

Factors that influence engagement in collaborative practice

How 8 health professionals became advocates

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ABSTRACT

OBJECTIVE To generate hypotheses regarding factors that might influence engagement in collaborative practice.

DESIGN Qualitative study using in-depth interviews.

SETTING Participants interviewed each other in dyads. The pairing was based upon geographical location and proximity to each other.

PARTICIPANTS Eight professionals from the disciplines of medicine, nursing, occupational therapy, physical therapy, and massage therapy.

METHOD Semistructured interviews, lasting 30 to 45 minutes each, were recorded and transcribed verbatim. The transcripts were read by all research team members using independent content analysis for common words, phrases, statements, or units of text for key themes. At a subsequent face-to-face meeting, the team used an iterative process of comparing and contrasting key themes until consensus was reached. The transcripts were then analyzed further for subthemes using NVivo software.

MAIN FINDINGS Initial findings suggest that some common characteristics grounded in family history, school experiences, social interactions, and professional training might influence collaborative practice choices. The narrative form of the interview broke down interpersonal and interprofessional barriers, creating a new level of trust and respect that could improve professional collaboration.

CONCLUSION This study suggests that life experiences from childhood into later adulthood can and do influence professional choices.

EDITOR'S KEY POINTS

- Rather than looking at how to practise collaboratively, this study looks at why people choose to practise in a collaborative way.
- The use of narratives provided a deeper understanding of the characteristics and experiences that influenced participants' career trajectories.
- An unexpected outcome of this study was that participants found that the act of telling their stories to each other was a powerful experience in itself.

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Collaborative practice “involves the continuous interaction of two or more professionals or disciplines, organized into a common effort, to solve or explore common issues with the best possible participation of the patient.”¹ Much has already been written about the challenges and advantages of collaborative practice in primary care,^{2,3} mental health care,⁴ and palliative care,⁵ and of its role in medical education.⁶

The overall purpose of this study was to generate hypotheses regarding factors that might influence engagement in collaborative practice, with a view to further research and possible trials of interventions. Rather than looking at how to practise collaboratively, this study looks at some of the factors that influence *why* people choose to practise in a collaborative way. While the primary objective of the study was to explore the characteristics and experiences of self-identified experts in collaborative practice through interviews, the use of narratives provided a deeper understanding of the characteristics and experiences that influenced participants’ careers.

Narratives help us make sense of the world around us, and through the telling and re-telling of stories, we construct particular representations of reality. As Riessman and Quinney⁷ point out, it is important to understand the concept of narrative: “all talk and text are not narrative.” Two key components of narratives distinguish them from other forms of discourse: sequence and consequence. *Sequence* refers to the order in which particular events are described in a narrative. The narrator chooses which parts of an experience to highlight, what to describe, and what to leave out of the telling. Thus, a plot is constructed and situated in space and time. In addition, events are connected in a particular order through the telling of a story so that a particular outcome or *consequence* is emphasized.⁸

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METHOD

This exploratory qualitative study emerged from a national meeting to set a research agenda for Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) in 2006 when a group of 6 health professionals expressed an interest in creating a research project by interviewing each other to determine how each of them had become leaders and advocates for collaborative practice. Two additional professionals were added to round out the mix of health professions represented. Thus, a total of 8 information-rich informants who considered themselves to be experts in collaborative care were recruited: 2 physiotherapists, 3 family physicians, 1 nurse, 1 occupational therapist, and 1 massage therapist. All were female. The mean number of years in profession was 29.5 with a range from 13 to 41 years. Participant demographics are outlined in **Table 1**.

Table 1. Participant demographics: All participants were women.

PROFESSION	# OF YEARS IN PROFESSION	AGE CATEGORY (YEARS)
Family physician	13	40-49
Family physician and university administrator	37	60+
Physiotherapist	29	50-59
Nurse	35	50-59
Physiotherapist and college administrator	33	50-59
Occupational therapist	41	60+
Massage therapist	26	50-59
Family physician	22	50-59

Data collection

The semistructured interview guide was prepared by one member of the research team and was reviewed and revised by team members. The interview guide was tested by one dyad, and minor changes were made based on the feedback. All participants were experienced in interview techniques. The pairing was based upon geographical location and proximity to each other.

Participants interviewed each other in dyads so that each person engaged in an individual semistructured interview that lasted approximately 30 to 45 minutes. Participants were asked during the interviews to describe their journey to a personal adoption of a collaborative model of professional practice. Questions were framed in a chronological order from childhood to the present. All interviews were digitally recorded and transcribed verbatim.

In this project, the distinction of researcher and participant was blurred; all of the researchers were

participants and had insider status. In consultation with the Chair of the Ethics Board for Health Sciences Research Involving Human Subjects at the University of Western Ontario, it was determined that ethical review was not required, given that all participants were also the researchers, and the authors gave consent for publication of their quotes by signing off on the manuscript.

Data analysis

The transcripts were read by all team members using independent content analysis for common words, phrases, statements, or units of text for key themes. At a subsequent face-to-face meeting, the team used an iterative process of comparing and contrasting key themes until consensus was reached. The transcripts were then analyzed further for subthemes by an independent research assistant. All transcripts were analyzed using QSR NVivo 2. Each participant was given a copy of the subthemes developed by the research assistant—a form of member checking. All participants came together in a telephone meeting to go through each of the subthemes and provide comments and feedback.

RESULTS

Participants were asked to define collaborative practice and then to develop narratives about their life and their experiences leading up to their successful engagement in collaborative models of practice. Several themes emerged as important for engaging in collaborative practice, including childhood experiences; societal expectations; influential people, role models, or mentors; positive exposure to collaborative environments; and negative experience in non-collaborative environments. Some challenges emerged as well.

Perspectives on collaborative practice

Participants highlighted key attitudes and skills they considered to be elements of collaboration (Table 2). Attitudes included maintaining an open mind, valuing other professions, having an awareness of power differentials, enjoying working with people, being patient-centred, and believing in lifelong learning. The following quotation links the ideas of working together for the benefit of the patient (being patient-centred), being open to discovery and surprise, and being respectful:

There's so little chance that any one person's going to be able to discover what's going to work. It's sort of by definition it has to be a group of people working on behalf of the patient doing that process of discovery. So collaboration for me is about discovery and surprise and experimenting and improvising on behalf of what a person [or a] patient needs or I guess what the

team members need, and the foundations of that are probably respectful, trusting relationships.

Participants emphasized that it is unnecessary or even impossible to eliminate power differences; however, it is important to recognize them:

I think that we can't shift some of the power relationships that exist, ...but we've got to acknowledge that they exist. ...People who are not hung up on themselves holding the power are much more likely to work more comfortably in a collaborative environment. Not that they won't be leaders, not that they won't have authority in some situations (maybe all the time), but they're not needing that for their self-identity.

A positive attitude toward lifelong learning was also emphasized: "I'm always open to learning something new. I think being a generalist is very helpful because I am used to thinking about knowledge as broad and my only having pieces of it."

Key skills included listening, learning from each other, team decision making, communication, establishing trust, and acting respectfully:

Collaborative practice requires mutual trust and respect, sufficient knowledge of each other to, in fact, trust in the skills of the other. That doesn't necessarily mean you had that knowledge before; it means that you create that knowledge exchange very early on in the practice setting, so you can get on with the business [at hand], which is solving the problem for the patient.

Table 2. Key attitudes, skills, and personal qualities

Attitudes
Maintaining an open mind
Valuing other professions
Having an awareness of power differentials
Enjoying working with people
Being patient-centred
Believing in lifelong learning
Skills
Listening
Learning from each other
Team decision making
Communication
Establishing trust
Acting respectfully toward one another
Personal qualities
Introspection and self-reflection
Humility
Confidence

Participants described key personal qualities that defined collaborative practice, such as introspection or self-reflection, humility, and confidence. One participant said about the notion that any single practitioner's self-reflection might lead to appropriate humility, "... Underline that, put it in bold that the self-awareness it's ... the humility, the learned humility." At the same time, self-confidence was also noted as an important quality:

Being confident enough in your own skills, to be able to be in partnership with other people, I think you have to bring something to the table, but [be] humble enough to recognize that there may be someone else at any one time that's better able to do something than you.

Influences on the choice to practise collaboratively

Childhood experiences. All participants began the interview by describing their childhood experiences, in small prairie towns, large Canadian cities, and cities in England. Being open and tolerant, seeking justice and fairness, positioning oneself within a broader global perspective, supporting inclusive friendships, being honest, and encouraging critical questioning were values participants described learning as children:

- "People of all colours and nationalities coming to the house."
- "I think growing up I had a very keen sense of justice and injustice."
- "But in point of fact, open debate and the valuing of opinion and shared decision-making was very much a part of my childhood."

As the quotes above demonstrate, most of the participants described being raised in families that were fairly liberal, open, and tolerant. This could have shaped attitudes and choices they made as adults, for example, their definitions of collaborative practitioners as respecting and valuing others.

Participants described themselves as being very involved in their communities as children, whether they were faith communities, clubs, sports teams, music, or drama: "[W]e were always part of clubs, you know. Brownies and Guides and those sorts of things, and so that sort of participation was really sort of valued and encouraged, [as was] working in groups."

Some described themselves in early childhood as being able to easily move between groups: "I was sort of betwixt and between a lot of different groups, so I could ... find my way into a lot of groupings without being the centre of any of them but could easily move among them...."

This exposure to teams and groups could have helped to prepare these participants for group collaboration

in their professional lives. The childhood feeling of being "betwixt and between" was connected later in this participant's story with listening skills, being open to learning from others, and humility: "I always felt I had so much more to learn, so that I feel that everybody can teach me something and I'm never sure how much I can teach others.... I'm not sure if that's related to ... that part that I never fit or never felt that I fit in throughout my childhood." Participants connected the liberal values and community involvement experienced in early childhood to later engagement in collaborative models of care.

Social norms. Participants described how social norms influenced their career path. Guidance counselors actively discouraged young women from pursuing careers in medicine. As a result, some participants followed alternative health career trajectories: "[A]s a young woman in the '60s, early '70s, ... you didn't, shouldn't really look into medicine. That's too hard to get into and it would not be that great of a career for a young woman."

Influential people, role models, and mentors. All of the participants described people who had been important role models or mentors in their choice of career: "Well, [X] is the leader, the medical leader of the Chronic Pain Team. I should name him because there's no question in my mind that he really showed me what mutual respect and regard really looks like in a health care team."

Positive exposure to collaborative environments. The importance of positive exposure to collaborative environments was emphasized. Participants described a range of contexts in which they were first introduced to collaborative models of care, including community health centres (CHCs), a kibbutz, rural practice settings, palliative care, a chronic pain team, problem-based learning, and the North American Primary Care Research Group (NAPCRG): "It was a street-front clinic, and I was just blown away by the teamwork and what everybody else could contribute to caring for these complex patient situations and family situations that they were dealing with there."

Negative experience in non-collaborative environments. Also influential in participants' decisions to practise collaboratively were the negative experiences they had, even in practice settings where (ostensibly) there were health care teams. Some described personal abuse by supervisors; many described a sense of professional isolation and a devaluing of certain professions.

Emotionally abusive supervisors

If I look at my whole spectrum of team experience and what's influenced some of my decisions and, you know, passion for interprofessional practice,

it's some of the negative ones [that] have influenced me as much as the positive ones, and one that sort of stands out in my mind was being in a team conference and with the physician and the OT and the nurse and a patient had come in and had been complaining, complained bitterly of pain and accusing me of not acknowledging her pain; ... the patient left and the physician turned to me and said, "Well what were you thinking? How come you didn't treat her pain or what, what's going on here?" I opened my mouth here to say what I thought and he yelled at me and said "I don't give a f**k what you thought!"... It's funny how you remember these things. ... I can remember it to this day because it was so totally inappropriate and that would be sort of the very low end of my horrible, horrible team experiences. ... But it really influenced me to think people shouldn't have to work in those environments and people shouldn't have those kinds of communications with each other and it's really important to have respectful communication.

Professional isolation and silos

Many participants had experienced traditional solo practice models in the past, which left them feeling isolated, unable to connect with other professionals to meet the needs of patients, and ultimately, unsatisfied: "When I came there, it was much more a traditional silo. There was a nurse and a doctor on every team; ... we didn't talk to one another and there was very little give and take, and I was very unsatisfied with that."

Devaluing of certain professions

Some participants described feeling devalued and humiliated as students in inter-professional settings, because of the hierarchy between professions:

OT students were the lowest rung on the ladder, in the orthopedic training environment particularly, and the specialists would come into rounds. The medical students would be sitting in the front row; you would greet them; you wouldn't greet anybody else. The physio students would make the tea and the OT students would hold the x-rays up to the x-ray box. The fact that there were perfectly good clips on the x-ray box had nothing to do with anything.

Others noted that attempts to develop collaborative practice were hampered by the hierarchy:

[One physician practised] pseudo-engagement of the community, but [was] really pretty patriarchal in his approach. So I learned from that; I watched that as a participant observer. I watched how hard it is when

you've all got the right language, but in fact you [act] in a way that doesn't allow for participation.

Through negative experiences with rigid hierarchical models of care, participants learned the value of encouraging genuine participation from all team members.

Benefits of, and challenges to, collaborative practice

Benefits of engaging in collaborative practice. Participants described the benefits of practising in a collaborative model as including improved patient care, support and shared responsibility leading to less isolation and burnout, increased work satisfaction, and enjoyment of interacting with and learning from others:

I think that it's very, very difficult to try and do everything for the patient. ... But if you can share some of the responsibility, the evidence is really clear that you provide better care; it's just more possible to do. [In my past work] I was involved with sexual assault, sexual abuse work, family violence, which is really difficult work. It saps your energy; it takes everything out; it doesn't give you much back. But if you're working with other people, you can do it. I've seen this, I've seen people burnt out; you burn out because you get used up. Collaborative practice protects you from being used up.

Challenges to collaborative practice. The main challenges are conflicts over power and turf and the time required to communicate in a collaborative model. Collaborative environments can become the arena in which conflicts over power are played out. Power struggles often emerge during decision making:

I think that choosing to work in a collaborative situation or framework [does] not fit with somebody who has an issue with power. ... If that is an issue and they have trouble with sharing this power or the decision making, then they would not be drawn [to] or comfortable [with] or ... able to even survive in that kind of situation without creating a lot of conflict.

Sometimes, the struggle to carve out a space for one's professional turf, advocating for one's profession, is at odds with the nature of collaborative practice: "[B]eing in a female-dominated career that was very much in its developmental stages, we were very much advocating for the profession, which in some ways was in conflict with being collaborative."

Collaborative models of practice do take more time. Team members must be committed to the belief that the patient benefits resulting from collaboration are worth the extra time involved: "I think often there is a perception that it does take longer, and that's when you see

people kind of rolling their eyes about the team meetings and having to be involved in those sorts of decisions. I think that's a deterrent for some."

Transferring the collaborative style to other relationships and settings

Participants described how they manifest a collaborative approach in other roles beyond practitioner, including administration, research, and teaching:

- "[W]hen I'm in an administrative role, can I also look at fostering relationships with colleagues using those same values?"
- "[T]o do that as an educator, by definition, I need to have other disciplines involved with me and learn from other disciplines in my own educational practice. So from the start of my involvement in teaching medical students, I've been partners with other disciplines."

In addition, participants described applying the same values and principles in their families: "I've approached my kids essentially in the same way, in childrearing... I was real clear about when I was the leader in that team, but still my children were raised in that sort of environment where their ideas mattered, their thoughts mattered, ... a willing sharing of power and influence."

DISCUSSION

One unexpected outcome of this study was that participants found that the act of telling their stories to each other was a powerful experience in itself. The reflective process allowed them to think back to early childhood, linking together significant events and people, making sense of their experiences from the perspective of their current professional practice. Doubtless, the stories would be told differently if told again to another listener, with new vignettes highlighted and others left out of the telling. In this way, it is the act of telling their story, rather than the specific content of what is told, that contributes to a feeling of empowerment, in keeping with the literature that emphasizes the narrative nature of medicine and healing.⁹⁻¹³

It is important to note that participants did not know each other well before this study. The iterative process began within the relative safety of dyads. After the stories were shared in the dyads, all participants read each others' transcripts and later came together for a group discussion. This process was described as providing a supportive and safe environment in which participants could gradually ease into a group discussion, after establishing trust and mutual respect in the dyad.

While the small number of participants included in this qualitative study precludes broad generalizations based on the results, the consistency in results was notable, among participants and with the objective analyst. As stated earlier, the overall purpose of this

study was to generate hypotheses regarding factors that might influence engagement in collaborative practice, with a view to further research and possible trials of interventions.

The stories told in this study offer insight into key factors that influence adoption of a collaborative style of practising. Several of the participants described being exposed to collaborative practice models and mentors early in their practice. However, negative educational and practice experiences also appear to have been powerful motivators. Poignant examples of negative experiences with associated effects, even many years after the events, point to the lasting effect of these experiences. Participants reported that sharing their stories reinforced their sense of self-efficacy.

Repeatedly, participants emphasized their trust and respect for what each member brings to the team. All participants, including physicians, expressed a preference for a less rigid hierarchy. Core values described by these participants were very similar to those found in other studies on successful team functioning.¹⁴

Limitations

All of the participants in this study were female. It would be interesting to explore whether men engaged in collaborative practice would have different experiences and to explore the factors that contribute to their practice style. Also, the participants in this study played the dual roles of participant and researcher. As such, they were insiders rather than outsiders conducting the research.¹⁵ While this is not necessarily troublesome in qualitative research, it does require reflection on the limitations of the findings. In particular, there could have been some tacit understandings that were shared within the group and that did not come to the surface or were not probed further in the dyad interviews because everyone was unconsciously or tacitly aware of them. In other words, there could be additional factors and influences on the participants' choice to practise in a collaborative environment that remain unspoken as a result of shared assumptions or understandings.

This study has prompted several questions for further study. Can the amplified process of narrative be used as an approach to developing collaborative practitioners? Are participants' self-confidence and willingness to tell their stories factors in their receptiveness to collaboration? Does life experience affect ability to develop collaborative partners (through narrative)? Can personal stories be used to confront and eliminate stereotypes and other barriers to collaboration among practitioners?

Conclusion

The results of this preliminary qualitative study suggest that life experiences from childhood into later adulthood can and do influence professional choices.

Additionally, professional experiences, particularly negative experiences in traditional practice relationships, affect career choices and can lead health care providers to seek collaborative practice models. The use of narrative, or telling one's story, can help to break down professional and personal barriers, helping to build trust and thereby enhancing collaboration. Further study focusing on the research questions identified will illuminate the use of narrative as a tool for facilitating collaborative practice.✱

Contributors

Dr Herbert and Ms Bainbridge conceived and designed the study, performed initial data collection and coding, contributed substantively to writing the article, and approved the final version of the manuscript. **Dr Baptiste, Dr Brajtman, Ms Dryden, Dr Hall, Dr Risdon, and Dr Solomon** were each involved in designing the research, data collection, and data coding. In addition, each contributed to and approved the final version of the manuscript. **Ms Bickford** conducted a secondary analysis of the interview data, wrote the first draft of the manuscript, and approved the final version of the manuscript.

Competing interests

None declared

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