboration. Having arrived to the Program with their own individual beliefs about collaboration, and not ever having entertained the notion of forming a common vision of collaboration, participants believed that differing views among members would be difficult to reconcile at this point in the Program. There was a realization that it was quite likely that their disparate views of collaboration had a negative impact on their practice, and had them moving in different directions. Certainly additional barriers such as differing personalities, values and attitudes, divisions among members, philosophical differences in their approach to practice, and ineffectual communication were also factors that prevented them from achieving a common vision of collaboration.

While participants acknowledged that forming a common vision was indeed necessary for successful collaboration, they found it difficult to articulate what it would look like and how it would unfold for their Program. They knew that they had to improve their interpersonal relationships, and they could explain how their interactions and the corresponding dynamics affected the outcomes of their collaboration. They were able to identify the interpersonal attributes and processes they believed were necessary for successful collaboration, but they did not see how forming a common vision could facilitate getting on the right path to better interpersonal relations. They did not see it because they were unaware of possibilities forming a common vision might achieve for them. It had not been a recognizable option, nor a route of action to take, despite the successes they had experienced with the other members, such as receiving recognition for their role, reaching consensus, and working well with others.

It was, in fact, their ability to create and sustain their interpersonal relationships that determined the quality of their collaboration.

Study Limitations and Discussion

The quantitative scientific paradigm of medical science has been pre-eminent in health care. Traditionally, science has been less concerned with the lived experience of individuals because these views are largely non-measurable, non-generalizable, and difficult to appreciate through observation alone (LeVasseur, 2003). There are many individuals concerned with the medical sciences of health care who believe that relying on self-reported perceptions without the incorporation of objective independent measures may result in an incomplete picture (El Ansari et al., 2001).

Such a view places limitations for the researcher who must justify why a qualitative approach was selected for the research and whether their findings are generalizable, replicable, valid, and reliable (Creswell, 2007).

While proponents who favour the quantitative paradigm might suggest that it would be difficult to generalize the findings of the study, the value of qualitative research lies in its exploratory and explanatory power (Attride-Stirling, 2001). Qualitative research has the potential to influence policy and practice, because it helps in the identification of strategies (Morse, 2003) and their impact on both the individual and the institution (Eisner, 2007). I think, based upon my experience, members of the health care professions would likely resonate with the interpretations presented. In some instances, as with health care professionals currently involved in interprofessional practice, the interpretations may also be similar to their own lived experience.

As a qualitative approach, phenomenology is particularly challenging because it cannot be reduced to one general set of strategies or research techniques (Van Manen, 2006). Phenomenology leaves one without a "tried and true" methodology as it is dependent on the beliefs, values, experiences, and ideas ascribed from the "particular" rather than of the "universal". And yet, it is precisely knowledge of the particular that sheds light on the individual understanding which is necessary for unraveling the complexities of a phenomenon. The recommendations, arising from a blend of articulations from the participants as well as the contributions as the researcher, can be 'universalized' to the specific notion of collaboration and therefore useful for both policy and practice.

It has been suggested that, with some phenomenological studies, there appears to be an absence of a connection between the method used and a clear statement of the philosophical assumptions that guide that method (Stubblefield & Murray, 2002). Implementing a method without an understanding of its philosophical underpinnings can result in research that is ambiguous in its purpose, structure, and findings. To avoid the imposition of limitations resulting from an approach that can be considered ambiguous in its purpose, structure, and findings, I tried to ensure that a connection was made between the philosophical assumptions of phenomenology and the approach selected for the inquiry, which was interpretive or hermeneutic methods. What makes interpretative phenomenological methodologies appealing is that they necessitate active engagement by both the researcher and the participants. However, there are potential limitations for the researcher that can result in introducing bias and personal opinions in the research (Linseth & Norberg, 2004). Gilgun (2006) made the following argument:

> Personal and professional values and personal experiences are inherent in the researcher making it very challenging if not impossible to set aside our personal experiences as we design, implement, and interpret, and disseminate our research. This does not mean that we impose our personal experiences on participants, just as we do not impose our theories, methodologies, values, and prior findings. To do so would violate a core assumption of most if not all forms of well-done qualitative research. This assumption is the idea that a main purpose of qualitative research is to understand participants in their own terms to the extent that this is possible. (p. 440)

I do not believe it was that difficult to set aside my own personal views of collaboration I expressed in my narrative at the beginning of the inquiry. Even as a novice to phenomenological inquiry, I understood the importance of capturing the experiences of the participants. As such, the interview experiences, the interactions with the participants, and their opinions of collaboration, were extremely meaningful. Their experiences were powerful, and their disclosure rewarding. An injection of my own biases or personal opinions would have been in opposition to the sincere appreciation I felt toward the participants for their vital role in the inquiry.

The hermeneutic approach to inquiry and, specifically, the concept of situated freedom, suggests that a connection exists between the participants' subjective experiences and the social, cultural, and political contexts that mark their existence. As such, it was important to examine all of the possible determinants that have been linked to collaboration. I could not dismiss them as being separate from the inquiry, for to do so would have been in opposition to the concept of situated freedom and the hermeneutic approach. The systemic determinants or the environmental conditions existing outside organizations that San Martin-Rodriguez et al. (2005) identify, such as social, cultural, and professional systems, did have an impact on participants' perceptions of collaboration. Interestingly, none of the organizational determinants or the conditions existing within an organizational setting that San Martin-Rodriguez et al. identify, such as the structure, values, and provision of resources, had any noticeable effect on the participants' perceptions of collaboration. One plausible explanation for this could be that the participants in this study were equipped with a

well-supported and novel program aimed directly at promoting interprofessional practice and the well-being of clients.

There are a host of methodological limitations that can potentially be problematic for a qualitative study. It was essential that the research questions were compatible for the methodology selected for the inquiry. Incompatibility between the research questions proposed for exploration, and the methods used in the design, can produce inadequate outcomes (Creswell, 2007). Although the participants were given a variety of questions on the topic of collaboration, they may have found some of the questions closely associated in wording. Occasionally participants asked for clarification, and some of the questions appeared more challenging than others, but there was no indication to suggest that they were uncomfortable with the approach that was taken. Employing an alternative approach equally suitable for phenomenological inquiry would have been to limit the focus of the exploration to one topic. This approach, however, would have also limited the scope of the exploration and, consequently, the aims of the inquiry.

It was important to select a research setting with a sufficient number of candidates who meet the criteria for participation in the study. Achieving the targeted recruitment can be a challenge for any researcher, and failing to do so would have resulted in limitations for the study. An inadequate sampling of participants can lead to insufficient data, impacting the outcomes of the research, and there can be delays with achieving recruitment. Practicing health care professionals may not have the time or interest in participating in the study. Fortunately, recruitment was sufficient having achieved an original sample size of 11 participants, which ended up being 10,

from 12 possible candidates. To this end, I am deeply grateful to the health care professionals in the Program for their participation in the study.

Despite the fact that the majority of health care professionals from the Program agreed to participate in the study, it was essential to safeguard confidentiality. As the participants worked closely with each other on a daily basis, conducting a subjectively-based inquiry with participants in close association was somewhat problematic. The quality of the interview might have been jeopardized if participants decide to withhold information from fear of being identified by other participants. In this case, participants were willing to, and often did, share some candid views during the interviews. That fact that they did so was an indication to me that they were comfortable with the interview, but there was still a concern that their identities would be revealed if some passages from the interview texts were revealed. After the interviews, a few participants felt it necessary to contact me after they had read their transcript for additional reassurances that I would not incorporate any of the passages that could identify them. For that reason, I decided that the best course of action was to include quotations I thought would not identify participants and omit those that appeared revealing or inflammatory. Specific client-based scenarios participants shared for describing their successes and challenges for collaboration were purposely omitted from the discussion to preserve their identity.

Despite incorporating these measures, I felt it was necessary to obtain permission from participants to include the quotations I used from the interview text in the presentation of the findings. Participants were sent an outline of their quotations with a request for their review and permission for use. One participant did request that I remove some of the wording in her quotations.

Although the sample was mixed, it was predominantly female. Inclusion of more male-affiliated experiences may have resulted in different views and, consequently, different findings. Participants were heterogeneous in age, gender, profession, and years of experience in health care. The differing characteristics of the participants help substantiate that the similarities found in their responses were due to a commonality in their experiences, and not because the characteristics of the sample were homogenous. Having achieved a cross-section of participants from the various health care disciplines, alleviated the possibility of role dominance and any impact it might have had on the findings.

I also had to carefully attend to the analytic processes I have selected for the study. The steps outlined in Ricoeur's interpretative hermeneutic methodology were followed for the analysis, with an understanding that insufficient attention to the processes could result in inaccurate results. The analysis took much longer than expected. Manual transcription was done without the aid of qualitative software so that I, as the researcher could focus directly on the words of the participants. It was necessary to read the transcripts several times. Participants were also asked to review their transcripts. One participant contacted me to make a few wording clarifications. One participant was not sent her transcript because she had left the Program soon after the interview. As a result, she was withdrawn from the study and the data were not used in the analysis.

Researcher's Narrative of the Research Experience

My scholarly training and experience as a doctoral student over the past six years allowed me to embark on a journey that was deeply interesting and meaningful. In

particular, my experience of undertaking this research was everything I had hoped it would be. As Dutton (2003) once suggested, "If you did not begin with research questions that tapped into your passion and abiding interest in a phenomenon, then it is likely you traveled away from your own center of interest and curiosity" (p. 6). Having the opportunity to conduct this research helped to achieve my goal which was to embark on a subjectively-based and reflexive inquiry that incorporated the experiences of health care professionals actively engaged in interprofessional practice. If my dissertation has illuminated some of the tensions surrounding the use of the concept of collaboration in health care, and, has made a modest contribution with its recommendations to help health care professionals achieve more success in their collaborations, then I have achieved my aims. Certainly the experience I have gained has deepened my understanding of collaboration.

I was fortunate to have found a unique and highly relevant setting for the inquiry, considering that the health care professionals in the Program were immersed in collaboration through engagement in interprofessional practice. Solid recruitment of willing health care professionals from a cross-section of the various health care disciplines was a good indicator that the topic of collaboration was relevant to them, and they were interested in sharing their experiences.

I consider my time with the participants to be first among the highlights that mark my experience. The interview process was particularly enjoyable. The participants were ready, willing, and able to engage in open and honest dialogue. Receptivity was captured through body language, emphasis placed on words, listening to the tone of voice, and watching observable moments of contemplation and concentration.

I discovered that there were many common threads of understanding as to the meaning of collaboration for the participants. Despite using a wide angled lens to explore numerous aspects of collaboration, I felt confident that I had reached the point of saturation just beyond the mid- point of recruitment. I do not believe that increasing the sample size would have garnered any new ideas or added substantially to the findings.

I wanted to engage in a reflexive experience, to satisfy my curiosity of the complex phenomenon of collaboration, and to get at the 'real world' experiences health care providers encounter in their collaborations. Nothing was more rewarding for me as a researcher with such aims than to have the opportunity to explore the 'real world' experience of collaboration, as told by individuals engaged in health care practice. I am forever grateful to the participants for taking the time away from their busy practice to share their views, successes, and challenges of collaboration.

Recommendations for Promoting Successful Collaboration

Participants were able to make a number of recommendations for promoting successful collaboration. While their responses were directed at improving collaboration in their Program, my contribution will be to add to their recommendations and make them applicable to the general context of health care professionals and interprofessional practice. The recommendations are presented as follows:

Improve the Interactional Dynamics of Collaboration

A number of the participants' recommendations were directed at improving the interactional dynamics of collaboration. Participants wanted to be included in the

decision-making process for clients. They wanted the other members to be more appreciative of the diverse network of health care professionals in the Program who were willing and available to contribute their skills and expertise toward improving the health and well being for the clients and their families. Participants also wanted the other members to be more forthcoming when issues arose for the clients and their families. They wanted their conflicts to be dealt with quickly and resolved.

Although participants believed that having different perspectives was an acceptable and even necessary feature of collaboration, it was relational conflict that was problematic because emotional issues hindered the collaborative. Intervening with early conflict resolution to resolve relational conflict would be a useful method to incorporate before issues move beyond the point of reconciliation. I believe that it is essential for health care professionals in interprofessional practice to address their interpersonal issues when they become problematic because they can interfere with the management and care of the clients. If the issues are ignored, they will most assuredly perpetuate. There are a number of approaches available to explore conflict negotiation and resolution and, with the expertise of a trained conflict facilitator, participants could explore both relational and task-oriented conflict, and develop constructive conflict resolution skills they can draw from thereafter.

Participants suggested that yearly team building sessions would help build cohesiveness among members. They also wanted to improve on the attributes they thought essential for collaboration. For example, they wanted members to work on being more open to discussing ideas, and engaging in ways that would achieve quality communication. They wanted someone with expertise, perhaps an external resource person, to make explicit to everyone what the dynamics of a successful

collaboration are. Similarly, they would have wanted such a person to help them resolve their internal differences.

Participants wanted to engage in more social activities and gatherings. Participation in activities with the sole purpose of being to have fun would be a welcoming departure from the intensity of their practice. In the social arena, they might find a new appreciation for differing personalities, values, and attitudes of the members. The few times members had engaged in a social activity were well received. As such, more opportunities for social interaction were desirable because they would help members achieve more social cohesiveness.

One would have to be bit cautious, however, not to overstep the limits of conduct in the social arena. There is always the possibility that members may become too dependant on each other. The type of social activity must be considered as well as the location. Social activities held on site may be preferable to those conducted away from the organization. It would be important for members to set a reasonable limit of activities to be held throughout the year.

Form a Common Vision of Collaboration

Participants wanted to form a common vision of collaboration with the other members of the Program. They wanted to reconcile their differing beliefs about collaboration and make the purpose and goals of their collaboration transparent. They wanted to find a common ground for their practice and to evaluate their progress on an annual basis thereafter.

There are other possibilities as well. In the process of forming a common vision, participants could clarify the meaning of collaboration and their expectations. They could identify the processes they believe were necessary to achieve successful

collaboration. They could express the interpersonal attributes they felt were essential for building their relationships, such as communication, openness, trust, and respect. They could develop life-affirming strategies that would enable their collaboration to be alive and meaningful.

Forming a common vision of collaboration would help participants establish shared priorities by having members discuss their philosophy of practice, and identify the discrepancies that exist in their approaches to care. The aim is to achieve inclusiveness and consensus for a new and revitalized approach to health care practice. As a collective, members would determine together which approach is the most complimentary for meeting the needs of the clients and their families while being careful not to discount one's, or each others', philosophies of practice. But to achieve this, it would be incumbent upon them to adopt a philosophy of practice that is mutually agreeable because they all come from various health care disciplines and have different backgrounds of experience.

They would have to incorporate processes in their negotiations that would enable them to be on an equal footing. This might be challenging given that health care professionals, on the most part, are used to operating within a traditional and hierarchical model of care. Not every health care professional, by their profession alone, is situated equally in the negotiation process. For example, physicians are the forerunners of the decision-making process because they possess the power to decide whether or not, and to what extent, collaboration will happen with other health care professions. In this case, there is also a manager who functions in a leadership role as administrator of the Program. Thus, it is essential for all collaborators to act as leaders in formation of a common vision for their collaboration. A focus on

prioritizing the needs, or even involving the clients and their families who attend the Program, can also help in deciding which approach is best. Additionally, having members revisit the common vision on a regular basis would help to keep the vision alive and allow them the opportunity to respond to any issues and resolve task conflict that may arise as they move forward in their practice.

Incorporate Care Planning and Case Studies

Participants recommended incorporation of care planning, including multidisciplinary rounds, to promote collaboration. The vision of care planning was expressed as a way to bring various health care professionals together to conduct case reviews, discuss issues for the clients and their families, and engage in problem-solving. Care planning facilitates shared decision-making, which is an essential feature of collaboration, but each member must be prepared and be willing to provide his/her input. Action-based goals for the client would be determined from input of all members. Care planning would be undertaken according to a regular schedule. The expectation would be that all members attend so work schedules and availability would have to be scheduled in advance.

Additional suggestions were to incorporate case studies that highlighted the successes and challenges of collaboration for discussion among the group. Gaining exposure from other well-functioning collaborative teams would provide insight as to how other teams achieved success with their collaborations. Participants identified two similar Programs existing in Canada and the United States that could be consulted to deepen members' understanding of their experiences and outcomes.

Make Collaboration an Imperative for New and Prospective Employees

Tschannen (2004) recommended that recruitment of health care professionals

must be those who understand that health care is at its best when health care professionals work collaboratively as members of a team, and are committed to providing the best possible client care. Participants echoed this recommendation by suggesting that all prospective employees be considered carefully. They wanted collaboration to be made a priority and included in the interview process for all prospective employees to be given the opportunity to articulate their successes and challenges. They wanted the selection of health care professionals to be from those who had prior collaborative experience and demonstrable proof that they could collaborate. They wanted collaboration included as a topic in the organization's orientation session for all new and prospective members. Most of all, they wanted the employer to be transparent with expectations of collaboration, and to ensure that all new and prospective members understood the expectations and were agreeable to them. If there was resistance, they were likely not seen as the most appropriate fit.

Bring Collaboration to the Forefront of Practice

A number of the recommendations to bring collaboration to the forefront of interprofessional practice were made. Not only was it essential to promote collaboration in the practice of health care, it must be actively facilitated as well. Health care professionals must be willing to embrace the notion of collaboration and keep it in the forefront of their endeavours.

The design and structure of the Program is a unique and promising departure from the more traditional models of health care. It represents what Herbert (2005) would identify as a major culture shift that requires dedication, commitment, and time. To achieve success is with the understanding that collaboration will not happen overnight. Health care members must be prepared to engage in ongoing and

regularly scheduled evaluation of their progress. They must understand that issues may arise especially when collaboration is problematic.

A good example can be drawn from participants' issues with time. The necessity of expending more time dealing with overlap of care for the clients, the follow-up that was needed, and the resultant confusion that occurred, prevented participants from investing the time they needed to build more positive collaborative relationships with each other. With processes in place that facilitate ongoing evaluation of their issues, there is more likelihood to have them resolved.

Preparing Future Health Care Professionals for Interprofessional Practice

More emphasis on educating health care professionals on the concept of collaboration was recommended. A number of participants believed that preparation of students from the various health care professions at the early stages of their professional development, and allowing more exposure to each other's profession, were necessary to achieve a better understanding of collaboration and would result in a more consistent approach to collaboration when moving forward into practice. Having more exposure to the other health professions would be advantageous in the sense that it would help prepare health care professionals for collaborative practice, and they would gain more insight and perhaps more of an appreciation for the contributions various health care professionals could bring to the practice setting.

These views have been supported by Herbert (2005) who suggests that schools must accommodate collaboration in their curricula. Collaboration could be facilitated, as Lindeke and Block (1998) encourages, by integrating students in education across the various heath care disciplines. Since collaboration is an important but complex phenomenon, it is incumbent for leaders in the educational

field to treat it as such and advocate for more collaboration among the various health care disciplines (Herbert, 2005).

Herbert (2005) also recommends that the use of role models and mentors from the various health care professions are necessary for both the educational and practice settings where there are those that have a good understanding of how their skills and expertise can facilitate collaboration to enhance the care of clients and their families. Given the essentialness of these aims, role models and mentors across the professions are the leaders who can create the right environment to bring positive change. In the educational setting, they can promote the value of collaboration in the early years of students' educational experiences. In the practice setting, they have the ability to influence other health care professionals through example and can actively facilitate the movement of collaboration in a productive direction.

Program managers and site administrators with demonstrated leadership qualities can also enhance collaboration in the practice environment. They are responsible for the daily management of their programs and, therefore, they have a good understanding of the relationships taking place among various members. Professional associations, universities, health organizations, and governments, who seed change through grants and contracts, can help bring collaboration to the forefront of practice with more financial incentives for developing, testing, and publicizing collaborative models.

Directions for Future Research

Despite the fact that collaboration is a popular and important concept for health care, more effort is needed to understand collaboration as it pertains to interprofessional practice. To do so, however, requires one to deal with potential

limitations, such as finding appropriate settings where collaboration is actively promoted, having access to a cross-section of disciplines, and finding health care professionals who are available and willing to participate in the research. If these limitations can be overcome, as they had been in this study, then the interprofessional practice setting is an ideal environment to explore collaboration.

The geriatric setting proved to be an excellent environment for exploring collaboration in interprofessional practice where the complexity of needs for the clients can be attended to by the expertise of providers from a variety of health care professions. However, as was evident from this study, disparate approaches of care by the health care providers can create barriers for collaboration. This finding was particularly disconcerting because it interferes directly with the aims and goals of collaboration. Thus, future directions for exploring the impact of collaboration on best practices in caring for elderly are warranted.

Although the use of subjective-forms of inquiry have their place in health care, quantitative methodologies have predominantly been the preferred approach to study collaboration. The methods used for this study were effective for exploring the meaning of collaboration and gaining an understanding of the interactional determinants of collaboration. There is ample opportunity to gain insight from the experiences of health care professionals and their collaborations from any number of the specializations of health care. As such, more effort to incorporate more subjective forms of inquiry to study collaboration is encouraged.

If clients and families are given the opportunity for inclusion in the collaborative arena, their leadership can be instrumental for inducing positive changes to the health care system. Inclusion of the clients' perceptions of health care professionals'

collaborations in interprofessional practice would have added an interesting dimension to the inquiry. Although this study did take into consideration the participants' perspectives regarding the outcomes of their collaboration and its impact on the clients, exploring the outcomes of collaboration from the perspectives of clients and on their satisfaction of care in particular would be topics worthy of pursuit. The specialty of geriatrics may not be the best setting given that clients are often faced with cognitive decline and memory impairment, but there are many opportunities available in other specialties across the continuum of health care.

This study begins to identify the discrepancies that exist in participants' perceptions of collaboration and the actual behaviours they exhibit in practice. It is reasonable to suggest that, in some instances, individual perceptions of collaboration and the actions exhibited do not always match up or compliment each other. These inconsistencies become even more evident in the relations health care professionals have with one another. Thus, future directions for this specific inquiry would include facilitation of the recommendations for participants through intervention and agreement, allowing time for participants to incorporate the recommendations, and then exploring their experiences to evaluate whether the recommendations were helpful for improving collaboration and their practice.

Conclusion

Although considered to be popular concept for health care, collaboration is often host to numerous ideas that have not been fleshed out, it is comprised of an activity or set of activities that cannot be pre-determined, and it is focused on a practice which is more commonly dependent on structure. Given that the intent of the

dissertation was not to generate theory *per se*, I believe the research has contributed to the theoretical development of the phenomenon of collaboration in a number of ways. The findings of this study suggest that collaboration is a genuinely experiential phenomenon: it is a human process requiring thinking, action, and collectivism on the part of health care professionals. It is fundamentally about building relationships, the life source of which stem from the interpersonal attributes such as quality communication, openness, trust, and respect. For many health care professionals, however, the reality is that such attributes are not always visible in the practice environment, nor are they easily attainable without being carefully cultivated and nurtured.

The multiplicity of disparate views so often associated with collaboration can be mitigated if collaborators participate in forming a common vision of their collaboration. This requires leadership on the part of all health care professionals to negotiate and agree upon the essential processes they believe are necessary for collaboration to unfold. Since collaboration is an ongoing and evolving process for health care professionals engaged in interprofessional practice, their continued leadership is also required to revisit and reshape their vision of collaboration over time.

From the standpoint of the participants in this study, more opportunities exist for health care professionals who have the ability to collaborate than those unable or resistant to it. Participants wanted to collaborate to produce the best outcomes and optimize the health and wellness of the clients, but relying solely on these aims was not enough to prevent the challenges from impeding their practices. Undoubtedly, the challenges such as differing beliefs about collaboration, differing personalities,

values, and attitudes, a marked division amongst the team, different philosophies in approaches to care, issues with time, and, ineffective communication which participants experienced had a significant impact on their relationships with one another, their practice, and on the clients and their families.

These findings resulted from the application of an interesting approach to study the concept of collaboration. Acquiring the 'real world' experiences of health care professionals engaged in interprofessional practice has generated a number of recommendations that can be offered to multiple stakeholders who are a part of the community-based geriatric setting, as well as extended to those across the various domains of health care. Collaboration is, and will always be a fascinating concept for health care. It is not to be assumed, assimilated, or taken for granted, but it should have the rightful attention from health care it appropriately deserves.

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Appendix A: List of Terms

Health Care Professional

A health care professional refers to any qualified individual who participates in the delivery of heath care such as a licensed physician, nurse, pharmacist, physical therapist, and occupational therapist.

Interprofessional Education

Interprofessional education occurs "when two or more professions learn with, from, and about each other to improve collaboration and the quality of care" (CAIPE, 2002, as cited in Onadsen & Reeves, 2005, p. 24).

Methodology

Methodology is the "general approach a researcher takes including both the data collection techniques and the theoretical assumptions they bring to the study" (Bogden & Biklen, 2007, p. 273).

Patient

A recipient of health care under pathological circumstances.

Phenomenology

The study of "phenomena" or "things" (Cohen 1987).

Phenomenological Study

A phenomenological study "describes the meaning for several individuals of their lived experiences of a concept or a phenomenon" (Creswell, 2007, p. 57).

Qualitative Research

Qualitative research is "an approach to social science research that emphasizes collecting descriptive data in natural settings, uses inductive thinking, and emphasizes understanding the subjects point of view" (Bogdan & Biklen, 2007, p. 274).

Appendix B: Education/Nursing Research Ethics Board Approval Letter

UNIVERSITY OF MANITOBA | Ethics
Office of the Vice-President (Research)

CTC Building
208 - 194 Dafoe Road
Winnipeg, MB R3T 2N2
Fax (204) 269-7173
www.umanitoba.ca/research

APPROVAL CERTIFICATE

November 1, 2010

(Advisor J. Wiens)

TO: **Alanna Baldwin**
Principal Investigator

FROM: **Stan Straw, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2010:114**
"Exploring the Interactional Determinants of Collaboration on Interprofessional Practice in Community-based Geriatric Care"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **If you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to the Office of Research Services, fax 261-0325 - please include the name of the funding agency and your UM Project number. This must be faxed before your account can be accessed.**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/ors/ethics/ors_ethics_human_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

Bringing Research to Life

Appendix C: Research Subject Information and Consent Form

Project Title: Exploring the Interactional Determinants of Collaboration on Interprofessional Practice in Community-Based Geriatric Care

Researcher: Alanna Baldwin (PhD student)
Faculty of Education, University of Manitoba
Telephone: (xxx) xxx-xxxx

Thesis Advisor: Dr. John Wiens
Faculty of Education, University of Manitoba
Telephone: (204) 474-9001

Sponsor: None

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Introduction and Purpose of the Research

Collaboration is an important concept for health care given the need for health care professionals from different disciplines to work together to deliver quality patient care. And while collaboration has gained popularity in recent years, having a clear understanding of what collaboration means and how it can be successfully achieved for health care professionals who must work together in practice is challenging. The purpose of the study is to explore the meaning of collaboration from the experiences of health care professionals and identify the processes needed for health care professionals to work together to deliver quality patient care.

You are being asked to participate in this study because you are a practicing health care professional of [*the Program*] working with health care professionals from other professions to care for the elderly in the community. Please take your time to make your decision about participating in this study. You may discuss it with anyone you wish before you make your decision. If, at anytime, you have questions about your participation, please feel free to contact the researcher, Alanna Baldwin, at (xxx) xxx-xxxx.

Study Procedures

You will be asked to select a time and a quiet location to participate in one interview that will take approximately 60 minutes of your time. To facilitate the beginning of the interview process, you will be invited to talk about yourself and what brought you to [*the Program*]. During the interview, you will be asked to draw from your experience and respond to the following questions: Can you describe what

collaboration means to you? How have health care professionals responded and reacted to the current emphasis place on collaboration? Can you talk about the successes and challenges you have experienced in collaboration with others? How might health care professionals better prepare themselves and others to work together to improve collaboration? What types of interpersonal dynamics or processes most often occur between health care professionals and their collaborations? What interpersonal dynamics and processes are necessary for health care professionals to successfully collaborate? What does forming a common vision of collaboration mean to you? Prior to ending the interview, you will be given an opportunity to discuss or offer any additional comments. The researcher will help guide you through the interview process.

The interview will be audio-taped to help the researcher produce a written record of the information you have provided for use in the analysis. You will be invited to review your written record approximately two weeks after the interview has been conducted to ensure that the information correctly reflects your experience and to offer feedback for changes where necessary.

Risks and Discomfort

There is minimal risk associated with participation is this study. You may experience discomfort if you are unfamiliar with participating in an interview. You may have difficulty expressing your views, remembering significant events, or understanding the questions the researcher asks. You may find that some experiences may be painful to discuss. The researcher will make every effort to minimize any discomfort you may experience. You do not have to respond to any questions that may make you feel uncomfortable.

Benefits

You make not benefit directly as a result of your participation in this study; however, your voluntary participation is greatly appreciated. It is anticipated that the results of this exploration will produce some recommendations that will be shared with you in a one-page summary report after completion of the study. You will be asked to provide the researcher with your name and address on a tear-off sheet to receive the summary report. It is anticipated that the summary of recommendations will be sent to you by September, 2011.

Costs

There is no cost for you to participate in this study.

Payment for Participation

This is a non-funded study being conduct by a student to complete the requirements of a doctoral program in the Faculty of Education at the University of Manitoba. No payment will be made available to you for participation in this study.

Confidentiality

Your identity will be treated as confidential in accordance with the Personal Health Information Act of Manitoba and will not be revealed in any reports, written transcripts, public forums, and publications that become available as result of your participation in study. A unique study code will be assigned to you at the beginning of the study and only the researcher involved in conducting the procedures of this study will know the link to your code and your identity. The information available on the audiotapes and the information contained in your transcript will be stored in a locked cabinet accessible only by the researcher. Only anonymized data, or data that cannot be linked directly back to you, will be stored electronically in the researcher's secure password encrypted computer and used only for the purposes of the analysis. Data will be kept for a period of three years and then all paper copies will be destroyed using confidential shredding, the audiotapes will be destroyed by pulling out the ribbon and using confidential disposal, and the database will be deleted.

Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. The thesis advisor for this study, Dr. John Wiens, will have access to confidential information and the data. Your personal information may be required by law. The University of Manitoba Research Ethics Board and representatives of the University of Manitoba Research Ethics Board Quality Assurance/Management Office may review the data for quality assurance purposes.

Voluntary Participation/Withdrawal

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from the study will not have an impact on your position as a health care professional of [*the Program*].

Questions

You are free to ask questions that you may have about the procedures and your rights as a participant in this study. If you have any questions during or after your participation, please contact the following:

Researcher: Alanna Baldwin Tel No. (xxx) xxx-xxxx

Thesis Advisor: Dr. John Wiens Tel No (204) 474-9001

For questions regarding your rights as a participant in a research study, or if you have any concerns or complaints about this project, you may contact the Human Ethics Secretariat at (204) 474-7122.

Do not sign this consent form unless you have had a chance to ask questions and have satisfactory answers to all of your questions.

Statement of Consent

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask questions throughout your participation. You are welcome to contact the researcher, Alanna Baldwin at (xxx) xxx-xxxx and the thesis advisor, Dr. John Wiens at (204) 474-9001. This research has been approved by the Education/Nursing Research Ethics Board, University of Manitoba. If you have any questions regarding your rights as a participant, or concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Secretariat at (204) 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Signature:_____ Date: _____

Printed name of above:_____

I confirm that I have explained the purpose and duration of this study as well as any potential risks and benefits, to the participant whose name and signature appears above. I confirm that I believe that the participant has understood and has knowingly given consent to participate by his/her personally dated signature.

Signature:_____ Date: _____

Printed name of above:_____

ALL SIGNATORIES MUST DATE THEIR OWN SIGNATURE

Appendix D: Letter of Invitation to Participants

Invitation to Participate in a Research Study for the Health Care Professionals of PRIME

My name is Alanna Baldwin and I am a doctoral student in the Faculty of Education, at the University of Manitoba. I am conducting a study that explores the concept of collaboration. I would like to invite you to share your experience of collaboration as a practicing health care professional and a member of PRIME. If you agree to participate in this study, you will be asked to sign a consent form and participate in one audio-taped interview that will take approximately one hour of your time. Your identity and the information you provide will remain confidential.

For more information, please contact me at:
Tel: (xxx) xxx-xxxx or by email at XXXXXXXXX

Thank you,
Alanna Baldwin

Appendix E: Interview Guide

Purpose: To arrive at a detailed understanding of collaboration from the lived experience of health care professionals who specialize in community-based geriatric care. Secondly, to explore the meaning health care professionals assign to the interactional nature of collaboration for themselves and for the collective.

Primary Research Questions:

1) What is the essential meaning of collaboration for health care professionals?
2) What underlying meanings do collaborators assign to the interactional nature of collaboration?

Interview Guide

Note: The probes provided are not inclusive. They are just examples that may or not be used depending on necessity and appropriateness for the actual interview.

1. Could you please first tell me a little bit about yourself? (Warm-up question)

2. Could you please tell me what brought you to PRIME?

Probes: Why PRIME?
How long have you been working for PRIME?
Can you please describe your role?
Can you please describe PRIME?
Can you please describe what working in PRIME means to you?

3. Drawing from your experience, can you describe what the meaning of collaboration is to you?

Probes: Please tell me why you think the concept of collaboration is "in vogue" or popular in health care?
What do you think is the purpose of collaboration?
What do you think are the aims or goals of collaboration?

4. Generally, how have health care professionals responded and reacted to the current emphasis placed on collaboration in health care?

Probes: Can you provide an example (or examples) to show how you have responded to the current emphasis placed on collaboration?
Can you provide an example (or examples) to show how your colleagues in PRIME have responded to the current emphasis placed on collaboration?

5. Can you please describe the successes you have experienced in collaboration with others in PRIME (if any)?

Probes: What impact do you think these successes have had on you as a health care professional?
What impact do you think these successes have had on others members involved in your collaborations?
What impact do you think these successes have for the patients of PRIME?

What types of opportunities exist for health care professionals who can successfully collaborate?

6. Can you please tell me about the type of challenges you have experienced in collaboration with others in PRIME (if any)?
Probes: What types of problems have you experienced?
What types of barriers exist when collaborating with others?
Can you describe from your experience instances where collaboration has failed?
How do you cope with these challenges?
What impact do you think these challenges have for the patients of PRIME?

7. Generally, how might health care professionals better prepare themselves and others to work together to improve collaboration?
Probes: How might you better prepare <u>yourself</u> to collaborate with others in PRIME?
How might the <u>other members</u> of PRIME better prepare themselves to collaborate with each other?

8. What types of interpersonal dynamics or processes most often occur between health care professionals in their collaborations?
Probes: Can you describe the interpersonal dynamics that most often occur in <u>your</u> collaborations with others in PRIME?
Can you provide an example or examples?
How do these interpersonal dynamics affect what it is you want to achieve with collaboration?

9. What interpersonal dynamics or processes do you believe are necessary to for health care professionals to successfully collaborate?
Probes: Why do you think these processes are necessary?
Can you provide an example or examples from you experience?

10. Can you describe what forming a common vision of collaboration means to you?
Probes: Is forming or having a common vision of collaboration necessary for health care professionals to work together?
If not, why is it not necessary?
If so, why is it necessary?
Have you and the other health care professionals of PRIME formed a common vision of collaboration?
If not, can you explain why?
If so, can you explain how? Has it been effective?
What recommendations can you share for how health care professionals can best achieve a common vision of collaboration together?

11. Is there anything else you would like to talk about that we did not discuss here today?